

Journal of the Irish Dental Association

Iris Cumainn Déadach na hÉireann



Mouth Cancer Awareness Day –
results from the 2010 and 2011 events

ANNUAL CONFERENCE
PREVIEW

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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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Working together

The Annual Conference, mouth cancer and benefits of membership are all on the agenda in this edition of the *Journal*.

This is the final edition with Dr Conor McAlister providing the President's message (p58). Dr McAlister has used his time as President of the Association to promote the better oral health of the population, and in doing so has helped to increase the numbers of people coming into dentists' chairs. This is good for the population's health and good for the profession. His work has been in keeping with the fine tradition of service to the profession by the leaders of the Association.

Evidence of Conor's championing of the expansion of Mouth Cancer Awareness Day (MCAD) can be seen in the peer-reviewed papers published in this edition. 'Outcomes from the first mouth cancer awareness and clinical check-up day in the Dublin Dental University Hospital' (pp101-108) and 'The development of mouth, head and neck cancer awareness in Ireland and results of Mouth Cancer Awareness Day 2011' (pp109-113) detail the outcomes of the initiative and the increase in numbers attending over the two years. This is, of course, due to the Association, and particularly the President, encouraging GPs to participate. And the profession has cause to be proud of its wholehearted participation.

If anyone retains the slightest scintilla of doubt about the potential impact of mouth cancer, please read Lia Mills' account of her experience as a patient (pp89-90). Early detection can save a life – and the earlier the detection, the greater the quality of life that the patient is likely to have. Cancer screening is a vital part of every dental appointment.

And staying with oral health, the Chief Executive of the Association, Fintan Hourihan (pp70-74), makes an impassioned plea for a new coalition to advocate change in the provision of such care in Ireland. Fintan points out the nature of the current crisis in the provision of oral healthcare, and argues that everyone concerned needs to get

involved – and to speak out. We need to work together to overcome the difficulties faced by every branch of dentistry.

'Wisdom in the Kingdom' is the theme of the comprehensive programme that has been devised for the Association's Annual Conference, which takes place in Killarney in May. We are all required to complete CPD days and the Annual Conference is the ideal place to fulfil at least some of that requirement. In doing so, we can enjoy excellent company and a couple of days' break from the routine of our work. Please read the preview of the event (p76-84) and I encourage all of you to consider joining us for at least one day of the Conference.

Finally, the *Journal* has been the recipient of some particularly excellent letters in this and recent issues. Our thanks to the authors – the Editorial Board is very well disposed to the receipt of well-argued missives.

I look forward to seeing as many of you as possible in Killarney at the Conference.



Leo F. A. Stassen

Prof. Leo F. A. Stassen

Honorary Editor

A privilege to serve in an extraordinary year

In his last message as IDA President, DR CONOR MCALISTER reflects on an eventful year.

During a recent desk clearout, I came across a sealed letter addressed to Dr Lynda Elliott, President, Metropolitan Branch, IDA. The letter was dated January 17, 2010, and was written in a familiar hand. It read as follows:

"Dear Lynda, Thank you and the Metropolitan Branch for the invitation to become president of the Irish Dental Association for 2011. I am humbled and honoured to be asked to represent the Metro Branch as president of our great association. However, it is with a mixture of relief and regret that I say no to this invitation. Having given it serious consideration, I feel it would be best for me not to accept the nomination at this time. Please convey my sincere thanks to your committee. I wish you luck in your endeavours to find the next president. Yours sincerely, Conor McAlister."

The letter was written with the intention of handing it to Lynda at the emergency meeting of IDA members held on Sunday January 17 at Croke Park. The meeting had been urgently convened in response to the drastic and disproportionate cuts to the two State-supported dental schemes announced in Budget 2010. Over 430 dentists attended the event and the atmosphere was encouraging and uplifting, despite everyone's shock at these changes and the obvious challenges that lay ahead.

The amazing attendance and atmosphere at this watershed meeting prompted a rethink on my part and the letter stayed in my inside pocket. It reminds me of the movie *Sliding Doors*, where two different scenarios are played out depending on whether the Gwyneth Paltrow character catches the train or not! As I write this, my final message as IDA President, I am very happy to say that the letter was never delivered. Sometimes the easy option is not the best option.

It has been a most enjoyable year as IDA President. A personal highlight was the success of Mouth Cancer Awareness Day 2011. Over 700 dentists in practice joined with staff and students at the two dental schools to wage war on mouth cancer and to raise awareness among the profession and the general public. Ireland has shown the lead to other countries with this initiative in the same way that we did when fluoridation of our water supply was introduced 50 years ago. I am delighted to report that, as a result of this initiative, Ireland (represented by the Irish Dental Association) has been invited to join the UK, Italy, Greece and Spain as partners in an EU project designed to raise awareness among dental professionals of oral cancer screening and early detection – see www.oralcancerldv.org. We hope that we can build on the success of MCAD 2011 this coming September.

My year as President has given me many opportunities, including the chance to witness at first hand the continuing hard work of the IDA secretariat and the

various committees in the Association. We are blessed with a wonderfully proactive secretariat, under the leadership of CEO Fintan Hourihan, which continues to improve benefits for members of the IDA/IDU. Not the least of the achievements in the last year has been the establishment of the Irish Dental Union. This has been a lengthy and complex process, which has secured trade union status and thereby significantly improved the negotiating rights of our members.

The commitment and contribution of many of our members to the various committees within the Association never ceases to amaze me. A dentist's free time is a valuable commodity, and yet these members continue to give of their valuable time to work on these committees on our behalf. It is the great strength of our association and we are most grateful for their invaluable contribution. Go raibh míle maith agaibh. My very best wishes to Dr Andrew Bolas who takes over the chain of office at the Annual Conference in Killarney in May. Andrew and his committee have assembled an excellent programme and I would urge you not to miss it!

Finally, I would like to thank Dr Lynda Elliott and the Metropolitan Branch for nominating me. It has been an honour and a privilege. Thank you for the opportunity. Ba mhór an onóir agus pribhléid é dom. Táim an bhuíoch as ucht an deis.

Dr Conor McAlister
IDA President



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Letters to the Editor

JOURNAL OF THE IRISH DENTAL ASSOCIATION

Dear Sir,

Re: Mr P.J. (Seamus) Keating BDS NUI FDS RCS Edin MScOrth DOrth RCS Eng FFD RCSI

Some of your readers may not be aware that Seamus Keating, a leading member of the Irish Dental Association and the Orthodontic Society of Ireland, passed away on December 26 last as a consequence of serious injuries suffered in a cycling accident. He was 61.

Seamus completed his dental degree in UCC in 1976 (BDS NUI), and followed the well-worn path to England where he worked in general practice in Hampshire and Kent. The lure of postgraduate education took him to Warwick Hospital, where he was an SHO in oral surgery, and to the Royal Dental Hospital in London, where he was a registrar in prosthetics in 1978/'79. Following this he entered a three-year programme in orthodontics at the Eastman Dental Institute, receiving his MScOrth in 1982 while also completing his DOrth and FDS examinations.

Seamus returned to Cork in 1982 with his wife Alison, taking up a registrar position in oral surgery in the Cork Dental Hospital. He set up his specialist practice in orthodontics the following year. A great advocate for orthodontics, Seamus was a founding member of the Orthodontic Society of Ireland in 1990. He served as President of the Society in 1997/'98. He also contributed wholeheartedly to the Irish Dental Association where he was President of the Munster Branch in the period 1994/'95. Seamus loved teaching and mentoring, and maintained his connection with Cork Dental Hospital through lecturing in orthodontics and craniofacial biology.

Seamus was inducted into Fellowship of the International College of Dentists in 1996 and was actively involved in the Faculty of Dentistry, RSCI where he was a board member and a member of the SAC in Orthodontics at various times.

Apart from dentistry, Seamus was best known and loved for his gregarious nature and enthusiastic personality. He was a keen sailor and a founding member and first President of the Lions Club, Kinsale. In more recent years he became an avid cyclist, touring throughout Ireland and the continent with different cycling groups. Together with Alison, he completed a Diploma in Art History in UCC in 2004. He had a great interest in history, literature and poetry. When his daughter Fiona set out on her post-university travels, Seamus gave her John Masefield's poem 'Sea Fever' and her brave and evocative recitation of this poem at his funeral Mass will live long in the memories of those in attendance.

It was a great shock to his family, friends and colleagues when Seamus suffered life-threatening injuries while cycling last August. True to character, he showed great fortitude and determination in confronting his paralysis. The constant stream of visitors in later weeks confirmed the deep affection and high regard in which he was held and will be a great source of comfort to his family in the future. Seamus was an inspiration to all who visited him and his buoyant personality, mischievous humour and most generous nature will be sadly missed.

Alison, David and Fiona have lost a wonderful husband and father.

Yours faithfully,

Desmond F.A. McElroy

Dear Editor,

The robust exchanges of views in the letters section of the February/March 2012 (Volume 58, Number 1) edition of the *Journal of the Irish Dental Association* were interesting. I agree with Messrs Batchelor and Stirling: the point at issue is Government policy. In an ideal world, Government policies are based on prior specification, monitoring and competition. In a less than ideal world, where Government fails to specify what it wants, policy develops as a result of human behaviour and anything that happened in the past is policy and Government policy is no policy. Government policy may also be developed by systems analysis. For example, the Department of Finance was subjected to systems analysis following the economic meltdown. Dentists interested in Government dental health policies should Google systems analysis.

Systems analysis follows the what, why, how model. The analysis of structure should state the views of the Department of Finance, Department of Health and all other Government departments, the views of the public, their representative organisations and pressure groups, and the Ombudsman. Why should the taxpayer fund dental healthcare? What are the economic externalities? What are the opportunity costs? What is the scope of the analysis? What are the time horizons?

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Analysis of process analyses how things are organised and done. How should Government-funded dental care be delivered? How can the dental care sector be exposed to competition? How can services be tendered out? What services should not be tendered out? What are the production possibilities for new treatment technologies? What are the production possibilities for new manpower arrangements? What is the difference between efficiency and productivity? How can moral hazard problems be mitigated?

Oral health is not in the market. What is in the market is treatment. The demand for treatment is derived from the demand for health. The demand for treatment is deferred until the patient has adequate knowledge about disease and treatment. Analysis of outcome is therefore a two-level analysis where treatment may be a proxy for both input and outcome, depending on the viewpoint underlying the analysis. Because the benefits of dental treatment are intangible and not easily evaluated, the analysis of outcome is frequently a re-working of the analysis of structure and process.

Executive decision makers in the Public Service want to make choices based on systems analysis. It would be appropriate for the Irish Dental Association to propose systems analysis.

Yours sincerely

Peter Hayden



Members save €1,000 on indemnity costs

Dental Protection’s new schedule of costs now contains savings of over €1,000 for dentists who are members of the Association. Dentists will be aware that there has been a very significant increase in claims against dentists in Ireland in the last three years. While it had been hoped that the increase in 2009/’10 was a spike, Dental Protection has reported a continuation of the trend. They have also noted a similar trend in medical claims, but not to the same scale as dentistry.

The result is a very significant increase in the cost of professional indemnity insurance for dental professionals. However, the introduction of the Dental Complaints Resolution Service (DCRS) will go some way to helping the situation and this is a free service to all members of the IDA. A consequence of dentists’ membership of the IDA, and of their participation in the DCRS, will be a saving of €1,000, on average, for GDPs with three years’ post graduation experience, in their professional indemnity insurance – when compared with similar non-members.

This is, in nearly all instances, a greater sum than the cost of membership of the Association.

Commenting, IDA Chief Executive, Fintan Hourihan said: “The saving of a sum of money greater than the cost of annual membership of the Association ensures that members are getting all of the great benefits of membership and fantastic value too. It’s a very convincing additional argument for being a member and I would extend a warm welcome to any dentist who might have been reluctant to join in the past, to come forward now and avail of the benefits of membership”.



Fintan Hourihan: IDA Chief Executive will welcome new members who wish to avail of the value offered by membership.

Dental sector faces 1,000 job losses in 2012

A new survey of dentists indicates that the sector is facing up to 1,000 job losses in 2012.

The survey found that 86% of dentists saw their turnover fall in 2011. Half of the dentists said they expected turnover to fall further in 2012, and one in four said they believed their practice would be reducing staff numbers in the coming year, including dentists, hygienists, technicians and receptionists.

According to the survey of over 300 dentists, which was carried out on behalf of the IDA by Omega Financial Management, 20% of dentists want to sell their practice but are prevented from doing so because there are few buyers in the market.

IDA Chief Executive Fintan Hourihan said the findings showed how the recession and the cutbacks to dental schemes are affecting

dentists all over the country.

“We have highlighted on many occasions the negative impact the cutbacks to the medical card scheme and the PRSI scheme are having on patients. This survey looks at the negative impacts they are having on dentists and employment. We have already seen 2,000 job losses over the last two years, and if one-quarter of dentists say they are looking at reducing staff numbers, that translates into 1,000 job losses,” he said.

John O’Connor of Omega Financial Management noted that 40% of dentists now expect to have to work until at least age 70, as their retirement plans have been compromised in recent years.

Fintan Hourihan also pointed out that most of the class of 2011 has emigrated to the UK, Australia, New Zealand and Canada.



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Acknowledgement: Dr Brendan Pigott



Dr Brendan Pigott retired recently as Chairman of the Dental Health Foundation after 47 years of voluntary service.

Dr Pigott qualified as a dentist in 1946 from University College Dublin, after which he worked for a number of years in London. On his return to Ireland he worked in private practice in Co. Tipperary until 1957, when he joined the Public Dental Service, first as Senior Dental Officer with Limerick County Council, and later as Chief Dental Officer for the Dublin Health Authority/Eastern Health Board. His interest in and commitment to public health dentistry spans six decades, and is testament to his lifelong commitment to the service of the dental community. Following his retirement from the Eastern Health Board, he continued to work on a voluntary basis with the Dental Health Foundation.

Dr Pigott was a founding member of the Foundation, and has described one of its many positive effects as being its ability to act as an advocate for those who suffer as a result of inequalities in the provision of oral healthcare. It has achieved this by: dental health education programmes in schools; support for those with special needs; and, the recent involvement with mouth, head and neck cancer groups. The role of fluoridation in public health dentistry has also been significant in this country and the Foundation, under Dr Pigott's Chairmanship, has provided the Secretariat to the Expert Body on Fluoridation since 2003. The Foundation currently receives funding from the Department of Health and the Health Service Executive to carry out these roles.

The profession and the public owe a significant debt of gratitude to Dr Pigott. Anyone who has ever worked with him would testify to his gentility, tremendous depth of knowledge, negotiating skills, attention to detail and commitment to getting a job done. We wish him well in his well-deserved retirement.

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Nominations to GP Committee of the Irish Dental Union

The Honorary Secretary of the Irish Dental Union (IDU), Dr Michael Crowe, has informed members that the term of office of the entire GP Committee of the IDU will expire at the commencement of the Union's AGM in Killarney on Thursday May 17, 2012.

A new committee will be constituted annually. Nominations for sections (i), (ii) and (iv) below will be made in writing by each Branch at least 35 days before the AGM of the Union. If no nomination is made by a Branch at least 35 days before the AGM, this position shall be deemed unfilled for that calendar year, unless otherwise determined by a simple majority vote of the Committee.

The membership of the GP Committee comprises the following:

- (i) a representative of each Branch of the Union;
- (ii) two additional representatives of the Metropolitan Branch similarly appointed (total of three Metropolitan Branch representatives);
- (iii) each Branch may also nominate an observer who may attend each meeting as a non-voting member; and,
- (iv) the Committee may fill up to three seats by co-option each year.

Back to Basics



Irish Society of Dentistry for Children

The Irish Society of Dentistry for Children has decided to get 'Back to Basics' at its Annual Scientific Meeting on Thursday, April 26, 2012 in Portlaoise. Professor Bill Bowen (USA) will discuss contemporary issues around caries in 'Myths and Mysteries of Dental Caries'. Prof. Bowen, a native of Wexford, became an Honorary Life Member of the IDA in 2008 for his lifetime of work on caries. He is recognised as an expert in cariology worldwide and has published and lectured extensively.

Management of the anxious child will be reviewed by Professor MT Hosey (UK), who has co-authored the book *Child Taming – how to manage children in dental practice*. Prof. Hosey has an international reputation and expertise in coping with anxiety in a dental setting.

These topics will be relevant to all members of the dental team, so please join us to update your knowledge of caries and behaviour. Registration details are available on www.dentistryforchildren.ie.

UK oral cancer cases on the increase

Oral cancer cases in the UK are increasing, with 6,200 this year, according to figures from Cancer Research UK. This compares with 4,400 cases a decade ago. Most cases are linked to smoking, but alcohol misuse and the human papillomavirus (HPV) infection have also been linked to the rise. Two-thirds of cases occur in men.

Richard Shaw, a Cancer Research UK expert in head and neck cancers based at the Liverpool Cancer Research UK Centre, said: "We have noticed that patients with HPV-related oral cancers tend to be younger, are less likely to be smokers and have better outcomes from treatment than those whose tumours show no evidence of HPV".

There have also been particularly sharp rises in the incidence rates of two specific types of oral cancer linked to HPV: tumours on the base of the tongue, which have risen by almost 90% from 284 to 595; and, tonsil cancers, which have seen a 70% rise from 573 to 1,052. Sara Hiom, Director of Information at Cancer Research UK, said: "It's worrying to see such a big rise but like many other cancers, if oral cancer is caught early, there is a better chance of successful treatment."

