Volume 54 Number 5 October/November 2008

IDA
irish dental association

Journal of the Irish Dental Association

Iris Cumainn Déadach na hÉireann

The Dental Council's Communications Code

SENSODYNE

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The search is on...

Sensodyne and the Journal of the Irish Dental Association are teaming up to find Ireland's most sensitive dentist. That's the dentist who, in the words of a patient, demonstrates the most care and attention, beyond the dental treatment provided.

An independent panel of judges will adjudicate on the nominations. The award-winning dentist will be announced in the December/January edition of the Journal while the patient who nominates the winning dentist will win a family holiday in Florida.

Posters and leaflets were provided to dentists for their surgery waiting rooms or reception areas, and the competition has been publicised nationally by Sensodyne.

For further information, see www.sensodyne.ie or contact the Journal of the Irish Dental Association on 01-8561166.

Closing date for completed entries is November 1, 2008. Full competition rules and complete information on prize is available on www.sensodyne.ie

IDA

journal of the irish dental association

Iris Cumainn Déadach na hÉireann

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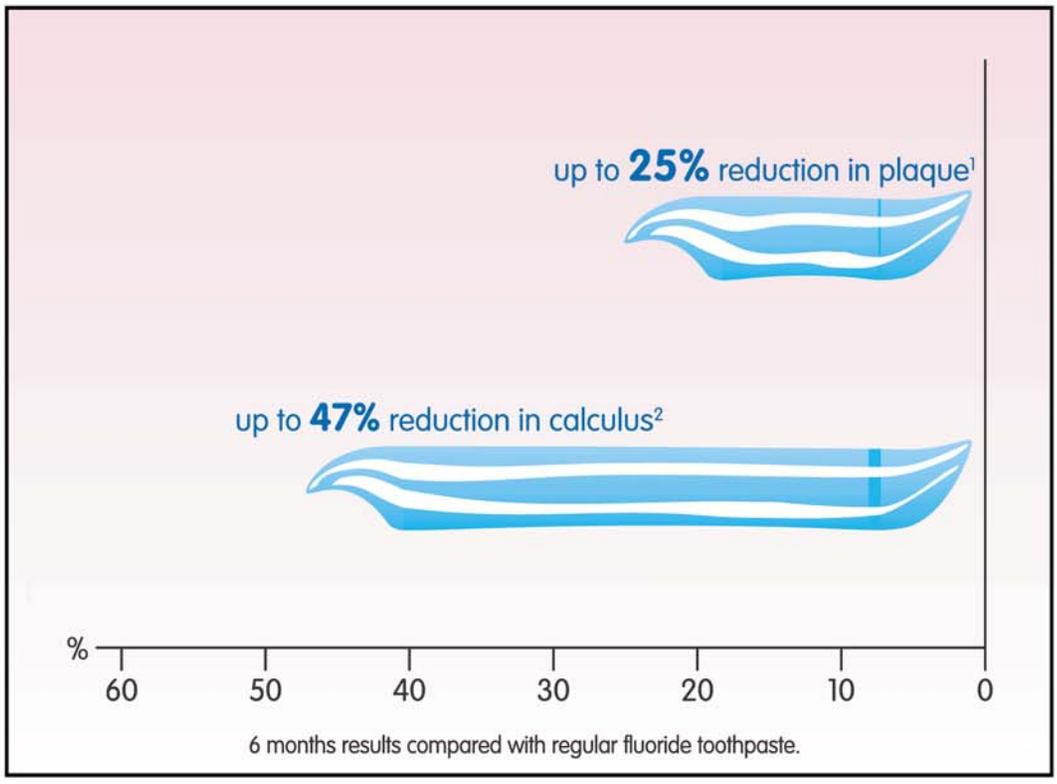
Colgate

Unbeatable sensitivity protection.

Protection against plaque and calculus build-up, plus gum problems.



Colgate Sensitive Multi-Protection for patients with compromised oral hygiene due to acute sensitivity:

- Contains potassium citrate for unbeatable sensitivity protection[4]
- Contains zinc citrate to help protect hypersensitive teeth from the effects of oral bacteria
- Shown to reduce the build-up of plaque[1,3] and calculus[2,5–7] and reduce gum problems[1,3]
- Same great taste as Colgate Sensitive, so you know that compliance will not be a problem

For further details, call 01 4039800 or log on to our website www.colgate.ie

All-round protection for sensitive teeth.