European role in IMS for Maria Dowling



Maria Dowling has been appointed the European Waste Manager for Initial Medical Services (IMS). Maria is a qualified Dangerous Goods Safety Advisor (DGSA) and has many years' experience in the shipment of hazard wastes throughout the EU. This appointment follows her most recent role as Dental Manager Ireland for the company. She will be responsible now for the co-ordination and

management of the compliant handling and movement of controlled dental waste streams for all its business locations.

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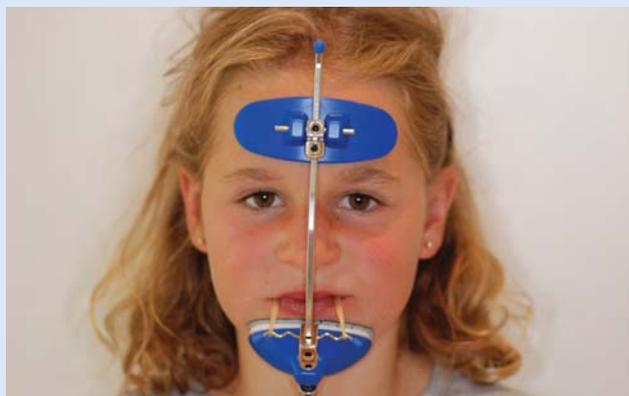
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Quiz

Submitted by Dr Ciara Scott.



1. What is this?
2. What is it used for?
3. How effective is it?

Answers on page 115.

MCAD 2012

Following on from the great success that was Mouth Cancer Awareness Day 2011, the date for the 2012 event has been announced. Mouth Cancer Awareness Day 2012 will take place on Wednesday, September 19. More details very soon.



New Listerine recommendation pad

To support the launch of Listerine Total Care Zero, the new alcohol-free daily mouthwash, the company has produced a recommendation pad to help dentists guide their patients through their personal oral care regime following their visit.

The pad allows dentists to write down advice on brushing, interdental cleaning and mouthwash usage. It also gives the option to select one of the Listerine Total Care products suitable to patients' needs, should the dentist wish to do so.

To assist dentists in deciding which product is right for their patients, the company has added some product information on the Listerine Total Care range inside the front cover.

In addition, Listerine has also included a €1 money off voucher for redemption in store.

To order some recommendation pads for your surgery, simply Email sharkin@its.jnj.com.

Listerine Total Care Zero is available through grocery and pharmacy outlets nationwide and is suitable for patients aged 6+.

Music to our ears

A European Union Court of Justice determination has found that dentists may not be liable to pay for sound recordings played in the dental practice.

The Court ruling was as follows:
 "A dentist who broadcasts phonograms (sound recordings) free of charge in his private dental practice is not making a 'communication to the public' within the meaning of EU law."



Such broadcasting does not, therefore, give rise to a right to remuneration for phonogram producers. Phonographic Performance Ireland (PPI) is a collecting society that represents the rights of 'phonogram producers' in Ireland. IMRO, the Irish Music Rights Organisation, represents composers and music publishers. Whenever copyright musical works are publicly performed, an IMRO licence is required. For most public performances of recorded music, both a PPI and IMRO licence are required.

It appears that the import of the recent Court of Justice decision is that dentists are not obliged to obtain a licence from the PPI when playing a radio in the dental practice. However, the position in regard to the refund of any fees already paid to the PPI and the position in regard to IMRO fees is not clear. We have referred the matter to our solicitors for advice, which we will circulate to members in due course. In the meantime, if any member receives correspondence from either of the above bodies, please contact the Association.

We have written to both the IMRO and PPI seeking confirmation that they will not be seeking further collection of licence fees from dentists.



The cover of the new Listerine recommendation pads, which are available to dentists.

Fluor-Kin toothpaste and mouthwash for children

Pamex Ltd recently launched Fluor-Kin for children between the ages of six and 14. According to Pamex, Fluor-Kin is a patented, child-friendly toothpaste and mouthwash combining fluoride and calcium, to give superior and advanced protection against cavities and plaque. As with all Kin products, the Fluor-Kin range is alcohol free with a very pleasant taste. According to the company, Fluor-Kin has a 16% greater remineralising effect compared with a fluoride only mouthwash. The combination of fluoride and calcium helps to reinforce dental enamel, improves fluoride capacity and reduces excess acid by maintaining an adequate pH in the mouth. The appealing strawberry flavour helps children to develop essential mouth care habits. Fluor-Kin is available in all good pharmacies and through Kin Direct to your practice.



Fluor-kin toothpaste and mouthwash for children is available from Pamex.

An Introduction to Dental Implantology

Course Date: Saturday May 26 2012, 9.00am–5.00pm



- A comprehensive one day presentation for GDPs
- An opportunity for interactive case discussion and treatment planning of potential cases
- A precursor for a one-year modular course in Limerick

6.5 CPD hours awarded

Saturday May 26 2012 at The Clarion, Limerick City (Aquila Room).

www.clarionhotellimerick.com

Tel (00353) 061444100

info@clarionhotellimerick.com

Speakers:

Mr Lloyd Searson, BDS, MS (Univ. of Michigan), FDS.RCS(Eng)

Specialist in Restorative Dentistry

Consultant in Restorative Dentistry, Kings' College Dental Hospital

Mr Kavir Shah, BDS, MFDS.RCS(Eng), M.Clin.Dent, MRD.RCS(Eng)

Specialist in Prosthodontics/Senior Clinical Teaching Fellow

in Implant Dentistry, UCL, Eastman Dental Institute.

Mr Robert Stone, BDS MSc (Con Dent)

Senior Clinical Teaching Fellow in Restorative Dentistry, UCL, Eastman Dental Institute.

Aims

- To provide participants with a fundamental knowledge of biological and biomechanical aspects of dental implantology.
- To provide an insight into the role of dental implants as a treatment option for the replacement of missing teeth.

Learning outcomes & objectives

- The biological concept of osseointegration and common factors that can affect its development and maintenance
- How to assess a patient that potentially requires restoration with dental implants
- The usual treatment sequence associated with the surgical insertion and subsequent restoration of a dental implant
- The role of dental implants in the prosthodontic rehabilitation of more complex cases

Course fee €350 including lunch and refreshments (full fee refundable one month before event).

Please send cheque payable to Shields Dental, with all contact details and Dental Council number to:

Shields Dental Centre, 10 Ashdown Centre, Courtbrack Avenue, SCR, Limerick.

If you have any queries please do not hesitate to contact us by telephone or email.

Tel (00 353) 061 480070 Email Info@shieldsdentalcentre.ie

Course details on www.neoss.com

Income protection stats released

The incomes of many dentists in Ireland are protected against illness and accident through day one income protection policies with DG Mutual, taken out through Omega Financial Management. Their income is protected from the first day of absence from work due to illness or accident.

DG Mutual has released their claims statistics for 2011. The company paid out 99% of claims for the fourth year running. A total of 46% were as a result of infections, with 28% coming from musculoskeletal disorders. Claims increased overall by 7% over 2010 levels.

According to John O'Connor of Omega Financial Management, the recommended adviser for day one income protection by the IDA: "The DG claim statistics further cement the benefits of this product for dentists who require a replacement income from day one when they get sick. Having to wait months before this kicks in doesn't work for them, as they are usually back at work at that stage".



John O'Connor of Omega Financial Management.

Extra discount for online orders



Dentists can avail of an extra 1.5% discount when ordering online from Henry Schein.

Henry Schein Ireland and Henry Schein Minerva offer customers an additional 1.5% discount when ordering online via their website – www.henryschein.ie. Online customers have continuous access to their Henry Schein account, can track their orders, receive instant order confirmation, and manage their accounts and returns.

Henry Schein provides dental practices and laboratories with a wide range of sundries, capital equipment and cabinetry, as well as computer software and surgery design. According to the company, they also specialise in digital x-ray, camera systems and CAD/CAM technology. General Manager Pat Bolger told the *Journal* recently: "At Henry Schein we pride ourselves on cultivating highly experienced local staff who provide expertise in engineering, telesales, field sales consultancy and digital technologies. We have a team of 14 engineers and 11 sales consultants based throughout Ireland. These experts help dentists to build and run their practice. With offices in Dublin, Cork and Belfast, Henry Schein Ireland and Henry Schein Minerva can play an important role in helping dentists to achieve business goals for their practice".

MPS raises issue of deteriorating claims environment at Dublin reception

On February 1, the Medical Protection Society (MPS) hosted a reception in Dublin, where it shared the organisation's recent medical and dental claims experience, as well as the medico-legal challenges on the horizon in Ireland.

The reception, hosted by MPS Chief Executive Simon Kayll, attracted more than 70 people from the healthcare and legal arenas.

Speaking at the reception, MPS



Director of Policy and Communications, Dr Stephanie Bown, said: "These are turbulent times. The numbers [of dental claims] are escalating – last year there were three times as many claims as five years ago".

Dr Bown outlined the possible reasons for the deteriorating claims environment, including high patient expectations and the increased risks associated with advances in technology and complex care.

"In such times, you need strength, security and stability. MPS is here for the long term, and we have shared interests with the health and legal communities of ensuring quality care, patient safety, professional support, and compensation where it is due.

"It's about giving doctors and dentists peace of mind, as well as helping to pick up the pieces when something does go wrong."

MPS has more than 12,000 doctor, dentist and health professional members in Ireland, and more than 270,000 members worldwide.

Dental Protection Limited is a member of the Medical Protection Society Limited group of companies.

TG Medical (Ireland)



Dr. Paul A. Tipton

B.D.S., M.S.c., D.G.D.P., R.C.S.
Specialist in Prosthodontics



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Commencing: Saturday 26th May 2012

Location: Belfast

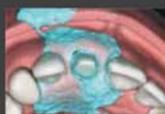
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- Implant Prosthetics
- Fee Planning
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- Marketing Strategies
- Smile Design
- Occlusion
- Adhesion
- Occlusal Splints
- Porcelain Veneers and Crowns
- Posts and Cores
- Tooth Preparation Techniques
- Private Practice Conversion
- Selling Techniques
- TMJ Treatment
- Tooth Wear
- Treatment Planning
- P.F.M. Crowns

"Having completed Paul Tipton's 1 year Restorative Course I can say that I found it extremely useful for general practice. I would recommend it to dentists looking to update or refresh their knowledge at a clinical and theoretical level. I found the occlusion aspect of the course brilliant and have applied them nearly every day since in practice. The variety of topics covered is broad and dips into all areas of dentistry"

*Dr. Annette O'Donovan,
Limerick*

"I found Paul to be an excellent lecturer and team motivator. His practical tips are especially useful in everyday practice"

*Dr. Brian Byrne
Sligo*

Bookings

For further details please contact
Ralf Sander, TG Medical (Ireland)
Telephone: 01-452 4818
Email: ralf@tgmedical.net.

To book a place, a non-refundable deposit of
€1,000.00 is required (this will be offset against
last days course fee). The course contributes 90
verifiable points for CPD.

Wrigleys conversing with the profession

Wrigley's Oral Healthcare Program (WOHP) is undertaking a number of research projects designed to gain a better understanding of dental professionals' awareness of the benefits of chewing sugar-free gum after eating and drinking. The results of this ongoing research will form the basis of a fresh approach to communicating with dental professionals, in order to increase the recommendation 'Eat, Drink, Chew' to patients.



A digital survey sent by WOHP to around 30,000 dental professionals and students in January explored awareness and recommendation levels, as well as asking for feedback about the kind of resources professionals need to help them to communicate the clinically proven benefits of chewing sugar-free gum to their patients. At the same time, WOHP attendance at an extended calendar of events in the UK and Ireland will focus on gaining more feedback from professionals about their approach to recommending sugar-free gum as part of a dental hygiene routine. The feedback from all of this activity will guide the development of a range of on and offline resources for 2012/'13 to complement and support product sampling.

Louisa Rowntree, Communications Manager for WOHP, says: "Talking to dental professionals to improve our understanding of their approach to recommending sugar-free gum to their patients is at the heart of our approach this year. We are focused on increasing patient recommendation, and feedback from research, from key opinion leaders and from the conversations we have with professionals at events and conferences, will guide the development of a range of new resources for dentists, hygienists and patients".

Geistlich biomaterials for dental tissue regeneration

According to the company, Geistlich is recognised as the global leader in dental tissue regeneration. The company says that its flagship products, Geistlich Bio-Gide, Geistlich Bio-Oss and Geistlich Bio-Oss Collagen, have helped to deliver more than four million successful clinical outcomes since the 1980s.

A spokesman stated: "This success comes from an evidence-based approach and scientific focus that also lies behind our Regeneration Support Team of dentally qualified professionals, to provide outstanding in-practice/hands-on training in the use of our biomaterials. Our commitment to the skills development needs of clinicians also includes an unmatched programme of national and international educational courses, all geared to successful dental tissue regeneration".

For further details, see: www.geistlich.co.uk.

Medray introduces Carestream 7600



The Carestream 7600.

Medray Imaging Systems, based in Dublin, is introducing the world's first intelligent plate imaging system, the Carestream 7600, to the Irish market.

According to the company, the CS 7600 sets a new standard in dental imaging, offering an unparalleled streamlined workflow, in addition to all the essential elements a dentist needs to generate outstanding images. This intelligent system automates tasks and combines speed, usability and quality to form one versatile and compact solution that is ideal for any practice.

To obtain a copy of the catalogue or to discuss different product features, dentists can contact Medray directly or meet company representatives at stand number one at the IDA Annual Conference in Killarney.

A new angle on interdental cleaning



The new TePe Angle.

TePe Angle is the new addition to the popular family of TePe interdental brushes, now offering a longer handle and a choice of angles and texture. According to a company statement: "TePe Angle was developed to improve access to all interdental spaces, particularly in difficult to reach areas. The angled head gives perfect access to posterior teeth without the need to bend the wire, thus enhancing their durability. The long and flat handle provides a stable, ergonomic grip and allows access both palatally and buccally.

TePe Angle is available in six colour-coded sizes – pink through to green. All TePe Interdental Brushes have plastic-coated wires for comfort and safety and come with a hygienic cover".

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Change needed

Difficult times call for radical measures and the Chief Executive of the Association is arguing for a new alliance to advocate better oral health.

Fintan Hourihan is a man on a mission. The Chief Executive of the Irish Dental Association says there is a crisis in oral health. That crisis, he feels, warrants concerted and co-ordinated action by everyone involved in the dental profession and oral health business. "At this time of crisis, with an obvious decline in oral health and the withdrawal of the State from supporting dental care, we believe that there is a need for a coalition for change. This should involve the profession, groups such as the Dental Health Foundation, the dental industry, dental academe and everyone with an interest in promoting dental health. It is an uphill battle to promote dental health; therefore, we need a more structured coming together of interests in the dental industry."

And he wants to hear more leaders of the profession speaking out about the consequences of the decline. He is prepared to facilitate them and even to provide a platform where necessary. "It is very striking to me that we have two dental schools with some extremely eminent consultants, but we would like to see those consultants becoming more vocal as public advocates. It is disappointing that there hasn't been more public comment from the leaders of the profession within the dental schools. There are many medical doctors who see it as not only an ethical obligation but also a personal responsibility to advocate for patient rights. Unfortunately it is not something we have seen much evidence of from dental academe. We would like to see more of it; we would co-operate with dental academe in it, and we would facilitate it where appropriate."

"At this time of crisis, with a decline in oral health and the withdrawal of State support, there is a need for a coalition for change."

Serving dentists under pressure

While he says that the Association is in a healthy state, with membership numbers holding up and the level of engagement and activity strong, the economic difficulties are directly affecting dentists in very significant ways. "It is compromising the ability of dentists to continue in practice.



We are mindful that we have to offer great value for membership and offer new services and supports for dentists. We are also enhancing our position as the primary CPD provider and planning to meet the needs of the profession at this time of great change."

Specifically, he says that the Association is providing information that is critically important: "We are giving advice on managing practices; we are communicating with members more than ever through emails, the very popular Dáil digest, new media like Twitter and Facebook; our plans for a new website are advanced; we are ensuring that members are compliant with ever-increasing legislation; we are offering advice on practice management including arranging speakers for dentists on how to generate greater revenue; we are committed to continuing the annual practice management seminar in January; and, we are engaging with the Revenue Commissioners to ensure certainty on the tax status of dental staff.

"On CPD, the information on the Annual Conference is in this *Journal* and we are expecting it to be highly successful again, with ever more dentists attending. We have started a new CPD Committee with Drs Garry Heavey, PJ Byrne, Paddy Crotty and Ciara Scott, and Elaine Hughes. It has developed ambitious plans to bring CPD events to the regions.

"Our *Journal* is going from strength to strength and we were delighted with the satisfaction ratings in the recent survey carried out for us and Omega Financial Management. We are looking at new ways of enhancing the *Journal* with an opportunity for members to get online CPD credits for reading the *Journal*.

"There was a very positive response to us offering access to the *Journal of the American Dental Association* to members. We are looking at similar initiatives to enhance the IDA offering for members. We are planning our three-day seminar for public dental surgeons in Galway in October. These are all actions in support of our members, many of whom feel besieged by the current economic downturn."

"The Association is providing information that is critically important for members, through email, print and new media."

The right to negotiate

Separately, the first full year of the Irish Dental Union is now complete. The decision to establish the Union arose because of concerns that the Association did not have the full legal protection available to members engaged in negotiations.

Fintan comments: "It means that in the event of any attacks on the contractual arrangements of our members, there won't be any challenge to our right to mount a vigorous defence. I think the absence of the threat of industrial action had always been a problem and made the position of the organisation more difficult". And what about the issue of competition law preventing negotiation between the professions and the Government? He says: "There was a view that we were not entitled to represent members

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because of competition law, and that view seemed to be exacerbated by the lack of a trade union licence. There is a danger for bodies without such a licence that they might be left outside the door if and when the competition law issue is resolved”.

Asked about any drawbacks associated with the establishment of the Union, Fintan observes: “There is an amount of time and cost, but for most dentists it has been a seamless change. We have both the Association and the Union established, so we have secured our role as representatives. Now we can move on to enhance our role as the primary CPD provider for dentists and also to develop the advocacy, publishing and scientific remit that has always existed for the Association”.

“Now we can move on to enhance our role as the primary CPD provider for dentists.”

Road map for CPD

And speaking of CPD, it prompts the question: why has the Association felt the need to put that new CPD Committee in place? Fintan says: “With every committee there is a need to ensure both continuity and a steady flow of new ideas and personnel. Dr Garry Heavey is highly respected and he is very committed to promoting CPD for the profession and high standards of dental care. We are delighted that he and others are giving so generously of their time. Many members continue to share their knowledge and expertise with the Association, and we are lucky to be able to call on so many eminent people within our own membership”.

The plan is for the Association to produce a road map for CPD for the next decade. It would take account of existing requirements and anticipate future developments. “We have a very hard working Quality and Patient Safety Committee and there is a great synergy between the two Committees: both are committed to the highest standards of patient care and professional education.”

He cites a recent example of how the Association facilitates best practice in dentistry:

“It is very telling that when the HSE looked to audit radiology in dental practices without the Association’s involvement, it was a dismal failure. Then the Association’s own representatives took on the task and we now see the HSE parading the strong compliance by dentists. Our incoming President, Dr Andrew Bolas, was instrumental in compiling the template for dental radiology, along with Drs Eamonn Croke and Maurice FitzGerald and a number of others”.

The Chief Executive comments that future issues include the Madden Report and the dental requirements for infection control and other related items. There will be a workshop on hand hygiene at the Annual Conference in Killarney and this workshop can be subsequently made available to branches as well.

Dental Complaints Resolution Service (DCRS)

There has been a long-standing policy within the Association to promote an alternative to patients bringing relatively minor complaints to the civil courts, the small claims court or the Dental Council. “Given

the alarming rise in the number of complaints and the associated rise in the size of awards and of legal costs, which are borne by the profession, we felt it was time to launch the Dental Complaints Resolution Service. This has been in gestation over the past number of years and we know from elsewhere that it has been a positive experience for dentists and the public.”

The facilitator is Michael Kilcoyne, who is currently the Chairman of the Consumer Association of Ireland. He is known to some members as a former member of the Dental Council and of the Medical Council. Fintan clearly feels that he is an excellent appointment: “He is a trade union official, so his day job is resolving problems. He has direct knowledge and experience of the dental and medical professions and we feel he has all the skills necessary to assist in resolving complaints. His background should offer confidence both to dentists and to the general public”.

The Association intends to launch the service just prior to the Annual Conference and DCRS materials will be sent to members and other dentists who choose to participate. There will also be a dedicated website.

Oral healthcare

Minister for Health Dr James Reilly has agreed to address the Annual Conference and Fintan says he hopes to get a clear indication of the Government’s intentions in relation to the dental profession. “We did get a pre-election commitment to review the two existing State dental schemes and also to appoint a Chief Dental Officer, and we feel now is the time for action. We hope that Minister Reilly will set out his intentions and his vision for dentistry at the Conference.”

In terms of advocacy for oral healthcare, a new PR Committee is working on initiatives. Last year, Mouth Cancer Awareness Day was a major success. There are plans for another one this year and Fintan says the Association is very grateful to all the members who gave their time freely to promote awareness of mouth cancer. “It will,” he says, “be a lasting legacy for the outgoing President, Dr Conor McAlister.”

The Association is also looking to develop structured communications with the medical profession and with doctors in general practice in particular. The intention is to build a greater awareness of conditions that suggest a referral to the dentist – and greater interaction in general. There have been some discussions with the Irish College of General Practitioners on that issue.

Broad themes

Fintan clearly feels that now that the Association has secured representation rights, it can expand its role as the primary CPD provider for dentists. He states: “I think as an Association we have the following broad themes:

- commitment to CPD;
- support for dentists and their practices;
- promoting high-quality patient care; and,
- advocating and supporting oral health.

We have been very busy and plan to further extend our services to members”.

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References: 1. Data on file 45348, McNEIL-PPC, Inc. 2. Data on file, microbiology dossier, McNEIL-PPC, Inc. 3. Data on file 103-0214, McNEIL-PPC, Inc. 4. Le Geros RZ et al. *Am J Dent* 1999; 12(2): 65-71.

KERRY

Wisdom in the Kingdom



May 17 – 20, 2012

The Malton Hotel, Killarney, Co. Kerry

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Join us to gain some ‘Wisdom in the Kingdom’

The IDA Annual Conference 2012 at the Malton Hotel, Killarney, will feature a fantastic mix of education and fun.

Members of the dental team will gather in the beautiful Malton Hotel from May 17 to 20 for a comprehensive programme of courses and lectures, as well as great social events.

In these challenging times, it is more important than ever for dentists to stay abreast of developments in clinical practice and research. This year’s conference will include courses and lectures from local and international speakers on topics from periodontics to posture, and from endo to emergencies. The scientific sessions have been approved for continuing professional development (CPD) credit, so make sure to obtain and fill in the relevant form each morning and evening from the information desk.

Most general and specialist dentists are also running a business, and our current economic difficulties are making it harder than ever to survive. From workshops on carrying out denture repairs, to presentations on consumer affairs and building better relationships with your patients, this year’s conference offers high quality advice to help dentists to prosper.

With the severe cutbacks introduced in recent years right across the dental profession, it is vital that members come together to keep informed, to protest, and to formulate solutions to our difficulties. This year’s conference will be addressed by the Minister for Health, Dr James Reilly TD, on Friday May 18. In addition to this important address, the GP meeting on the same evening will discuss issues central to general practice, and a presentation aimed specifically at associates on Saturday May 19 will cover legal and taxation issues of crucial importance to this branch of the profession. On Thursday May

17, the IDA and IDU AGMs will take place, and members will have the opportunity to help formulate Association policy by voting on motions and electing committee members.

This year’s trade exhibition will feature more than 40 of the top companies in the dental industry (see map on page 84), so be sure to visit and meet the representatives. We are very grateful to our sponsors for their support; without them, events like the Annual Conference would not be possible.

Finally, from pub quizzes and dancing to golf and hillwalking, the social programme organised for this year’s Conference has something for everyone, culminating in the fantastic black-tie President’s dinner on Saturday night, an event not to be missed.

Kingsley Aikins – guest speaker at Annual Dinner

Former President and CEO of The Ireland Funds and distinguished international speaker Kingsley Aikins will be the guest speaker at the Annual President’s Dinner on May 19.

During his 21 years with The Ireland Funds, Kingsley raised over a quarter of a billion dollars for over 1,200 organisations throughout the island of Ireland. He has built a formidable speaking reputation, and has spoken to over half a million people in 39 cities around the world. In 2008 he was awarded a CBE for fostering British-Irish relations.



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Pre-conference programme



Dr Pat Cleary



Dr George Priest



Dr Don Morrow



Dr Jennifer Irwin



Dr Edward Cotter



Ms Bethany Valachi

Thursday's pre-conference programme features full- and half-day courses and lectures covering both clinical and management issues. Dr Pat Cleary will show you how to develop your routine for endodontics, while Dr George Priest will offer invaluable insight into smile line revitalisation. Drs Don Morrow and Jennifer Irwin will focus on

motivational interviewing skills for dental professionals, and Dr Ed Cotter's half-day practical course will provide participants with the skills to carry out effective denture repairs in daily practice. Finally, Bethany Valachi can tell us how to make the practice of dentistry pain free, at least in the physical sense!



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- Additional cover for children of up to 70% for sealants, space maintainers and stainless steel crowns

Great value

- Dental Plan costs from just €18 per month for an adult, €9 per month for a child

Tel: 094 937 2277

Email: iedentists@decare.com Web: www.ddii.ie

The above summary is intended as a guide only. For full details on our plans and associated terms & conditions, please refer to our website. DeCare Dental Insurance Ireland Limited is regulated by the Central Bank of Ireland. DeCare Dental Insurance Ireland Limited is a registered dental insurance underwriter and administrator. Registration #383762. The Voluntary Health Insurance Board (trading as Vhi Healthcare) is a Multi-Agency Intermediary regulated by the Central Bank of Ireland.



Lecture programme

Friday is dental team day, and presentation topics include: taking a risk-based approach to perio medicine; motivating staff in the dental practice; and, how to deal with challenging patients. Friday afternoon will also feature an address by the Minister for Health, Dr James Reilly TD, and a panel discussion on consumer issues.



On Saturday, lecture programmes are tailored to the needs of each member of the dental team. In the parallel sessions, which are arranged so that delegates can move from room to room to attend the lectures most appropriate to their needs, dentists can learn about how

your oral and maxillofacial surgeon can help you, management of orofacial pain and TMD, and tooth discolouration.

The dental nurses' programme includes lectures on minimising infection risk in the surgery, modern orthodontics and oral radiology for the dental nurse.

Dental hygienists can learn about back health for hygienists, changing patients' habits, and a different approach to debridement, while the dental technicians' programme will cover resin-metal fixed restorations for implant patients, CAD/CAM solutions made in Ireland, and motivating patients.

CPR stations

CPR is a mandatory requirement for continuing dental education. All registered delegates will have the opportunity to take part in a CPR course on Friday 18 and Saturday 19 May. Delegates must register for the CPR courses at the registration desk at the Conference. All members of the dental team are welcome.



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Dr Joe Moloney Award

This year sees the continuation of the Dr Joe Moloney Award, kindly sponsored by the Dental Health Foundation. This award will be given to the presentation judged as Best Table Demonstration by a panel of judges. A magnificent glass trophy will be awarded in perpetuity. We are also asking all those who are willing to present to note that the format specifies a practical demonstration that will recycle in five minutes or less rather than a mini-lecture presentation. A poster presentation, while welcome, will not be eligible for the Award.

Tony Costello Memorial Medal

The competition for the Tony Costello Memorial Medal will be judged on a Table Demonstration or Poster Presentation of not more than 10 minutes on a subject applicable to general dental practice. Each of the three dental schools may enter a team of a maximum of two people. The presentation will be judged on:

- clinical usefulness; ■ academic content;
- presentation; and, ■ originality.

The Irish Dental Association will make a grant of €400 per demonstration.

Audits in hand hygiene – information workshop

The Quality and Patient Safety Committee has been working hard developing new areas of best practice in decontamination. As part of this work, a series of 40-minute hand hygiene workshops will take place in Killarney. Dr Jane Ranehan, Principal Dental Surgeon in the HSE, will conduct these workshops, which are open to all dental team members.

The dental clinician must perform hand hygiene at key points in time to disrupt the transmission of microorganisms. But what is the correct technique for hand washing and using hand gel? Are your hand washing facilities what they should be? In this short session you will answer these questions and come away with an audit tool to record that your hand hygiene meets the HIQA standard.

Workshop times

Friday: 11:00am

Saturday: 9:30am, 11:00am

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Social programme

As always, this year's Conference includes a terrific social programme where delegates can meet old friends and new. Thursday night's team night features a gameshow and quiz night, where popular TV gameshows such as *Family Fortunes* and *The Price is Right* will be mixed in with our ever-popular table quiz. In a fantastic innovation, there's no need for paper or for marking score sheets this year, as it's all done on a wireless digipad. Get your dental team in place to take part in this interactive, fun evening! Spot prizes, music and great fun guaranteed! Friday will feature the trade show party, which all delegates and trade show exhibitors are invited to attend from 5.30pm to 7.30pm in the trade show area.

The emphasis on Saturday morning is on getting out and about, with a hillwalk in the magnificent Killarney Park. Dan Counihan will lead walkers through the National Park at Torc Mountain. Packed lunches can be arranged on request, and walkers should be sure to bring walking boots and waterproof gear. If hillwalking sounds a bit strenuous, but you'd like to get out and about to see some more of Killarney, why not take part in a guided tour of historic Muckross House and Traditional Farms, starting with a trip to Muckross by jaunting car?



Viewing of the House and Gardens and Farm will take approximately two hours, and lunch will be available in Muckross House afterwards. As ever, the highlight of the social programme will be the Annual President's Dinner on Saturday evening. A drinks reception will take place at 7.30pm followed by dinner and dancing. Always a fantastic night, you'd be mad to miss it! On Sunday, another great IDA conference tradition takes place, as the President's Golf Competition visits Mahony's Point Golf Club. All delegates, accompanying persons and trade exhibitors are welcome to play.

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KERRY
Wisdom in the Kingdom



Mouth cancer awareness: what's at stake?

This is a modified version of a speech given by LIA MILLS at the launch of Mouth Cancer Awareness Day 2011. Lia was one of several patients present.



Author and mouth cancer survivor Lia Mills has written about her experiences with the disease.

You've heard it all before. 'If in doubt, get checked out'. 'Early diagnosis leads to better outcomes.' These slogans trip so easily off the tongue, you'd think we all know what they mean, and that they apply equally to all kinds of cancer. But do they? Are oral cancers like other cancers? I'm asking you to think about this, offering my own story as an example.

I should have known

I should have known – doesn't everyone? – that if you have a lump or a sore anywhere and it doesn't clear up within two to three weeks, you get it checked.

I had more reason for knowing it than most, because 20 years ago my sister, Lyn, developed a painful lump in her breast. She was told by several doctors, over the course of a year in which her health deteriorated, that her lump was benign. They put her loss of energy down to other causes. They never even did a biopsy. By the time she ended up in the casualty department of her local hospital, the cancer

that had been in her breast all along had spread to her liver. She was dead three weeks later. She was 33 years old.

So, you see, I really thought I knew. And I went for regular check-ups at a breast clinic, to be sure.

But I didn't know it was possible to get cancer of the mouth, because I'd never heard of it. When a stubborn sore developed in my cheek, the idea of cancer never crossed my mind. I did look for help for this sore, as it spread and became more painful, but the people I consulted thought the condition I had was benign and I took their word for it. A lifetime of avoiding dentists and hoping that if I ignored a toothache it would go away had prepared me for eight long months of putting up with something which, if it had been anywhere else in my body, I'd have taken to a specialist faster than you could say 'emergency'. The irony is that, during those eight months, I sailed in and out of St Luke's for breast checks, and never once mentioned the presence of a tumour, so close to the surface it could be seen by the naked eye. It

never occurred to me that they could be interested in what I thought was a mouth ulcer gone mad. All that time, my mouth was eating me.

The benefit of hindsight

If I, or any of my friends, had known about mouth cancer, I'd have been a lot more persistent about finding clinical help sooner than I did. As for the people I consulted, I believe they were slow to recognise the tumour for what it was because I didn't belong to a recognised risk category: I was a woman, in my forties, a social drinker. I hadn't smoked in eight years. I thought I'd got away with it. At a lecture given to the Irish Dental Association recently, I was very glad to hear it said that the old 'categories' shouldn't be taken into account any more. Suspect lesions need to be taken seriously no matter who presents with them, man or woman, young or old, heavy smoker and drinker or neither.

Early diagnosis means a stronger chance of a cure. That's important. But bear with me a minute, while I say that there's a lot more at stake than that. The effects of treatment are not just cosmetic.

It's not my intention to frighten anyone and I'm certainly not looking for sympathy, but I have a point to make and if I don't say what I mean, I may as well not speak at all. This isn't about me, it's about what's at stake. Any of the patients here today could tell similar stories. So here goes.

Consequences

By the time I was diagnosed, the squamous cell carcinoma in my cheek and gums was advanced (Stage 4) and had spread to several lymph nodes in my neck. I needed radical surgery. Here's what the maxillo-facial team in St James's Hospital had to do:

They split my lip, and then my chin. They lifted my face open. To remove the tumour, they had to cut out some jaw, pieces of cheekbone, several teeth. They peeled away the lining from my cheek and replaced it with fat from my leg; they took the lymph nodes, muscle and nerves from my neck, where the cancer had spread. They took bone from my leg and combined it with titanium, to re-arrange my face into what it is today. And I will never, ever be able to thank them enough, for any of it. When I went into that operation we thought I might lose part of my tongue. We were worried about my eye. They saved them. I should be dead by now, and I'm not.

After surgery, I needed aggressive radiotherapy, which might not have been necessary if the tumour had been caught sooner. I needed treatment in three hospitals: St James's, St Luke's, and the Dental Hospital. My treatment required input from maxillo-facial surgeons, oncologists, plastic and orthopaedic surgeons, dentists, hygienists, nurses, dieticians, speech therapists, physiotherapists; I had complications, re-admissions. My GP had to mop me up several times. Off and on, I spent more than nine weeks in hospital, all because my diagnosis came late. This is not an insignificant, or even a personal, point.