References: 1. Williams C, McBride S, Mostler K *et al.* Efficacy of a dentifrice containing zinc citrate for the control of plaque and gingivitis: A 6-month study in adults. Compend Contin Educ Dent 1998; 19(2 Suppl): 4–15. **2.** Petrone M, Lobene RR, Harrison LB *et al.* Clinical comparison of the anti-calculus efficacy of three commercially available dentifrices. Clin Prev Dent 1991; 13(4): 18–21. **3.** Data on file. Clinical efficacy of a zinc citrate dentifrice in the control of plaque and gingivitis: A 6-month study in adults. Colgate-Palmolive Ltd. **4.** Data on file. Comparative clinical study of the desensitizing efficacy of Sensitive Multi-Protection: A four week study. Colgate-Palmolive Co. **5.** Schiff TG, Volpe AR, Gaffar A *et al.* The comparative anticalculus effect of dentifrices containing 1.30% soluble pyrophosphate with and without copolymer. J Clin Dent 1990; 2(2): 48–52. **6.** Singh SM, Petrone ME, Volpe AR *et al.* Comparison of the anticalculus effect of two soluble pyrophosphate dentifrices with and without a copolymer. J Clin Dent 1990; 2(2): 53–55. **7.** Sowinski J, Petrone DM, Simone AJ *et al.* Clinical efficacy of a dentifrice containing zinc citrate: A 12 week calculus clinical study in adults. Compend Contin Educ Dent 1998; 19(2 Suppl): 16–19.

EDITORIAL

Moving forward in difficult times

In September, I attended and spoke at the 17th Annual Scientific Conference of the European Association for Osseointegration in Warsaw, Poland. This was under the Presidency of Prof. Friedrich Neukam and Scientific Chairmanships of Prof. Andrzej Wojtowicz and our own Dr David Harris. This meeting showed the level of scientific research that is being undertaken in implant cases in Europe and the excellent partnerships between industry, clinicians and scientists. It was a great meeting and an opportunity to see both what we are doing well and what we can improve on. A most intriguing and exciting lecture was also given by the Professor of Astronomy from the Nicolaus Copernicus University on 'Children of the Universe', highlighting where we have come from and, more importantly, where we are going.

It is hard to concentrate on academic/Journal business with many of us transfixed by the banks/shares/US elections and wondering what is happening around us. Is there something we can do? Are we all simply pawns in a rapidly changing and often seemingly corrupt world? What about those who have nothing? Sometimes it is hard to realise how lucky we are.

This Journal highlights some important issues that we all need to be aware of. The Dental Council's Communication Code (pp.213-214) is no surprise and hopefully will bring some co-ordination. It is worth reading to make sure that we are following the guidelines. We must also, despite the hardships, manage our practice finances in the present economy (pp.226-227), as well as preparing to manage our pensions (pp.228-229).

The IDA's pre-budget submission (p.199) will hopefully be read and it shows a great sense of proactive policy by our Council. It is sensible and, more importantly, possible, with no significant financial outlay on the part of the DoH&C. The letter to the HSE Employers Agency on the issue of blood-borne viruses is an essential piece of information required for all who have employees and highlights the risks to patients and clinical staff. The collaboration between Dental Protection and the IDA (p.208) highlights the need for discussion on risk management and communication skills. These are two very inter-related issues as many problems arise because of a breakdown in communications. The Colgate Oral Health Survey (p.202) unfortunately highlights how poorly our patients look after their oral health – with men doing particularly badly – while still recognising how important it is. I did not recognise many of the international celebrities named but that might reflect my age, and I have never had anybody leave money under my pillow yet!

The Honorary CED Treasurer (pp.210-212) again writes with a 'knowledgeable hand', keeping us abreast of what is going on in Europe. The meeting with Francoise Grossetete MEP was particularly important. Her email address is worth noting.

The scientific section (pp.215-222) highlights where we are with selection of adhesive systems for resin-based luting agents, and how we can manage our patients with renal disease. The number of scientific articles we are getting is increasing, with articles covering most areas in dentistry. We are maintaining high standards and are now producing six issues per year. The Editorial Board is proposing that the Journal be an 'open book' on the IDA website and have the support of the IDA CEO, subject to resolving some funding issues. This will be a big step forwards and thanks to all who have supported this development.