Things to think about

Think of all the money and time that could be saved in the health service

if a small, localised tumour could be removed, almost as cleanly and simply as a tooth.

It doesn't take a genius to see that if you offer cancer time and space to grow, it'll take it. Cancers of the mouth entrench themselves in delicate, sensitive, necessary places, meaning that the effects of treatment can be hard to live with. I'm not just talking about facial disfigurement, although that's part of it. I'm talking about being able to open your mouth without a struggle. To produce a reliable quantity of saliva instead of too much or too little or none at all. The ability to chew or swallow. The sense of taste. The ability to speak or smile can be damaged, or destroyed altogether.

But again, I'm not here to scare people. No two cancers are the same. Everyone's experience of cancer is different. But we have to acknowledge that early intervention is about more than survival, it's about quality of life.

Clearly, I've been lucky. Here I am, five years later, talking to you. I know people who still can't, and never will, eat, speak clearly, or smile again. Think about that. What it would be like. How easy it is to avoid, through awareness and early intervention.

Which would you prefer, if it was you?

Your mouth

Think about your own mouth, just for a minute. What's it for? It might not rank particularly high on your list of favourite body parts. You probably don't think about it at all – unless there's something there that bothers you.

Think about all the living your mouth does for you, how social it is. It's a little like a docking station, where the self encounters the world, where they check each other out, take each other in. It's intimate and public at the same time. You use it to express yourself, to smile, laugh, kiss, talk, sing – how else would you communicate, or respond to other people?

Think how acutely sensitive and knowing your mouth is, how discriminating, if not downright opinionated: sweet/sour, salt/spice, hot/cold.

Imagine a life with no flavour in it. Imagine if you couldn't move your tongue, or lick your lips, or fit your mouth around a double-decker sandwich, or ever yawn a great, big, gorgeous yawn again. Now, think about a cold sore or a mouth ulcer; how excruciating pain is, in those sensitive, silky membranes, so richly supplied with blood and nerves, so talented at conveying sensation. Think how you ignore a toothache, because who has time to go the dentist? Who even wants to go to the dentist?

Think about the relief you feel when you've been, when your mouth is your own again; yours to forget about. If you're lucky.

Think about it, just for a minute.

Your mouth.

How will you use yours, today?

Lia Mills is a writer and a survivor of mouth cancer. She is the author of In Your Face (Penguin Ireland, 2007), a memoir of her experience of mouth cancer.

KERRY

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PRE CONFERENCE COURSES

There are four pre-conference courses on Thursday May 17.

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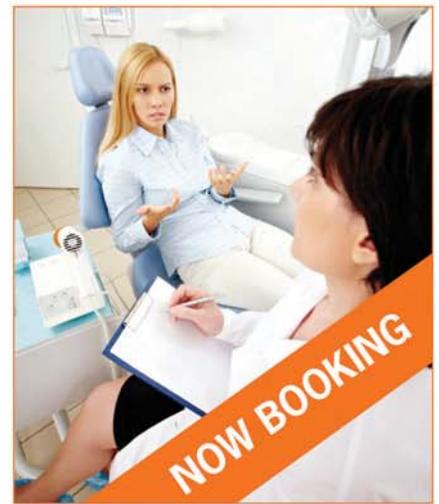
Smile line revitalisation with crowns, veneers and implants

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Oral health: Motivational interviewing skills for dental professionals

HALF-DAY WORKSHOP



NOW BOOKING

These half-day workshops are experiential, practical sessions devoted to hands-on learning of motivational interview skills. Participants will learn applied skills such as: using powerful questions; listening more acutely; moving status talk to change talk; using accountabilities and acknowledgements; rolling with patient resistance; and, shifting perspectives to change behaviour. Our learning objective is focused on how to integrate motivational interviewing tools and skills into professional practice in order to have a greater impact on patient oral healthcare.

The IDA Annual Conference
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A fun-packed educational programme is planned for what is expected to be an outstanding conference.

Contact Elaine at IDA HQ (01) 295 0072

RPII inspections in the dental sector

DR STEPHEN FENNELL explains what is involved in an inspection of a dental practice by the Radiological Protection Institute of Ireland.



Introduction

The Irish licensing system was first established in 1977 with the passage of the Nuclear Energy (General Control of Fissile Materials, Radioactive Substances and Irradiating Apparatus) Order 1977. This legislation has long since been revoked and current regulations are provided by S.I. No. 125 of 2000. The Radiological Protection Institute of Ireland's (RPII) predecessor, the Nuclear Energy Board (NEB), commenced issuing licences in 1977 and by 1985 there were 300 active licences in the medical and industrial sectors. In 1989, the dental sector was brought within the licensing system, resulting in a significant increase in the number of licences issued by the RPII. Since then, there has been a steady increase in the number of new licences issued, and currently there are 1,743 licences issued to licensees in the dental, medical, industrial, educational, veterinary and distribution sectors. The dental sector represents a significant proportion of the licensee base and **Figure 1** shows the number of dental licences for the period 1992-2011.

There are currently 947 dental licensees, and for the most part they comprise private dental surgeries with a single intra-oral dental x-ray unit. Other dental practices currently licensed include the HSE public dental clinics, the two dental teaching hospitals and the dental facilities in prisons and defence force bases, the responsibilities for

which fall under the Departments of Justice and Defence, respectively. In recent years more complex procedures using equipment such as cone-beam CT units are being carried out in dental practices. At present, there are 12 licensees using these units.

The RPII is responsible for ensuring that workers and members of the public are adequately protected against the harmful effects of ionising radiation in accordance with the requirements of S.I. No. 125 of 2000, which enacts the 1996 European Basic Safety Standards Directive. However, its remit does not extend to ensuring the protection of the patient. This responsibility falls to the Minister for Health under S.I. No. 478 of 2002, which enacts the 1997 European Medical Exposures Directive in Irish legislation. Therefore, when carrying out an inspection, the RPII does not consider patient-related issues, such as diagnostic reference levels or clinical procedures. However, patients of the practice are considered by the RPII to be members of the public while they are sitting in the waiting room.

The total number of inspections undertaken in a given year broadly reflects the staff resources available and the priorities identified at any given time. Inspections of dental practices have always represented a small proportion of the total number of inspections carried out each year by the RPII. **Figure 2** illustrates the number of dental inspections



FIGURE 1: Dental licensees for the period 1992-2011.

undertaken in the years 1996 to 2011. The number of inspections carried out in other sectors is also included for comparison.

Purpose of inspections

Each year the RPII undertakes a programme of inspections, which is approved by its Board. In developing the inspection programme, account is taken of the following factors:

- i. radiological risk associated with each category of licensee;
- ii. date of most recent inspection for each licensee;
- iii. number of licensees within each category;
- iv. reported incidents during the year;
- v. issues related to individual licensees;
- vi. recommendations from all inspectors or other relevant personnel; and,
- vii. a policy direction from the Board of the RPII.

As the radiological risk associated with dental radiology is far lower than that associated with, for example, a nuclear medicine or radiotherapy department, a much greater priority is placed on inspections of large hospitals instead of low-risk activities such as dental radiology or DXA screening. However, in line with a proportionate approach to surveillance in the sector, a small number of inspections of dental practices are carried out each year.

In an initiative to assess the overall radiation protection standards since the introduction of the radiation protection adviser (RPA) requirements in 2008, the inspection programmes for 2010 and 2011 included a focus on dental licensees. Over the course of these two years, 107 inspections were completed in dental practices in both the private and public sectors. One hundred and three of these were planned and the dentist given advance notice of the date of the inspection, three were unannounced, and one was undertaken as a result of a concern from a member of the public who had contacted the RPII. The findings of these inspections are currently being analysed and will be taken into account in the development of a new graded approach to authorisation, which will look at introducing alternative models to licensing in the future.

While inspections are undertaken to assess compliance with legislation

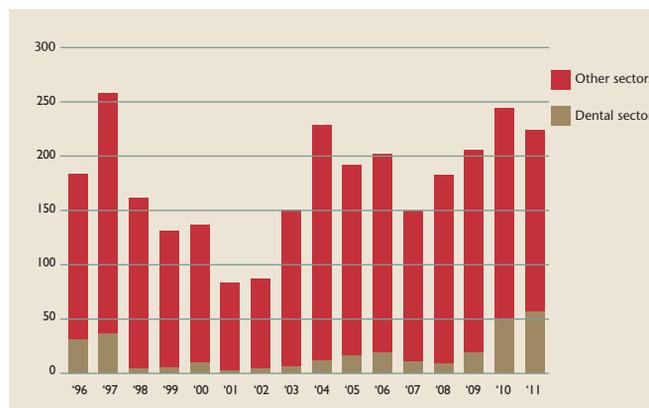


FIGURE 2: Inspections carried out in the period 1996-2011.

and licence conditions, an inspector's main concern is to ensure that the dentist and staff, as well as any members of the public, including patients in the waiting areas, are protected against the harmful effects of ionising radiation. In many cases an inspector will highlight examples of good practice previously observed in similar practices, or identify issues that should be discussed by the dentist with their appointed RPA. Accordingly, the inspection provides an opportunity to further improve radiation protection standards to the benefit of the dentist, staff and the public.

Accreditation

The RPII has developed a quality system for its inspection activities and is accredited to ISO 17020, which is an international standard specifically designed for inspection bodies. The quality system provides a framework for planning and reviewing the annual inspection programme, how inspections shall be conducted, the follow-up of inspections and the training of inspectors. Each year the Irish National Accreditation Board (INAB) carries out a surveillance visit on the RPII to assess whether it continues to comply with the requirements of the standard. A major component of the INAB annual visit involves the observation of RPII inspectors carrying out inspections across various sectors, including the dental sector. In addition to this external audit, the technical manager of the RPII's Regulatory Service witnesses each inspector on an annual basis while he/she carries out an inspection. This inspection witnessing ensures that appropriate standards for inspections are maintained and helps to ensure consistency between inspections and individual inspectors.

Inspection format

Inspections of dental practices are usually arranged in advance by telephone, and an email is sent to confirm the date and time. While the RPII can also carry out inspections unannounced, in practice almost all inspections are carried out by prior appointment. The email also advises as to what records the inspector will want to review on the day of the inspection, such as RPA risk assessments, quality assurance (QA) reports, shielding assessments, equipment service records and personal dosimetry records where relevant. The inspector

will want to meet with the radiation protection officer who is responsible for the day-to-day radiation protection matters. While the dentist is welcome to invite their RPA to attend the inspection, their participation is not required by the RPII. An inspection of a dental practice will usually take about an hour and a half. The inspector will, where possible, try to fit in with the dentist's schedule and minimise the time during which the x-ray unit/surgery is unavailable to the practice. All inspectors carry photographic identification and an inspector's warrant, which is available for examination.

The inspection commences with an entrance meeting, at which the inspector explains to the dentist the purpose and format of the inspection. The inspector will then go through the administrative aspects of the licence, recording all information received on an inspection audit form. Issues usually considered during this meeting include QA testing, RPA reports, requirements for personal dosimetry and servicing arrangements.

Once the entrance meeting has been completed, the inspection moves to the locations where the x-ray units are used. The inspector will usually invite the dentist to explain the procedure he/she follows when taking x-rays. This is to ensure that proper radiation protection procedures are

being implemented. The inspection will also examine the x-ray unit to assess its physical condition and will undertake some spot check measurements of its radiation output. Measurements are normally made on intra-oral units and parameters checked, including the kilovoltage, radiation output and exposure duration for a typical setting used for an x-ray of an adult mandibular molar tooth. These tests are undertaken to assess the performance of the x-ray unit rather than the dose delivered to the patient, which is outside the remit of the RPII. Where the measured values fall outside expected values, the dentist is usually advised to consult with their appointed RPA or service engineer. The inspector also reviews the layout of the facility to determine whether there are any concerns for possible exposure to the dentist, staff or patients in the waiting room. In particular, the location of the x-ray unit within the surgery, the presence of doors and windows, as well as the use of adjoining locations, are all considered by the inspector. Experience to date has shown that where the dentist has consulted with an RPA in the design and layout of the surgery, few problems have arisen. In the event that an inspector observes a situation that compromises radiation safety and which, in the opinion of the inspector, poses a serious hazard to workers or members of the public, the dentist is advised of this issue immediately and directed to cease using the x-ray unit until such time as the situation has been rectified.

To conclude the inspection, an exit meeting is convened between the inspector and the dentist, during which a summary of the inspection findings is presented verbally. The RPII will issue an inspection report to the dentist within 28 days of the inspection date. The report sets out the non-compliances observed, as measured against the licence conditions and relevant legislation, as well as other items requiring attention. Each of these items must be addressed by the dentist, who must forward a written response to the RPII within 28 days of receiving the report. In some cases it will not be possible to address all of the inspection findings within 28 days – in these cases the dentist should advise the RPII of their plans for the completion of these issues, including time lines where relevant. In addition, the inspection report may also include some recommendations that the practice could consider towards the further improvement of radiation protection practices.

Conclusion

Since the RPII commenced inspections of dental practices in the 1980s, there have been significant improvements in radiation protection across the sector. X-ray units that did not provide for appropriate protection, such as those with mechanical timers or pointed cones, have long since been decommissioned, and modern units are generally safer and more reliable. While almost all inspections result in some findings or observations, it is reassuring to note that many of these relate to administrative requirements of the licence rather than poor radiation protection. Overall, the standards of radiation protection across the Irish dental sector are very good.

Dr Stephen Fennell, Manager, Regulatory Services, Radiological Protection Institute of Ireland.

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Endodontic-periodontal management of a maxillary lateral incisor with an associated radicular lingual groove and severe periapical osseous destruction – a case report

Précis

Radicular lingual grooves are morphological defects that can create periodontal and pulpal pathology, but they may be difficult to identify as an aetiological factor. This article discusses their presentation and management.

Abstract

Radicular lingual grooves are morphological defects, which are found most frequently in maxillary anterior teeth and are a predisposing factor for periodontal disease. They are easily overlooked as aetiological factors, as these grooves are covered by periodontal tissues. This case report presents a successful management of a case of a maxillary lateral incisor with an associated radicular lingual groove and severe periapical osseous destruction in a 30-year-old female patient. A combination of endodontic treatment, radiculoplasty to eliminate the radicular lingual groove, and periapical surgery to eliminate the periapical osseous defect was used. At two-year follow-up, the patient was comfortable and complete resolution of the periapical pathology was evident.

Key words: maxillary lateral incisor, periapical surgery, radicular lingual groove.

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Introduction

The radicular lingual groove (RLG) is a developmental anomaly in which an infolding of the inner enamel epithelium and Hertwig's epithelial root sheath (HERS) creates a groove that passes from the cingulum of maxillary incisors apically onto the root.¹ Radicular lingual grooves have also been termed palatal radicular grooves,¹ distolingual grooves,² palato-gingival grooves,³ radicular grooves² and vertical development grooves.^{3,4}

The aetiology of the groove is not fully understood. Some clinicians believe that the groove originates with alteration in the growth of inner enamel epithelium and HERS.² According to some authors, the RLG is embryologically related to dens invaginatus.^{5,6} Ennes and Lara suggested that the RLG could be the result of an alteration of genetic mechanisms.⁷ Other investigators claim that this malformation results from an incomplete attempt of the tooth to form another root.^{4,8}



FIGURE 1: Preoperative clinical photograph showing a groove on the lingual surface of the maxillary left lateral incisor.



FIGURE 2: Preoperative radiograph showing large periapical radiolucency and a lateral localised periodontal defect associated with the maxillary left lateral incisor with a radicular lingual groove.



FIGURE 3: Postobturation radiograph.

RLGs can create periodontal and pulpal pathology. The presence of an RLG does not always indicate the development of pathology. In most cases the epithelial attachment remains intact across the groove, and the periodontium remains healthy. Once the attachment is breached, however, a self-containing periodontal pocket forms along the length of the groove. The attachment may be breached due to endodontic involvement. Inflammation can progress from an apical lesion coronally along the groove, causing a primary endodontic/secondary periodontic lesion.⁹ Conversely, the epithelial attachment may be breached due to the accumulation of bacterial plaque and calculus⁶ on the irregular external surface of the groove resulting in onset and progression of periodontal disease. As a result of this breach in the epithelial attachment, the progression of bacterial products through dentinal tubules could secondarily compromise the pulp tissue, causing a primary periodontic/secondary endodontic lesion.⁹ Goon (1991) classified RLGs as simple and complex.¹⁰ Simple RLGs do not have communication with the pulp and terminate at the cemento-enamel junction. The complex RLGs have direct communication with the pulp and extend to various lengths along the root. In rare cases, the most complex forms occur as deeply invaginated defects that separate as an accessory root from the main root trunk.^{4,8} The clinical significance of RLG is related to the incidence of localised periodontitis with or without pulpal pathosis, depending on the depth, extent and complexity of the groove.⁶ Accurate diagnosis and elimination of the inflammatory irritants and other contributory factors are extremely important in achieving successful treatment outcome. This report presents a successful endodontic and periodontal management of a maxillary lateral incisor with an associated RLG and severe periapical osseous destruction.

Case report

A 30-year-old female patient reported to the Department of Conservative Dentistry and Endodontics at Prabhu Dayal Memorial (PDM) Dental College and Research Institute, Bahadurgarh, Haryana, India, with a chief complaint of mobility and discharge of pus in the upper anterior region for ten days. Clinical examination revealed a fistulous tract on the labial gingival surface adjacent to the maxillary left lateral incisor. There was no history of trauma and/or discolouration of the tooth. Medical history was noncontributory. The maxillary left lateral incisor did not respond to electric and thermal pulp testing, whereas testing of adjacent and contralateral teeth elicited normal responses. On further clinical examination, a groove was noted on the lingual surface of the maxillary left lateral incisor extending subgingivally from the cingulum and a 6mm periodontal pocket was associated with the groove (**Figure 1**).

An intra-oral periapical radiograph revealed a large periapical radiolucency and the presence of a localised lateral periodontal defect around the maxillary left lateral incisor (**Figure 2**). Apical periodontal widening was also evident. Based on the clinical and radiographic findings, a diagnosis of an endo-perio lesion of the maxillary left lateral incisor associated with an RLG was made. The treatment plan consisted of conventional root canal treatment, radiculoplasty of the RLG, and periapical surgery to eliminate the periapical osseous defect.

Management

A decision to endodontically treat the tooth followed by periapical surgery was made, and informed consent was obtained from the patient. After prophylaxis and removal of localised calculus, the tooth was anaesthetised with 2% lidocaine with 1:100,000 epinephrine, and

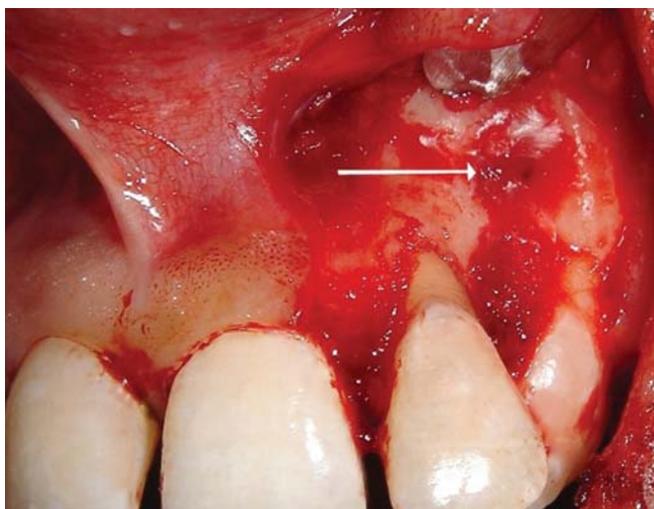


FIGURE 4: Clinical view after reflection of a labial full-thickness flap, revealing the periapical lesion, as shown by arrow.



FIGURE 5: Clinical view after reflection of a palatal full-thickness flap, revealing the extent of the radicular lingual groove.

a rubber dam was applied. The endodontic access cavity was prepared on the palatal surface by using a no.2 round bur (Mani; Tochigi, Japan) and the canal orifice was found. Working length of the canal was determined with the help of an electronic apex locator (Root ZX; Morita, Tokyo, Japan) and then confirmed by a radiograph. This was followed by cleaning and shaping of the canal with Gates Glidden drills (numbers 3 and 2; Dentsply Maillefer) and nickel titanium hand files up to an apical file size 50 (Dentsply Maillefer, Ballaigues, Switzerland). Copious irrigation with 2.5% sodium hypochlorite was done at every step of instrumentation. The canal was dried using sterile paper points, following which calcium hydroxide (Ultracal XS; Ultradent, South Jordan, UT, USA) was placed as an intracanal medicament and the access cavity was sealed with Cavit G (3M ESPE, Seefeld, Germany).

The patient was recalled after one week and canal filling was completed with cold lateral compaction using gutta-percha and Roth sealer (Roth drug Co., Chicago, IL; **Figure 3**). The access cavity was restored with light-cured composite resin (P60; 3M Dental Products, St Paul, MN). The patient was recalled after intervals of two, four, eight and 12 weeks. During these phases of intervals it was seen that the patient had become symptomatic and there was no evidence of healing of the sinus. It was further seen that at the interval of 12 weeks there was no reduction in the size of the periapical lesion. Based on these observations, it was decided to opt for periapical surgery in combination with curettage of the lateral periodontal defect.

During the surgical phase, a full-thickness flap was reflected on both labial and palatal aspects to expose the lesion. The reflected flap on the labial surface revealed a bony fenestration corresponding to the location of the previously existing sinus tract (**Figure 4**). On the palatal

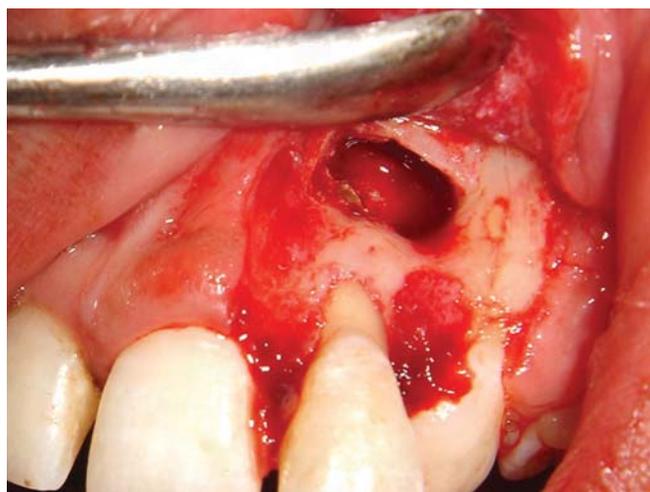


FIGURE 6: Lesion was curetted. Notice the extent of the bony defect with intact palatal bone.

side, the RLG emerged from the cingulum, ran apically and distally, and finally terminated at the middle third of the root (**Figure 5**). The window into the lesion on the labial aspect was enlarged, and the soft tissue contents were removed (**Figure 6**). With the help of an air-driven surgical handpiece (Impact Air; Palisade Dental), the apical root end was resected and sealed by burnishing the gutta-percha. On the palatal aspect, thorough scaling and root planing were performed over the groove and the bony defect, and granulation tissue was debrided (with Gracey curette number 1, 2; Hu-Friedy Manufacturing Co, Chicago, IL, USA). Saucerisation of the groove by grinding it out



FIGURE 7: Sealing of radicular lingual groove by using glass ionomer cement.



FIGURE 8: Bone graft placement.

to its depth using a small round diamond bur was performed. This was followed by conditioning the groove with 10% polyacrylic acid and sealing the defect with glass ionomer cement (FUJI II; GC Corporation, Tokyo, Japan; **Figure 7**). Surgical haemostasis during setting of the glass ionomer cement was achieved by using a haemostatic gelatin sponge (Pfizer Inc, New York, USA).

After the cement had hardened, the bony defect was filled with a bone graft (Ossifi; Equinox medical technologies, Netherland, Holland; **Figure 8**) and the flaps were reapproximated and sutured (**Figure 9**). This was followed by coe-pak application (GC America, Alsip, IL, USA). A postoperative radiograph was taken after closure of wounds (**Figure 10**). A non-steroidal anti-inflammatory drug, Voveran SR 100mg (twice daily for three days) and a mouthwash containing 0.2% chlorhexidine gluconate (twice a day for four weeks) were prescribed postoperatively. Healing was uneventful and sutures were removed seven days postoperatively. At three months' follow-up, the patient was asymptomatic, the sinus tract had closed, and probing depth was significantly reduced. A two-year postoperative radiograph revealed complete resolution of periapical radiolucency and normal periodontal probing depth (**Figure 11**).

Discussion

The treatment of RLG presents a clinical challenge, as the long-term prognosis depends on the length, depth and complexity of the groove. Teeth with physiologic mobility and shallow grooves might be corrected by odontoplasty in conjunction with periodontal treatment including curettage of granulation tissue.¹¹ However, when the groove is more advanced and associated with extensive periodontal destruction, the treatment of the teeth is complex.¹² Elimination of the groove and appropriate treatment of the

periodontal defect would reduce inflammatory irritants, thus favourably influencing the prognosis of such teeth.¹³

Simon *et al.* described two types of endo-perio lesions in teeth involved with RLG. Primary endodontic lesion with secondary periodontal involvement and primary periodontic lesion with secondary endodontic involvement depend upon whether pulpal pathosis occurred prior to periodontal destruction or vice versa.⁹ The endo-perio lesion in the present case seems to be a primary periodontic lesion with secondary endodontic involvement. This was because of the fact that there was no history of trauma and/or discolouration of the tooth. Moreover, surgical opening of the RLG did not reveal carious involvement of the groove.

The groove had a funnel-like shape and irregularities on the external surface that promoted the accumulation of bacterial plaque and calculus, resulting in the onset and progression of periodontal disease. As a result of this breach in the epithelial attachment, the progression of bacterial products through dentinal tubules could secondarily compromise the pulp tissue, causing a primary periodontal/secondary endodontic lesion, which necessitated both pulpal and periodontal therapy, as conventional endodontic treatment alone will not be effective, because the bacterial aetiology is residing extra radicularly, as a self-sustaining lesion.¹⁴

Radiculoplasty was performed to eliminate the groove, which often harbours bacteria and debris leading to local inflammatory reaction. Root planing was performed as it encourages sulcular re-attachment and prevents bacteria from gaining access to the groove at a deeper level.^{11,12}

The success of periapical surgery depends on regeneration of the periapical tissues and filling of osseous defects. In the present case a bone graft material, Ossifi™ (Equinox Medical Technologies, Holland)



FIGURE 9: Labial view showing suturing.

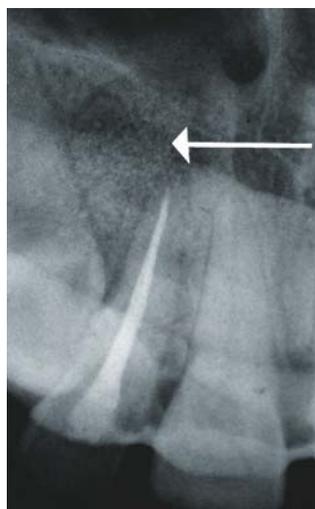


FIGURE 10: Postoperative radiograph showing bone graft in place (arrow).



FIGURE 11: Follow-up radiograph at two years; the radiolucency has completely resolved and the tooth is asymptomatic, indicating that it has healed.

was used to fill the osseous defect. It is a synthesised combination of hydroxyapatite and -tricalcium phosphate in a 70/30 ratio, and has calcium phosphate in its purest form. This molecule remains constant throughout the whole process of resorption and bone formation, reducing the risk of cavities of fibrous ingrowth. It has a bioceramic matrix that is extremely biocompatible and highly osteoconductive.

This graft was selected to fill the bony defect as it only occupies 10% of the defect space, leaving 90% of the space for regeneration of new bone. The pore size of this material is highly reproducible and constant. This reproducible interconnected porosity combined with a large granular inner surface area provides the highest degree of osteoconductivity through clot stabilisation, vascularisation, cell adhesion and penetration of host bone repair into the inner part of the graft material. The post-surgical results obtained in the present case, both clinically and radiographically, showed predictable clinical outcome. Complete periapical healing was evident on the radiograph over a period of two years. The results of the present case were similar to those achieved in previous studies.¹⁵⁻¹⁷

Several materials, such as composite and amalgam, have been used to fill the RLG. Friedman and Goultshin salvaged a tooth by placing amalgam into a grooved root that was refractory to extensive periodontal procedures. This apparently eliminated the pathway for bacterial ingress along the groove and the symptoms abated with time.¹⁴ Torabinejad *et al.* developed a new cement, mineral trioxide aggregate (MTA).¹⁸ MTA is the only material that is unaffected by moisture or blood contamination. MTA is considered today to be the material of choice for closing open apices,¹⁹ repairing perforations,²⁰ and sealing the retro-preparations in surgical endodontics.²¹ As MTA has low compressive strength,¹⁸ it should not be placed in functional areas and in the present case MTA was not used to seal the groove, as

it might get washed off from the transgingival defect. Instead, glass ionomer cement was chosen, as it does not have this limitation. It also has the advantage of having antibacterial action,²² biocompatibility,²² adequate sealing ability,²³ and promotion of epithelial and connective tissue attachment. Moreover, it bonds to tooth structure by chemical adhesion.²⁴

Conclusion

RLGs can initiate periodontal and pulpal involvement that can be difficult to diagnose and manage. However, if clinicians are aware of the forms in which the condition may occur and can apply the treatment modalities in a proper way, a number of teeth with RLGs may be saved. In the present case, in a two-year follow-up, the patient was asymptomatic, the sinus tract had closed, there was a 3mm non-bleeding sulcus and signs of bone deposition radiographically, suggesting active healing of the periodontal ligament attachment and alveolar bone.

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Outcomes from the first mouth cancer awareness and clinical check-up day in the Dublin Dental University Hospital

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Précis

A total of 1,661 individuals attended the first Mouth Cancer Awareness Day in the Dublin Dental University Hospital in September 2010. Following the clinical check-up, five cancers were detected and scheduled for early treatment. Demographic, clinical and histopathological outcomes are presented.

Abstract

Purpose of the study: To increase public awareness about mouth cancer, the Dublin Dental University Hospital (DDUH) hosted an awareness day and free mouth check-up in September 2010. The messages of information, self-examination and risk management, and the importance of early detection, were available to all attendees. The role of general dental and medical practitioners in examination of the mouth was stressed.

Material and methods: A questionnaire regarding knowledge about the causes of and risk factors for mouth cancer, and a clinical check-up, were completed.

Results: A total of 1,661 individuals (675 male, 986 female) were examined. The mean age was 59.6 years. Just over one-third (36.5%) of those examined required no action, and slightly less (30%) were advised to return to their general dental or medical practitioner (GDP/GMP). Some 21% were advised about self-examination of the mouth, and 8% about smoking cessation. Of the remainder, 52 people (3.5%) were sent for a second opinion. Of these, 30 individuals were referred for further investigation, including biopsy in 27 cases. Following biopsy, five individuals were diagnosed with carcinoma *in situ* or carcinoma.

Conclusions: The diagnosis of five people with mouth cancers, who may not otherwise have been identified for early treatment, highlights the need for regular mouth examination. It is inappropriate that such an exercise would remain the preserve of the dental teaching hospitals, and it is vital that all dentists take on the responsibility for regular mouth checks for all of their patients. More should be done to encourage those identified as high risk to visit their dentist. There is a need for recognition of the additional resources required for the detection and timely management of such cancers.

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Introduction

Cancer of the head and neck region presents a challenge since, unlike other areas of the body, the boundaries are not always easy to delineate. Head and neck (H&N) cancer is described as cancer of the lip, mouth, tongue, tonsil, pharynx (unspecified), salivary gland, hypopharynx, larynx and

other. Oral cancer refers to cancers of the tongue, gingiva, floor of the mouth, palate, vestibule and retromolar area.¹ Unlike other areas in the body, the oral epithelium is readily accessible for inspection and self-examination, but over 60% of patients present with oral cancer with either regional or distant spread.² The five-year survival rates

for oral cancer range between 50 and 80% depending on the stage of the disease, varying from 86% for stage I to 12-16% for stage IV.^{3,4} Between 2000 and 2004, the Irish National Cancer Registry¹ reported 400 cases of H&N cancer in Ireland annually, and in the region of 150 deaths annually. H&N cancers are the sixth most common cancer diagnoses in men, as they include laryngeal cancer, which occurs most commonly in middle-aged to elderly men. They are the 16th most common cancer diagnoses in women, with increasing prevalence in young women. H&N cancers account for 2.9% of all cancer diagnoses in Ireland. In the United Kingdom, incidence and mortality have increased recently, and overall survival rates have only shown a slight improvement, standing at 50% for intra-oral lesions and with a poorer prognosis for lower socio-economic groups.⁵

Cancer of the head and neck largely affects an older population, with males more frequently affected than females. Lifestyle factors, in particular tobacco smoking,^{6,7} alcohol consumption⁸ and use of betel quid⁹ are implicated in the aetiology. Alcohol consumption may be associated with a higher prevalence of cancers involving the floor of mouth, tongue and buccal mucosa, and a synergistic effect between alcohol and tobacco use has been documented.¹⁰ The evidence for the involvement of human papillomavirus in the aetiology of oral cancers suggests that it may be a co-factor, particularly in the development of carcinoma of the oropharynx in younger populations.⁸

Prevention strategies include smoking cessation programmes, reduced use of betel, areca nut and smokeless tobacco, reduction in alcohol consumption and a diet rich in antioxidants.

A major factor in poor outcome for oral cancers is late presentation, due in part to lack of awareness about oral cancers in the community. In a recent study of an outpatient hospital population,¹¹ it was concluded that there was a poor level of knowledge about H&N cancers in a population in the West of Ireland. Some 70% of respondents had never heard of H&N cancer, 73% did not consider alcohol a risk factor and less than 50% would be concerned by persistent hoarseness or a prolonged oral ulcer. A study in rural communities in Sri Lanka¹² found that there was a good level of public awareness about mouth cancer. However, there was low awareness of early lesions and of risk/lifestyle factors, especially in low socio-economic groups. Of the individuals referred to a dental school in Iran, 89% had little or no knowledge about oral cancer.¹³ In an Indian study of male prisoner tobacco use and oral cancer knowledge, it was found that knowledge about oral cancer did not impact on decisions regarding tobacco use.¹⁴ Subjects in an oral cancer awareness study in the northwest of England¹⁵ were asked to list cancers that they had heard of, and only 11% mentioned oral cancer in the top three. Some 60% of respondents listed cervical cancer as more common than oral cancer. However, 74% were aware that smoking was a risk factor and 61% and 27%, respectively, would attend the doctor or the dentist with a painful mouth ulcer. An earlier UK study¹⁶ reported an awareness of oral cancer among 56% of respondents, compared with 85% awareness of lung, cervical and skin cancers. Some 75% of the population was aware that smoking was a risk factor, but only 19%

linked oral cancer to alcohol. These figures were similar to those reported in a similar study from the United States.¹⁷

Mouth self-examination to improve oral cancer awareness and early detection in a high-risk population was tested in an Indian community.¹⁸ The subjects self-examined, and were subsequently examined by healthcare workers and specialists. Self-examination identified red patches and non-healing ulcers, but the detection rate was low for white patches. As a consequence, awareness of oral cancer improved but compliance to seek treatment was poor. The idea of mouth self-examination was well received by a group of high-risk individuals in London.¹⁹ However, they found it difficult to identify lesions and did not readily accept the importance of lifestyle issues in the development of oral cancers.