It was sad to hear of the death of Prof. John Lowry, a colleague and friend, on 29 September 2008. Prof. Lowry dedicated his life to oral and maxillofacial surgery through his international, European and UK connections. He was a friend to all in dentistry and surgery, and showed us what is possible when we work together. His family will be comforted by those who knew him and his life will be respected by all he touched.

Leo F. A. Stassen

Prof. Leo F. A. Stassen
Honorary Editor

PRESIDENT'S NEWS

Successful Oral Health Month

IDA President DR ENA BRENNAN welcomes new members to the Association, and gives an update on current and upcoming events.

Welcome back

A big welcome back to you all after the summer months, during which I hope most of you managed to get a holiday from your busy practices! We are now in October and back into the thick of IDA business for another season.

The autumn period is usually the time when branch activities start again for the year and I am delighted to see such a varied calendar of events scheduled in many branches from now until Christmas. I would like to take this opportunity to congratulate all the branches that are active throughout the country, and to encourage you all to get involved in your local branch. Remember, your branch can only operate if YOU get involved.

Colgate Oral Health Month

For the sixth year running, we had a very successful Colgate Oral Health Month in September. With over 500 dental practices involved in Colgate Oral Health Month it has become the leading Irish oral health campaign. Many regional road shows were organised to bring the message of the importance of good oral healthcare to the public. I would like to thank all of you who got involved; it was a great pleasure to see so many of the profession actively involved and promoting good oral care in your surgeries.

Roll on Colgate Oral Health Month 2009!

Annual Conference 2009

Plans are well underway for the Annual Conference – Skillkenny 2009. Next year's event takes place in the fantastic setting of Hotel Kilkenny and a very interesting line-up of national and international speakers is expected. As you are well aware, continuing education will be mandatory for all dentists from January 2010 and I urge each and every one of you to attend your national conference in 2009 to prepare yourself to meet the mandatory requirements well in advance of the January 2010 deadline. Continuing dental education is a very welcome development for our profession and can only lead to a better skilled and educated dental profession in Ireland.

National Oral Health Strategy

There was an extensive report regarding the National Oral Health Strategy in the last edition of the Journal. Unfortunately, to date, no interim report has been issued by the Core Group and the IDA has been advised that this will be published towards the end of the year. We will keep members updated on any developments in this regard.

New members

I am delighted to see so many new members joining the IDA over the summer months. I was particularly pleased to see a large number of new graduates joining the Association as they graduate from their respective universities and move on to the next phase of their careers in dentistry. Please remember that new graduates enjoy free membership for their first year after graduating, so encourage any of them that you know to join the Association.

Ena Brennan

Dr Ena Brennan
IDA President

Association makes pre-budget submission

The IDA is seeking tax relief and allowances to facilitate better oral health for the population, and for the development of dental surgical practices.

The Irish Dental Association has, for the first time, made a pre-budget submission to the Government. Cognisant of the difficult times faced by the country, the Association couches its arguments in prudent terms. It seeks to achieve two main aims: better oral health for the population through alleviating costs for patients; and, development of dental surgical practices, equipment and education. The submission states that it seeks to achieve these goals with the assistance of the Government and that the primary vehicle for such assistance will be tax relief and allowances, rather than any additional direct state investments.

In seeking to achieve better oral health for the population, the Association's submission argues that VAT should be removed from essential oral health products such as toothbrushes, inter-dental brushes, oral mouthwashes and flosses. Additionally, the IDA argues in favour of the extension of tax relief for patients attending for dental treatment, and lists a set of specific items that could be allowed for tax relief for the general good of the population's oral health.

The submission calls for the introduction of specific allowances or relief to cover a number of items, including:

- the introduction of separate decontamination rooms and segregated areas;
- the purchase of amalgam separators;
- the installation of digital radiography;
- attendance at relevant safety training courses;
- refurbishment work in dental practices; and,
- access to enhancement work (to allow improved access for the elderly, specials needs and mobility-restricted patients).

The proposals include the consideration of introducing accelerated capital allowances.

The section on 'Promoting employment and alleviating costs' seeks initiatives to meet the initial cost of employing nursing and administrative staff, as well as some form of relief to help towards the cost of professional indemnity insurance. (Relief is available to medical practitioners, but not to dental practitioners.)