An Australian study²⁰ found that television advertisements and pictorial health warnings on cigarette packets may operate in a complementary manner, that is, to positively influence awareness of the health consequences of smoking and motivation to quit. A multifaceted social marketing campaign including radio advertisements, billboards and education sessions was found to effectively target a high-risk African-American population.²¹ This could result in a significant number of people availing of screening; however, evaluation of the programme is ongoing regarding uptake and cost.

The following assessment strategies have been considered as means to increase early detection:

- national screening programmes;
- targeted screening of risk groups; and,
- opportunistic screening in a primary care setting.

However, there is no clear evidence for the optimal management of potentially malignant lesions. The issue is whether all lesions deemed to be high risk should be surgically removed or should a watch and wait policy be advised. Therefore, national screening programmes for H&N cancers cannot be advocated at the present time.²² Targeted screening of risk groups has been found to be effective. In the Kerala study²³ it was found that, in a high-risk population, a visual oral examination may detect pathology and save lives. Opportunistic screening of high-risk groups in a primary care setting may promote early detection and be cost-effective, as shown in a simulation modelling study.²⁴ Opportunistic screening of the oral soft tissues by the dental team at every dental check-up is recommended.^{25,26,27} However, consideration must be given to the fact that high-risk individuals are often poor dental attendees.²⁸

In May 2009 Lia Mills,²⁹ a writer and survivor of mouth cancer, started a campaign to increase awareness about mouth cancer in Ireland as she was astounded at the lack of knowledge and information available. A group of H&N cancer survivors, healthcare professionals, the Dental Health Foundation and the Irish Cancer Society came together to form Mouth, Head and Neck Cancer Awareness Ireland (MHNCAI). Discussion regarding the way forward included education of dental, medical and pharmaceutical students about mouth, head and neck cancers, public awareness campaigns, and collaboration

Table 1: Demographic details – age and gender.

Age	%
<35	5
35-44	8
45-54	17
55-64	30
65-74	28
75-84	11
85+	0.3
Mean	59.6 (SD=13)
Male	41
Female	59
Total number attended	N = 1,661

with national organisations to advance the availability of information for the public. By mid 2010, an information brochure³⁰ had been developed and the Irish Cancer Society had updated their website information on H&N cancers. In order to increase public awareness, it was decided that the Dublin Dental University Hospital and the Cork University Dental School and Hospital should host an awareness day and free mouth check-up in September 2010. The message on the day would focus on information, self-examination, risk management and the importance of early detection. The role of general dental and medical practitioners in the examination of the mouth would also be stressed.

Materials and method

September 28, 2010, was identified as the first Irish Mouth Cancer Awareness Day, with information about the disease, advice regarding self-examination and free mouth check-up. Ethical approval was obtained from the Faculty of Health Sciences (Trinity College Dublin) Research Ethics Committee. A pathway was developed to best utilise the attendee experience at the Mouth Cancer Awareness and Check-up Day with information, advice and clinical examination. Examination criteria were developed and a questionnaire was prepared for those attending for the check-up. Information about the disease was provided on the day by H&N cancer survivors, the Dental Health Foundation and the Irish Cancer Society. Disease prevention advice in relation to smoking cessation and self-examination was provided by dental and dental hygiene students of the Dublin Dental University Hospital. It was a stated objective to involve general dental (and medical) practitioners in this initiative in the future. Even though H&N cancer includes the larynx, nasopharynx and base of the tongue, the epithelium in these areas is not readily accessible for clinical examination.

The event was publicised widely by the organisations and groups involved. Several mouth, head and neck cancer survivors offered to give interviews on television, radio and in newspapers about their experiences during treatment of their disease. A mouth cancer

Table 2: Outcomes following clinical check-up.

Action	%
Biopsy and follow-up in DDUH	3.5
Smoking cessation advice	8.0
Self-examination advice	21.3
Advice to return to GDP/GMP	30.0
Other follow-up in DDUH	0.6
No action required	36.5

Table 3: Habits or activities that might cause mouth cancer as listed by attendees (n=1,559).

Habit/activity	N	(%)
Alcohol	177	(11)
Smoking	1,190	(76)
Poor diet, overweight	5	(<0.5)
Mouth ulcer	18	(1)
Sore throat/hoarseness	6	(<0.5)
Poor oral hygiene/bad teeth	39	(2)
Don't know	96	(6)
Genetic	2	(<0.5)
Dentures	4	(<0.5)
Dust inhalation	1	(<0.5)
Hot drinks/food	11	(0.7)
Chewing gum	3	(<0.5)
Sun	1	(<0.5)
Traffic fumes	1	(<0.5)
Trauma, e.g., biting nails	5	(<0.5)
Other	13	(0.8)

awareness leaflet (Mouth, head and neck cancer: what you should know) was launched prior to Mouth Cancer Awareness Day. This was developed and funded in collaboration with the Dental Health Foundation and the Irish Cancer Society. The event received large coverage in the national media. Data were collected from attendees on the day by questionnaire (see **Appendix 1**).

Results

A total of 1,661 individuals (675 male, 986 female) were examined over a day and a half (**Table 1**).

The mean age was 60 years (SD=13). Of these, 1,599 completed questionnaires. Almost 70% of those attending were over 55 years of age. Women were represented in a ratio of 3:2.

A total of 36.5% of those people examined required no action, and slightly less (30%) were advised to return to their general dental practitioner if dental problems were noticed, and to their general medical practitioner if the attendee complained of a cough, hoarseness or difficulty swallowing. Some 8% required smoking cessation advice. If a non-suspicious area was noticed in the mouth,

Table 4: Correlation between question response and outcome of clinical examination (row percentages displayed and result of chi-square test of independence).

Question		N (%)		Action %			p-value
		Count		Advice	Follow-up or Biopsy	No action	
Received previous information on mouth cancer?	Yes	101	(6)	56	8	36	0.02
	No	1,576	(94)	61	3	36	
Been shown how to do self-examination?	Yes	42	(3)	48	12	40	0.002
	No	1,528	(97)	61	3	36	
Attend GDP?	Never	99	(6)	62	6	32	0.02
	Only when in pain	271	(17)	68	4	28	
	Every few years	397	(25)	61	2	37	
	Every year	453	(30)	60	4	39	
	Every six months	3,439	(22)	57	2	41	
Own natural teeth?	Yes	1,428	(90)	60	3	37	0.31
	No	152	(10)	64	5	31	
Brush teeth?	Daily	1,515	(96)	60	3	37	0.19
	Weekly	38	(2)	71	5	24	
	Never	21	(2)	62	9	29	
Use mouthwash?	Daily	608	(40)	59	4	37	0.64
	Weekly	329	(21)	64	4	32	
	Rarely	8	(<1)	63	0	37	
	Never	592	(39)	59	3	38	
Smoker?	Yes	269	(17)	67	6	27	<0.001
	No	1,312	(83)	59	3	38	
Drink alcohol?	Yes	1,181	(75)	60	3	37	0.32
	No	398	(25)	60	4	36	
Total		1,599		959 (60)	57 (3.5)	583 (36.5)	<0.001

the individual was advised to carry out self-examination (21.3%). Of the remainder, 3.5% were sent for follow-up or biopsy (**Table 2**). Some 76% of individuals identified smoking as a risk factor for mouth cancer. However, only 11% identified alcohol. This is worrying in a group where 75% of attendees drink alcohol. It should be noted that the numbers of actions required for attendees did not necessarily add up to 100%, as two actions were often recommended (**Table 3**).

Correlation of question by type of action, following clinical check-up, is presented in **Table 4**, along with a chi-square test of association. As the sample was entirely self-selected, a formal interpretation of the chi-square test of independence is not appropriate. The p-value presented can be considered as an indication of possibly interesting

differences across response levels. A total of 1,599 attendees (96.2%) completed the questionnaire, with 62 declining. Fifty-two attendees required specialist advice following the clinical check-up and 30 of these were sent for further examination. Twenty-seven of this group required biopsy. The results are presented in **Table 5**.

For further information regarding the questionnaire and clinical check-up forms, see **Appendix 2**.

Discussion

The data presented here cannot be said to have been drawn from a true random sample, so the results must be viewed in that context, and the possibility of selection bias considered.

Table 5: Individuals referred for further investigation of mucosal lesions (n=27).

Number of cases	Clinical description at check-up	Biopsy	Histopathological report
3	Lump, ulcer	Yes	Benign (pyogenic granuloma, squamous papilloma, other)
1	White patch	Yes	Inflammation and fibrosis
7	White patch	Yes	Mild dysplasia
5	White patch, ulcer	Yes	Moderate dysplasia
1	White patch, ulcer	Yes	Severe dysplasia
1	Blister	Yes	Linear IgA
4	White/red mucosa	Yes	Lichen planus
3	White patch, ulcer, verrucous	Yes	Carcinoma <i>in situ</i>
2	Ulcer	Yes	Squamous cell carcinoma

Of the 1,599 attendees with completed questionnaires, 3.5% were referred for follow-up and possible biopsy at the Dublin Dental University Hospital. Over one-third required no action and 60% were offered advice and/or requested to attend general dental or general medical practitioners. A total of 647 people did not need any further treatment, 964 were advised to attend their general dental or general medical practitioner, and 52 required specialist advice on the check-up day. Of these, 30 individuals were referred for follow-up and possible biopsy. Five people were identified from these investigations as needing active intervention for a mouth cancer (squamous cell carcinomas or carcinoma *in situ*).

In the questionnaire, when asked about the habits or activities that may cause mouth cancers, participants were asked to suggest two possible causes. Some 60% suggested smoking first and alcohol second, 9% suggested alcohol followed by smoking, 5% suggested smoking and poor oral hygiene/bad teeth, 1% suggested poor oral hygiene/bad teeth followed by smoking and <1% suggested all other combinations. Some 75% of the attendees recognised that smoking might cause cancer, with a further 11% suggesting that alcohol consumption might cause mouth cancers. Some 6% of the 269 smokers were referred for biopsy, whereas only 3% of non-smokers were referred.

Oral health advice regarding smoking cessation and self-examination was available for all attendees and was provided by dental and dental hygiene students.

Despite the gender predilection for males demonstrated in the

epidemiology surrounding mouth cancers, the numbers presenting here show the opposite trend, but are consistent with women's greater and earlier use of health services generally. This is reflected in the outcomes from the check-up day in that far more men were referred for possible biopsy of suspect areas in their mouths (Table 1). Awareness around the need to undertake regular self-examination of the mouth was low, with only 42 people indicating that they did so. Some 12% of these people were referred for biopsy, whereas only 3% of those who said that they did not self-examine were referred. However, these numbers are very small.

The purpose of the awareness day was to do just that – raise awareness around mouth cancers. From this questionnaire data, this was evidently an important aim since very few people knew much about mouth cancers, in keeping with the results from other studies,^{11,13,15,16} and an even smaller proportion admitted to carrying out self-examination of their mouths. Other studies have identified a willingness among individuals to undertake mouth cancer self-examination.^{18,19} However, the outcome in the latter study was non-acceptance on the part of those examined to modify lifestyle risk factors in spite of the fact that they were a high-risk population.

More than half of the sample claimed to visit a dentist at least annually. This is higher than the proportion of people who, in the 2002 Irish National Oral Health Survey of Adults,³¹ claimed to be regular attendees. As such, a significant proportion of the people attending the awareness day in September 2010 must represent the 'worried well'. In part this is reflected in the profile of people attending who were predominantly dentate, claimed to brush their teeth at least twice a day, and with a significant proportion using mouthwash, at least weekly. In relation to risk factors, however, while the majority were non-smokers, the majority consumed alcohol. The frequency and amounts of tobacco and alcohol consumption were not documented.

It has been reported in a 10-year follow-up study²⁸ that it is not feasible to include high-risk groups in opportunistic oral cancer screening by dentists, as they are not regular attendees. However, it was advised that dentists should continue to opportunistically screen all patients, as oral cancers and potentially malignant disorders are also found in regular attendees. More should be done to encourage high-risk groups to visit their dentists.

It is salutary that this opportunity to undertake mouth checks on nearly 1,661 people identified suspicious areas in the mouths of 52 (3.5%). Of these, 30 (1.8%) were referred for further investigation. That such an exercise can pick up five people with mouth cancers, who may not otherwise have been identified for further treatment, means that the inevitable additional burden that this imposes on already overstretched diagnostic and treatment services for mouth as well as other H&N cancers is justified.

However, it is inappropriate that such an exercise would remain the preserve of the dental teaching hospitals and it is vital that all dentists – those in primary, secondary and tertiary care – take on the responsibility for the regular mouth checks of all of their patients. There is also a need to mount awareness days as described here to

reach that segment of the population who may not regularly engage with dental services. Such a venture opens up access for a greater number of people, many of whom may not attend the dentist unless in pain.

Notwithstanding the desirability of the campaign, there needs to be recognition of the additional resources required for the detection and timely management of such cancers, particularly acknowledging the way that such exercises inevitably adversely impact on other oral and dental care services.

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Appendix 2:

Consent to oral cancer check-up, September 29, 2010

Patient name _____

ID number: _____ DOB: _____

I _____ consent to being checked for oral cancer today.
I fully understand that this check-up is only for oral cancer and that I will not be advised about or offered any treatment for any other oral or dental problem.

SIGNED: _____

Oral cancer check-up – *clinical*

- | | |
|-----------------|------------------------------|
| Action (circle) | Biopsy and follow up in DDSH |
| | Smoking cessation advice |
| | Self-examination advice |
| | Advise to return to GDP/GMP |
| | No action required |

Examiner: _____

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The development of mouth, head and neck cancer awareness in Ireland and results of Mouth Cancer Awareness Day 2011

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Introduction

Cancer is a very important word, especially for those who have it. Both healthcare workers and the general public are very aware of the seriousness of breast, prostate and bowel cancer, but until recently, the Irish public were generally unaware of mouth cancer. This is despite many organisations, including the Dublin Dental University Hospital (DDUH), the Cork University Dental School & Hospital (CUDSH), the Faculty of Dentistry of the Royal College of Surgeons in Ireland (RCSI), ear, nose and throat/oral and maxillofacial courses, and various patient groups trying to highlight its importance. Mouth cancer is a serious condition and the effects of the disease, its treatment and its outcome can be catastrophic, if diagnosis is late. The oral cavity and face have a very significant nerve representation in our brain for good reason – we taste, smell, see, hear, feel, breathe, drink, chew, eat and swallow. These senses and functions are frequently affected if the disease presents late. The disease and its treatment may have serious psychological effects on our patients, as the results of treatment can be debilitating and disfiguring.

Oral and pharyngeal cancer is the sixth most common form of cancer globally (all cancers = 405,300 per year), and oral cancer constitutes approximately 275,000 cases per year. More than 300 cases of cancer of the oral cavity and pharynx are reported in

Ireland every year. In Britain, the incidence of mouth cancer has increased faster than any other cancer in the past 25 years (p63). If the disease is diagnosed early the prognosis is very good, with an 80% survival rate. If the disease presents at an advanced stage, the prognosis can be as poor as 15% or less. Overall, despite all advances in diagnosis and treatment, the prognosis is 50% five-year survival.

In 2006, author Lia Mills was diagnosed with mouth cancer and she told her story at the launch of the 2011 Mouth Cancer Awareness Day (MCAD) in the Royal College of Physicians in Dublin. (An article based on Lia's speech is featured on page 89-90 of this *Journal*.) During her treatment, Lia voiced her concern at the lack of information available to the Irish public regarding mouth cancer. Something to try and improve the prognosis was required, and this led to the development of 'mouth cancer awareness'. During discussions, it became clear that an awareness campaign without informed and educated healthcare support might raise public concern without the ability to assess and hopefully reassure people. It was planned to include as many willing and informed healthcare workers (dentists initially) as possible in the campaign. These healthcare workers would require education, supportive documentation and a means to refer any

Table 1: Symptoms and signs.

■ A sore or ulcer in the mouth that does not heal (>2/52), especially in a smoker;
■ leukoplakia (white) or erythroplakia (red) patches inside the mouth for no known cause;
■ a new lump in the mouth/neck/salivary glands;
■ thickening or hardening of the cheek/tongue/salivary glands;
■ unexplained numbness of the lip, tongue or face;
■ difficulty chewing (limited mouth opening), swallowing or moving the tongue (fixed);
■ unexplained loose teeth;
■ persistent sore throat/hoarseness >3/52; and/or,
■ persistent nosebleeds/stuffy nose.

potential patient for treatment.

The term mouth cancer was used rather than oral cancer in order to help the public to understand, and to make it easier for dentists and other healthcare workers to explain the condition to their patients. Prevention is better than cure and the public needs to be made aware of the risk factors for mouth cancer. Smoking, especially with alcohol consumption, has been shown to be the major cause, but identification of symptoms and signs (Table 1) is essential, as non-smokers and non-drinkers have developed the disease. There have been many public health efforts to persuade people to reduce smoking and contain their alcohol intake. Diet is another important, and often ignored, risk factor, and this is being addressed through the five-a-day campaign. There remained a need to educate the public on the early symptoms and signs, and what to do if a person develops any of these symptoms and signs. People talk to their friends, their friendly pharmacist, their doctor and usually their dentist, when they have one. It is because the disease occurs in the mouth and neck that dentists must have a key role to play in the early detection of this disease, so all members of the public, young or old, should have a dentist. Like all of the healthcare team, dentists and dental hygienists need educational updates, support, information and a reliable referral process. Dentists and dental hygienists also have an important role in prevention, with regard to advice on smoking cessation, alcohol intake and diet, and the diagnosis of any 'potentially malignant lesions' such as leuko/erythroleukoplakia.

A group of mouth, head and neck cancer survivors, in collaboration with representatives from the DDUH, the CUDSH, the Dental Health Foundation and the Irish Cancer Society, came together to consider how to develop a mouth cancer awareness programme. The primary aim of the group was to raise awareness of mouth cancer as a

disease that affects an increasing number of people in Ireland, many of whom do not fall into recognised risk categories. Mouth, Head and Neck Cancer Awareness Ireland (MHNCAI) aimed to form a coherent national organisation that would include representatives from professional groups involved in oral healthcare, cancer care and health promotion, along with patients and carers. The group hoped to involve and inform the general public and cancer care providers at the primary, secondary and tertiary levels. The MHNCAI group was formally launched on September 27, 2010, with the publication of the leaflet 'Mouth, Head and Neck Cancer: what you should know', funded by the Irish Cancer Society and the Dental Health Foundation. The first MCAD was held in the two dental schools on September 29, 2010, and the results are reported elsewhere in this Journal (MacCarthy *et al.*, page 101). A total of 1,661 individuals were examined in the DDUH and 1,355 in the CUDSH, and from this group six individuals were diagnosed with a biopsy-confirmed mouth cancer. The patients with confirmed squamous cell carcinoma have all been treated. The Minister for Health and all Opposition health spokespersons were supportive of the initiative and encouraged future health programmes.

In 2011, Dr Conor McAlister, President of the Irish Dental Association (IDA), made mouth cancer awareness a major focus of his education programme. The IDA agreed to extend the mouth cancer awareness campaign to all dentists in Ireland, bringing the educational programme to all parts of the country. The concept of a second mouth cancer awareness day was launched to the dental profession at the IDA Annual Conference in May 2011. A logo was designed and work commenced on a website, designed and maintained free of charge by Think Media, publishers to the *Journal of the IDA*. A domain name – www.mouthcancerawareness.ie – was registered. Information about mouth cancer in general, and MCAD 2011 in particular, was made available to the dental profession and to members of the public on the website.

Approximately 700 dentists signed up to participate in MCAD 2011. A dedicated volume of the *Journal of the Irish Dental Association* (Volume 57, Number 4, August/September 2011) was published on mouth cancer, including an article on 'Oral and neck examination for early detection of oral cancer – a practical guide (MacCarthy *et al.*, 2011), so that all clinicians might carry out examinations in a similar manner. The *Journal* was sent to all dentists on the island of Ireland, and various marketing materials were distributed by Colgate to every participating dental surgery, including information on smoking cessation, mouth head and neck cancer information, leaflets from the Irish Cancer Society and MCAD posters. In addition to the educational material on the website, a number of lectures and presentations took place around the country to educate dental practitioners about mouth cancer and the examination procedure. Lectures took place in the following areas, and the attendance numbers in brackets testify to the outstanding interest shown by the dental profession in this initiative: Sligo (20), Galway (70), Dublin (200), Cork (150), Waterford (80) and Limerick (50). These lectures were organised by the IDA and were open to all dentists, including

non-members. Lectures were presented by experienced clinicians on the signs and symptoms of mouth cancer, how to examine and what to do if concerned about the findings on examination. In Dublin, over 200 dentists attended a lecture given by Professor Saman Warnakulasuriya from King's College, London. Professor Warnakulasuriya has published and lectured extensively on the subject of oral cancer and pre-cancer, and is currently Director of the WHO Collaboration Centre for Oral Cancer in the United Kingdom. King's College represents the UK as one of three countries involved in an EU (Leonardo da Vinci) project to raise awareness among dental professionals of oral cancer screening and early detection through lifelong learning. Greece and Italy are the other two countries involved in this partnership since it commenced in 2009. As a result of MCAD 2011, Ireland (represented by the IDA) has been invited to join Phase 2 of this Leonardo da Vinci partnership – www.oralcancerldv.org. Spain has also been invited to participate. The IDA offered the services of its PR company, Gordon MRM, for planning and publicity for MCAD. The event was launched on Wednesday September 14 at the Royal College of Physicians, Kildare Street, Dublin. A large number of mouth cancer patients were in attendance, along with members of the committee and interested professionals. The event attracted a large amount of print media attention and extensive coverage on radio and TV.

The awareness day was supported by an Irish Cancer Society media campaign highlighting the Society's National Cancer Helpline (freephone 1800 200 700), and encouraging anyone concerned about mouth cancer to call. There was an increased volume of calls to the helpline during the campaign.

The second MCAD (September 21, 2011) was hosted in approximately 70% of general dental practices around the country, as well as in the two dental schools. A total of 435 individuals were seen in the DDUH, and 568 in the CUDSH. In the CUDSH, screening was carried out by staff and final-year dental students under the close supervision of clinical staff. In the DDUH, students were involved in helping to co-ordinate the public through the process. Self-examination of the mouth, smoking cessation and oral hygiene advice was given by dental students and dental hygiene students. Based on the figures retrieved from forms returned by participating dentists, approximately 7,000 individuals had a free mouth cancer examination in general dental practices around the country. However, the number probably far exceeds this, as not all participating GDPs had returned their feedback forms at the time of writing (Table 2).

Results

Information regarding MCAD was spread through media coverage, advertising by individual dental practices, posters, and an advertising campaign run by the Irish Cancer Society. Dentists signed up to participate in MCAD 2011 through the website, which was constantly updated.

Approximately 695 dentists from 515 dental practices registered for MCAD 2011. A total of 428 participant feedback forms were returned. Assuming that one form per practice was returned, this

Table 2: Distribution of general dental practices that returned information on Mouth Cancer Awareness Day.

Connaught	Leinster	Munster	Ulster	Total
Galway: 31	Carlow: 6	Clare: 7	Cavan: 4	
Mayo: 11	Dublin: 142	Cork: 68	Donegal: 2	
Roscommon: 1	Kildare: 23	Kerry: 15	Monaghan: 3	
Sligo: 3	Kilkenny: 10	Limerick: 18		
	Laois: 3	Tipperary: 13		
	Longford: 3	Waterford: 15		
	Louth: 8			
	Meath: 7			
	Offaly: 2			
	Westmeath: 10			
	Wexford: 9			
	Wicklow: 14			
46	237	136	9	428

represents a response rate of approximately 83%. However, information on actual numbers of participating dentists was not always given by group practices.

The results tabulated in Table 2 are therefore based on an 83% response rate, which is a greater than expected response.

On the day, 6,728 individuals attended general dental practitioners for a free check-up (Table 3). Of these, 68 individuals were referred for urgent examination and 371 for follow-up of non-urgent intra-oral lesions. A total of 1,652 individuals were advised to attend their general dental practitioner for dental care and smoking cessation advice. Some 213 individuals were advised to attend their general medical practitioner for issues such as hoarseness, dysphagia and weight loss. A total of 4,738 individuals were advised after examination on the day that they did not need any further follow-up, but should attend their dental practitioner for routine dental care as normal.

On the day, 568 individuals attended the CUDSH. Of these, 10 required urgent specialist opinion, resulting in diagnosis of two malignant tumours. A total of 435 individuals attended the DDUH, with five requiring urgent specialist opinion, with one malignancy detected.

Following MCAD 2011, 225 individuals were referred by their general dental practitioners on an urgent or non-urgent basis for specialist opinion, examination, advice and treatment as required (Table 4). The CUDSH received 78 referrals and the DDUH received 147 referrals. From these 225 patients, 52 biopsies were done. In the DDUH, squamous cell carcinoma (SCC) was diagnosed in eight cases

Table 3: Number of attendees and results of Mouth Cancer Awareness Day on September 21, 2011.

	General dental practice	Cork University Dental School & Hospital	Dublin Dental University Hospital	Total (%)
Number of attendees	6,728	568	435	7,731
Urgent referrals	68	10	5	83 (1.08%)
Non-urgent referrals	371	42	1	414 (5.35%)
Advised to attend GDP	1,652	81	183	1,916 (24.8%)
Advised to attend GMP	213	35	38	286 (3.72%)
No further treatment	4,738	400	236	5,374 (69.48%)
Biopsy		6	5	
Outcomes		2 squamous cell carcinomas – floor of mouth and soft palate 2 dysplasia/atypia 2 benign lesions	1 squamous cell carcinoma-retromolar area 2 Dysplasia/keratosis and 2 benign	

Table 4: Number of attendees referred by general dental practitioners for additional advice and treatment following Mouth Cancer Awareness Day.

	Cork University Dental School & Hospital (n=78)	Dublin Dental University Hospital (n=147)
Urgent referrals	13 (2 refused) – 11 seen	55
Biopsy	2	50
	Squamous cell carcinoma – tongue x 1 Lip – atypia x 1	Squamous cell carcinoma – tongue (5) buccal mucosa (1), gingiva (1), lip (1) Dysplasia (16: severe – 3, moderate – 7, mild – 6, other – 26)
Non-urgent referrals	65 (6 refused appointment) – 59 seen	92 (7 refused appointment) – 85 seen

– five tongue, one buccal mucosa, one gingiva and one lip. There were 18 cases of mucosal dysplasia or atypia detected in the DDUH, requiring regular follow-up in its joint oral medicine/oral and maxillofacial dysplasia clinic. In the CUDSH, one SCC was diagnosed and one patient with atypia in a lip requires follow-up.

The total number of malignant lesions detected, as a direct result of MCAD 2011, was 12. It is important to note that the histopathology results reported here relate to biopsy examinations in the Cork and Dublin Dental Hospitals only. We have not yet received feedback regarding biopsies taken in other centres.

Discussion

This report provides a brief overview of the work undertaken to date by the MHNCAI group in close collaboration with the Cork

and Dublin Dental University Hospitals, the Dental Health Foundation, the Irish Cancer Society and the Irish Dental Association. From the outset, the aim of this group has been to raise public and professional awareness of mouth, head and neck cancer in Ireland. The ability to control this cancer depends largely on prevention and early diagnosis. International research suggests that primary prevention, i.e., education and behaviour modification, could produce a 90% reduction in oral and pharyngeal incidence rates simply by avoiding or drastically reducing exposures to tobacco and alcohol (Hennessey, *et al.*, 2009; US Surgeon General, 2000). Detection of potentially malignant lesions or early asymptomatic cancers, and facilitating the fast-tracking of these patients for appropriate intervention, is a key factor in reducing cancer mortality and morbidity. Research has shown that the

probability of avoiding regional spread, and the associated 50% reduction in survival, is inversely related to diagnostic delay (Speight and Warnakulasuriya, 2010; Ferlito *et al.*, 2002). The significant link between diagnostic delay and advanced stage presentation in relation to oral and pharyngeal cancer was confirmed in a recent meta-analysis by Gomez *et al.* (2011). Although the cost of treatment in personal and financial terms is significant, the use of a formal screening campaign is at present too expensive and inappropriate. However, research indicates that most oral cancers are currently detected once they become symptomatic, despite the relative accessibility of these sites and the non-invasive nature of an oral examination. National and international studies have consistently revealed a poor level of knowledge among members of the general public regarding the risk factors and warning signs associated with oral and pharyngeal cancer (O'Connor *et al.*, 2010). This suggests a clear need for educational campaigns, at local and national levels, to raise public awareness of this disease and to promote behavioural change. Mouth cancer survivors have played a very important role in educating and supporting others by speaking out about their own experiences.

The recent mouth head and neck cancer awareness days have raised the profile of this disease among members of the general public, dentists, dental nurses and dental hygienists. General dental practitioners embraced this campaign with enthusiasm, keenness and a desire to contribute. Patients who attended the screening and awareness days in the various centres received information on the risk factors, and advice regarding behaviour modification and the warning signs of this disease. Dental professionals are ideally situated to provide advice regarding smoking cessation and alcohol moderation to their patients because of the significant impact of both substances on oral and general health.

Awareness days may provide potentially life-saving intervention to those diagnosed with an oral malignancy. However, the true number of people who might subsequently benefit from the information given to the estimated 10,000+ attendees is difficult to estimate. Like ripples in a pond, the knowledge gained by one person can spread out to touch and enhance the lives of many others. This campaign has enhanced professional awareness, as evidenced by the record-breaking attendance of general dental practitioners at the lectures, demonstrating their interest in this disease and their willingness to engage fully with this campaign. The active participation of the Irish Cancer Society, the Dental Health Foundation, the Cork and Dublin Dental Schools (staff and students) and the IDA is testament to what can be achieved when everyone works together. The website developed to support participants remains active at www.mouthcancerawareness.ie, and should serve as a useful resource for all in clinical practice. The Irish Cancer Society has developed an information booklet on 'Understanding Cancers of the Head, Neck and Mouth, caring for people with cancer' in 2012, and this is available through their office. The Society has also recently identified a project, 'Mouth, Head and Neck Cancer: The Patient Pathway in Ireland', to help

identify the important areas to be highlighted for improvement.

As dental practitioners and dental hygienists are currently the only primary healthcare professionals trained in examination of the mouth, it is critically important that this examination is integrated into our routine daily practice, and that people are encouraged to attend regularly. It is also worth 'talking aloud' through the examination process, so that patients realise that this is an integral part of their check-up. This also provides an ideal opportunity to highlight the relevant risk factors. This type of opportunistic screening was strongly endorsed by the NHS National Screening Criteria expert panel on oral cancer (Speight and Warnakulasuriya, 2010).

Our thanks to all those who made this possible, and in particular to the patients who attended in 2010 and 2011. It is hoped that pharmacists and general medical practitioners will become involved in future mouth cancer awareness campaigns. Finally, we would like to congratulate and thank all who contributed to the success of last year's event. We hope that you will once again wholeheartedly support Mouth Cancer Awareness Day on Wednesday September 19, 2012, and will encourage colleagues who could not participate last year to consider doing so in the future.

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Does three-dimensional imaging offer a financial benefit for treating maxillary molars with furcation involvement? A pilot clinical case series

Walter, C., Weiger, R., Dietrich, T., Lang, N.P., Zitzmann, N.U.

Aim

To assess the financial benefit of cone-beam computed tomography (CBCT) for the treatment options of maxillary molars including periodontal surgery and extraction followed by implant placement.

Material and methods

Twelve patients with generalised chronic periodontitis were recruited, and CBCT was performed in maxillary molars (n=22) with clinical furcation involvement and increased probing pocket depths. Treatment recommendations were either based on conventional periodontal diagnostics (clinical examinations and periapical radiographs), or on the additional CBCT data. Clinical recommendations comprised a minimal (e.g., supportive periodontal treatment) and a maximal invasive therapy (e.g., extraction and implant placement), and these were compared with CBCT-based recommendations. According to the Swiss dental tariff structure, the probabilities of saving costs or time, and the numbers needed to treat, were analysed with an empirical cumulative distribution function.

Results

Average cost reduction from CBCT amounted to CHF 915 ± 1,470 and saved 136 ± 217 minutes. Greatest reductions were found with maximal invasive clinically based treatment decisions (CHF 1,566 ± 1,840), particularly for second molars (CHF 2,485 ± 2,226). To compensate CBCT costs, 1.7 subjects were needed to treat to at least break even.

Conclusions

Data from CBCT facilitated a reduction in treatment costs and time for periodontally involved maxillary molars in Switzerland. Based on these cost analyses, however, CBCT as additional diagnostic measure is justified only when more invasive therapies are planned.

Clinical Oral Implants Research 2012; 23 (3): 351-358.

Periodontal healing following avulsion and re-plantation of teeth: a multi-centre randomised controlled trial to compare two root canal medicaments

Day, P.F., Gregg, T.A., Ashley, A., Welbury, R.A., Cole, B.O., High, A.S., et al.

Background

Non-setting calcium hydroxide (Ultracal XS®) is recommended by the International Association of Dental Traumatology as the initial medicament following avulsion and re-plantation of mature teeth. There is experimental evidence to suggest that Ledermix®, placed as an alternative inter-visit dressing, may improve periodontal healing.

Aim

This study investigated, using a multi-centre randomised controlled trial, the effect of two root canal medicaments, Ledermix® and Ultracal XS®, on periodontal healing of avulsed and re-planted teeth.

Material and methods

Children were recruited if they fulfilled all inclusion criteria. Treatment followed a standardised protocol. Assessment of periodontal healing or ankylosis was made clinically and radiographically by an experienced, 'blinded' clinician at 12 months.

Results

Over 200 patients were assessed for eligibility at five centres. Twenty-nine patients were eligible for inclusion. Final analysis involved 22 patients with 27 teeth. Ankylosis was detected in four of the 12 teeth in the Ledermix® group, and nine of 15 in the Ultracal XS® group. No significant difference between medicaments was found in the proportion of teeth or patients showing periodontal healing.

Discussion

There was no significant difference in periodontal healing between the two medicaments at either tooth or patient level. The numbers recruited fell short of an estimated power calculation. For patients meeting the inclusion criteria and completing the trial, periodontal healing was seen in 52% of teeth at the 12-month assessment between both groups. The only factor found to significantly influence the periodontal outcome was dry time.

Dental Traumatology 2012; 28 (1): 55-64.

Evaluation of cleaning capacity and instrumentation time of manual, hybrid and rotary instrumentation techniques in primary molars

Pinheiro, S.L., Araujo, G., Bincelli, I., Cunha, R., Bueno, C.

Aim

To compare the cleaning effectiveness of manual, hybrid and rotary instrumentation techniques in primary molar teeth.

Methodology

Fifteen primary molars were selected. After endodontic access, the teeth were immersed in a medium containing *Enterococcus faecalis* and divided into three groups, according to the root canal instrumentation technique: group 1 – manual; group 2 – hybrid; and, group 3 – nickel-titanium (NiTi) rotary files. For microbiological evaluation, comparisons before and after instrumentation were performed using the paired Student's t-test. One-way anova complemented with the Student's t-test was used to compare the percentage of microbial reduction. Instrumentation time was evaluated by Kruskal-Wallis and Student-Newman-Keuls tests. Images obtained

under scanning electron microscopy were analysed by three blinded examiners, and kappa statistics were used to evaluate calibration among examiners. The most frequent results among examiners were analysed using Kruskal-Wallis and Student-Newman-Keuls tests.

Results

The hybrid technique required a significantly longer instrumentation time than the manual and rotary techniques ($p < 0.05$). All techniques tested were able to significantly reduce the number of *E. faecalis* ($p < 0.05$). The hybrid technique was associated with the highest intracanal bacterial reduction, with a statistically significant difference compared with manual instrumentation ($p = 0.01$). Manual instrumentation resulted in the lowest amount of debris and the highest amount of smear layer when compared with the rotary and hybrid techniques ($p < 0.05$). There was no difference between rotary and hybrid instrumentation in the removal of debris and smear layer.

Conclusion

The use of NiTi rotary files is an option for root canal instrumentation in primary teeth.

International Endodontic Journal 2012; 45 (4): 379-385.

Treatment of gingival recession defects using coronally advanced flap with a porcine collagen matrix compared to coronally advanced flap with connective tissue graft: a randomised controlled clinical trial

Cardaropoli, D., Tamagnone, L., Roffredo, A., Gaveglio, L.

Background

Connective tissue graft (CTG) plus coronally advanced flap (CAF) is the reference therapy for root coverage. The aim of the present study is to evaluate the use of a porcine collagen matrix (PCM) plus CAF as an alternative to CTG+CAF for the treatment of gingival recessions (RECs), in a prospective randomised, controlled clinical trial.

Methods

Eighteen adult patients participated in this study. The patients presented 22 single Miller's Class I or II RECs, randomly assigned to the test (PCM+CAF) or control (CTG+CAF) group. REC, probing depth, clinical attachment level (CAL) and width of keratinised tissue (KG) were evaluated at 12 months. In addition, the gingival thickness (GT) was measured 1mm apical to the bottom of the sulcus.

Results

At 12 months, mean REC was 0.23mm for test sites and 0.09mm for control sites ($p < 0.01$), whereas percentage of root coverage was 94.32% and 96.97%, respectively. CAL gain was 2.41mm in test sites and 2.95mm in control sites ($p < 0.01$). KG gain was 1.23mm in the test group and 1.27mm in the control group ($p < 0.01$). In test sites, GT

changed from 0.82 to 1.82mm, and in control sites, from 0.86 to 2.09mm ($p < 0.01$).

Conclusions

Within the limits of the study, both treatment procedures resulted in significant reduction in REC at 12 months. No statistically significant differences were found between PCM+CAF and CTG+CAF with regard to any clinical parameter. The collagen matrix represents a possible alternative to CTG.

Journal of Periodontology 2012; 83 (3): 321-328.

Quiz

Questions on page 64

Answers

1. The image depicts an orthodontic facemask/protraction facemask.
2. This is used for the early treatment of skeletal CI III malocclusion with protraction therapy (early is patients under 10).
3. In well-selected cases, it can achieve positive dental and skeletal changes, to increase the overjet and achieve some favourable maxillary growth.

A recent multi-centre, randomised controlled trial in the UK¹ found that positive dental and skeletal changes, such as a positive overjet, were achieved in 70% of cases in the short term (15 months). The average increase in overjet was 4.4mm. Long-term follow-up is ongoing in this study. Studies that have looked at the long-term effects of facemasks to improve CI III malocclusions have found that a severe skeletal discrepancy, an increased vertical dimension, reduced overbite and a prognathic mandible were unfavourable factors for long-term stability following early treatment.² Early intervention may not negate the need for orthognathic surgery in these patients to achieve the most ideal result, but will increase the duration of treatment.

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Classified advert procedure

Please read these instructions prior to sending an advertisement. Below are the charges for placing an advertisement for both members and non-members. Advertisements will only be accepted in writing via fax (01- 295 0092), letter or email (fionnuala@irishdentalassoc.ie). Non-members must pre-pay for advertisements, which must arrive no later than Friday May 11, 2012, by cheque made payable to the Irish Dental Association. If a box number is required, please indicate this at the end of the ad (replies to box number X). Classified ads placed in the *Journal* are also published on our website www.dentist.ie for 12 weeks.

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

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

Only if the advert is in excess of 40 words, then please contact: Think Media

The Malthouse, 537 North Circular Road, Dublin 1.
Tel: 01-856 1166 Fax: 01-856 1169 Email: paul@thinkmedia.ie

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

- ▶ Positions Wanted
- ▶ Positions Vacant
- ▶ Practices for Sale/To Let
- ▶ Practices Wanted
- ▶ Unwanted/Second Hand Equipment for Sale

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

POSITIONS WANTED

Experienced, friendly dentist seeks full-time/part-time position in the West of Ireland. CV available on request. Please Email: dentistwest9@gmail.com.

POSITIONS VACANT

Associate required to replace departing colleague in Gorey, Co.

Wexford. Full/part-time. Late evenings available. Full book. New chair. New computer system. Qualified DSA. OPG. Hygienist. 40 minutes from Dublin. To start May 2012,
Email: info@thebridgedentalsurgery.ie.

Associate position available in a growing, state-of-the-art, computerised, mixed practice. Please Email CV to: info@blackglendental.ie.

Associate required, initially Monday, Tuesday. Private and PRSI, 45 minutes north of Dublin. March start. Tel: 046-943 3189 between 8.00pm and 9.00pm.

Dental associate required for Co. Galway town. Must be available to work late evenings and Saturdays. Minimum three years' experience. Please Email: countygallowaydentist@gmail.com.

A busy practice in South East Galway requires a full-time associate to join their team. We are a group-led practice with modern facilities, including a hygiene service and OPG, etc. Please Email: rothdent@hotmail.com.

Full-time dental associate required for Carlow town. To start in May. Must be enthusiastic and good communicator for busy, friendly practice. Six surgeries, OPG, computerised. Three part-time hygienists. Visiting orthodontist, endodontist and oral surgeon. Tel: 086-338 8120, or Email CV to: rsgillman1@hotmail.com.

Experienced associate dentist required to replace departing colleague in busy modern practice in Co. Mayo. Excellent support staff, hygienist and OPG. Email CV to: reception@drrosemarysmith.com.

Dental associate required part-time for Killaloe, Co. Clare. Two days per week. Experienced team, pleasant working environment. Please respond with CV by Email: brendaodowd@eircom.net.

Associate dentist with minimum three years' experience required for existing book on Saturdays at a practice 35 minutes from Dublin. Fully computerised and every possible mod con with in-house periodontist, endodontist and orthodontist. Please reply with CV to abbeydentists@hotmail.com or Box No. J212.001.

Visodental, City of Derry. Associate position. One-year-old vibrant city centre practice. Private/NHS. Fully digital and computerised. ADEC 500, Kodak intraoral camera, LDU, RA implant service within practice. Please contact Daniel, Tel: 028-7130 8762, or Email CV to: patriciamullanvisio@btconnect.com.

We have first-class facilities, an excellent team and lovely patients. We need a personable, experienced dentist two days per week including Saturday. Check us out on www.wq dental.com.

Experienced dentist required for busy central Mayo practice. Modern computerised practice with intra-oral cameras and radiographs. Experienced team, pleasant working environment. Great opportunity four days weekly, with buy-in option. To apply, please Email: dentistvacancy12@gmail.com.

Part-time dentist required for practice in Dublin SW. Minimum of three years' experience required. Please respond with CV by Email: adasethsmith@gmail.com.

Busy general dental practice Kilkenny City seeks locum dentist four to five days per week (to include Saturday morning) to cover four weeks' leave from March 15 to April 14. Interested candidates please Tel: 087-230 0379.

Part-time locum required for maternity cover. April to July. Co. Kildare, 30 minutes west of Dublin. Please Email: glenaree@googlemail.com for details.

Locum dentist to start April 5 for five to six weeks, including Saturday mornings. Please Tel: 01-454 9400, or Email: niallmacdonagh dental@eircom.net.

Orthodontist required part-time for established busy practice in the Dublin area. Please submit CV, which will be dealt with in the strictest of confidence. Email: 1casanaview@gmail.com.

Part-time registered orthodontist required for busy general dentist practice in multi-disciplinary clinic, Kilkenny City. The Springhill Clinic is a modern clinic with digital OPG, excellent staff and a large patient base with a demand for orthodontic treatment. Tel: 086-320 8826, or Email: info@springhillclinic.ie.

Experienced orthodontist required for busy general practice in West Dublin. Would suit outreach to main practice. Flexible options. New patient numbers strong. Tel: 086-807 5273, or Email: niall@innovatedental.com.

Orthodontist required for sessions in a well-established busy specialist practice. Dublin 4 area. Flexible options. Please contact Grace, Tel: 086-264 8970, or Email: grace@mahonpembrokesurgery.com.

A fantastic opportunity for an orthodontist to set up in a well-established fully private practice in Limerick City. Please Tel: 087-906 5705, or Email: cormac.shields@gmail.com.

Orthodontist. Part-time orthodontist required for busy general/implant clinic in Sligo Town. Ultra modern clinic with digital OPT, excellent staff, large patient base and demand for ortho treatments. Tel: 087-775 0938, or Email: dandckennedy@eircom.net.

Endodontist required for sessions in a well-established busy specialist practice. Dublin 4 area. Flexible options. Please contact Grace, Tel: 086-264 8970, or Email: grace@mahonpembrokesurgery.com.

Opportunity for specialist dentist to join a multidisciplinary team in Dublin City Centre. Please forward curriculum vitae to: dentalspecialistrecruitment@gmail.com.

Enthusiastic DSA required in Dublin 14 practice, full/part-time. Apply by Email with CV to: rdpdentnurse@gmail.com.

City Centre Dublin. Enthusiastic, experienced – three years+ – DSA required. Excellent interpersonal skills. Must be computer literate and flexible in availability. Very good terms offered to right candidate. Tel: 086-807 5273, or apply by Email to: niall@innovatedental.com.

Experienced dental assistant required in Ashbourne dental practice, to cover maternity leave starting in April for six months. Please send CV to: philip@ashbournedentalcentre.ie.

Experienced dental nurse required. Part-time position in South Dublin dental practice. Hours would involve early mornings and late evenings. Candidate must be flexible and ideally have at least three years' experience. Please Email CV and cover letter to njdental2011@gmail.com.

Specialist dental practice in Dublin 4 requires a qualified dental nurse with computer skills to cover maternity leave from June to December 2012. Please phone during office hours, Tel: 01-269 3155, or Email: reception@belfielddental.ie.

Are you an outgoing, warm, well presented, highly organised and caring dental nurse with a good eye for detail and excellent computer skills? Maybe you would like to join us creating winning smiles at Clontarf Orthodontics, Tel: 01-818 6571. Training provided but experience an advantage.

PRACTICES FOR SALE/TO LET

For sale. Busy dental practice in Waterford City. 40 years established. Dentist retiring. Tel: 051-382401, or Email: gilesraff@gmail.com.

For sale. Excellent orthodontic practice. Superb opportunity. Long established. South Dublin location. Two surgeries. Expansion possible, plans available. Flexible lease options. Buy-in over three to four years. Excellent figures – great staff. Fully computerised. Well stocked. Tel: 086-807 5273, or Email: niall@innovatedental.com.

For sale. Modern dental practice with great equipment in a South Dublin location (Rathfarnham/Dundrum area). Email: redek78@gmail.com.

For sale – West of Ireland. Very busy, long established, modern, well-equipped walkinable large practice. Digitalised/OPG. Hygienist. Excellent loyal staff. Immediate profits. Large potential for growth. Genuine reason for fast sale. Tel: 086-807 5273, or Email: niall@innovatedental.com.

Prospering private practice for sale – County Donegal. Two surgeries fully equipped with up-to-date digitalised OPG, intra-oral x-ray, two fully equipped dental chairs, plasma lamp, etc. Viewing essential to appreciate. Specialises in cosmetic dentistry. Tel: 074-973 2684.

Millstreet, Co.Cork. Tremendous business opportunity for a variety of professionals, e.g., dentists, pharmacists. High specification units/offices to let, competitively priced, generous rent-free period, fit-out provided, ample parking. Contact Catherine, Dick Pomeroy & Co., IPAV, Millstreet, Tel: 029-70700/087-224 8432.

Unit suitable for dental practice, Clonee, Dublin 15. Approx 620 sq ft. Rent €8,000 pa. Beside medical centre/large primary school and densely populated residential neighbourhood. Previously established dental practice within centre. Ample car parking. Tel: 086-243 7911.

Rooms to let in specialist practice, Dublin 3, on DART line, parking on site. Suit all specialties – ortho, paedo, perio, pros. Contact Shona, Tel: 01-818 6571.

Diary of events

JOURNAL OF THE IRISH DENTAL ASSOCIATION

APRIL

Kerry Branch IDA – Meeting: Update on imaging techniques for implant assessment

April 19 *Malton Hotel, Killarney*
Meeting starts at 8.00pm. Speaker is Dr Sean McCarthy.

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Munster Branch IDA – President's Dinner

April 20 *Crawford Art Gallery*
Limited numbers. Contact Judith Phelan, President, Tel: 085-708 7080, or Fiona Twohig, Secretary, Tel: 021-496 1776.

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Irish Society of Dentistry for Children – Annual Scientific Meeting 2012

April 26 *Portlaoise Heritage Hotel*
Guest speakers are Prof. Bill Bowen, University of Rochester NY, on 'Cariology', and Dr Marie Therese Hosey, King's College Dental School, London, on 'Behaviour management techniques'. For details, log on to www.dentistryforchildren.ie.

Orthodontic Society of Ireland – Meeting

April 27-28 *Faithlegg House, Waterford*
Speakers are Dr Vince Kokich Jnr on 'Aesthetics, finishing and interdisciplinary treatment' and Drs Albino Triaca, Marco Tribo and Luca Signorelli on 'Surgical orthodontics'.

JUNE

European Society of Dental Ergonomics – 25th Annual Meeting: Well-being of the dental team – a multi-disciplinary approach

June 1-2 *Maastricht*
Further details are available on www.esde.org.

Europerio7 – 7th Congress of the European Federation of Periodontology

June 6-9 *Vienna, Austria*
Learn the newest techniques and treatment methods in the field of periodontology, implantology and dental hygiene from renowned experts. More information on this conference can be found on the website – www.europerio7.com.

Irish Society for Disability and Oral Health – Conference

June 22 *Dublin Conference Centre*

SEPTEMBER

Mouth Cancer Awareness Day

September 19 *Nationwide*

BDA Seminar Series – Crown and bridgework: improve your skills, update your knowledge and get the best results

September 28 *Belfast*
To view the full programme and to book, contact Rebecca Hancock, Tel: 020-7563 4590, or Email: events@bda.org. CPD verifiable.

OCTOBER

HSE Group of the IDA – Annual Seminar

October 10-12 *Galway Bay Hotel, Galway*



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

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

October 28-31 *Melbourne, Australia*
For further information, see www.iadh2012.com.

Faculty of Dentistry of the Royal College of Surgeons in Ireland – 2012 Annual Scientific Meeting:

An overview of aesthetic dentistry

October 26-27
Further information to follow when available.

NOVEMBER

Orthodontic Society of Ireland – Meeting

November 23-24 *K Club, Co. Kildare*
Speakers are Drs Marco Rosa, Renato Colconi and Mirco Raffaini, on 'The face and occlusion in the diagnostic process: new strategies for treatment from mixed dentition to surgery'.

The Asia Pacific Orthodontic Conference

November 29 to December 2 *New Delhi, India*
For further information, see www.8thapoc-47thioc.in

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I've heard that chewing Extra Ice helps to neutralise plaque acid attacks.

Keep your lid on!



Teeth need extra protection after eating and drinking, especially when people are on the go and can't brush.

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