A full section is dedicated to ways in which the Government could assist the public dental service, stating: "A properly funded public dental service has the potential to provide excellent value for money in delivering dental care to children and the vulnerable adult population". In this section, issues relating to the potential (unfulfilled) of the school dental service; HSE staffing; and, the reform of the DTSS, are fully outlined. The Association is grateful to MedAccount for its assistance in the preparation of the submission.

Appointments at IDA House

Claire Cosgrave has been appointed as Employment/Industrial Relations Officer with the IDA. A native of Co. Limerick, Claire joins IDA from Cork-based multinational RCI. Claire holds a Business Studies degree from University of Limerick and is currently studying for an MBS – Human Resource Management at UL.

Dario Gioe commenced his role as Marketing and Events Administrator with the IDA in September. Dario comes to the IDA from British Telecom, where he has worked for nearly two years after moving from his native Sicily to Ireland in 2005.

We welcome both Claire and Dario to IDA House.

Blood-borne viruses

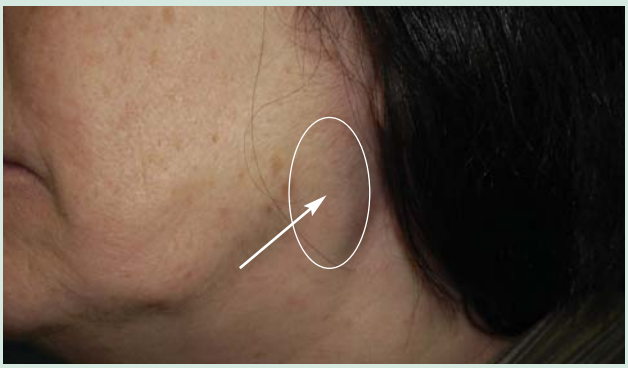
The Association has written to the HSE Employers Agency in relation to a recent HSE Circular on 'Prevention of the Transmission of Blood-Borne Viruses'. The letter seeks information on progress made in establishing supports for infected staff, particularly a confidential helpline; and, on the referral pathways to be used when a healthcare worker is injured following contact with high-risk patients.

DTSS scheme comes under fire

Fintan Hourihan, IDA CEO, criticised the DTSS.

In answer to a written parliamentary question from Caoimhghín Ó Caoláin, TD, Minister for Health Mary Harney, TD, revealed that 190 dentists had withdrawn from the Dental Treatment Services Scheme (DTSS) over the last 18 months. Commenting on the situation in several media, the Chief Executive Officer of the Association, Fintan Hourihan, emphasised the difficulties facing dentists in relation to the operation of the DTSS. He said: "Dentists are frustrated at the significant under-funding of the service and the refusal of the HSE to address the difficulties that are there with the medical card scheme."

Quiz



A 45-year-old woman presents with a two-month history of a non-tender lump in the left side of her neck.

What are the important symptoms and signs?
What are the three most likely diagnoses?
What investigations are required?

Answers on page 225.

IDA Golf Society Captain's Prize

2008 Captain's Prize winner Lynda Elliott is presented with her prize by IDA Golf Society Captain Billy Davis.

The IDA Golf Society's annual Captain's Prize took place on Saturday September 6 at the beautiful Carlow Golf Club. Despite adverse weather conditions leading up to the day, the club managed to get the course opened, and despite a few waterlogged patches, it was, as usual, enjoyable to play. The event was very well organised by Captain Billy Davis and committee, and extremely well attended, with 60 players, including our IDA President Ena Brennan, taking part.

The event was generously sponsored by Biomet 3i. Following the golf, most players stayed on for a fabulous meal and prize-giving in the Carlow clubhouse. Many excellent prizes were awarded to the deserving players, with the overall prize of a silver wine coaster and a box of premier cru wine going to Lynda Elliott, who scored 42 points.

Although the event was well attended, there was a noticeable gender imbalance, with only three ladies playing on the day. The committee would like to encourage ladies at all levels to join the Golf Society and to come along to the next outing – The Christmas Hamper – at The Royal Dublin Golf Club on December 5. Many thanks again to Billy Davis and committee for organising such a great day and we hope to see you all in The Royal Dublin on December 5.

Colgate Total accreditation

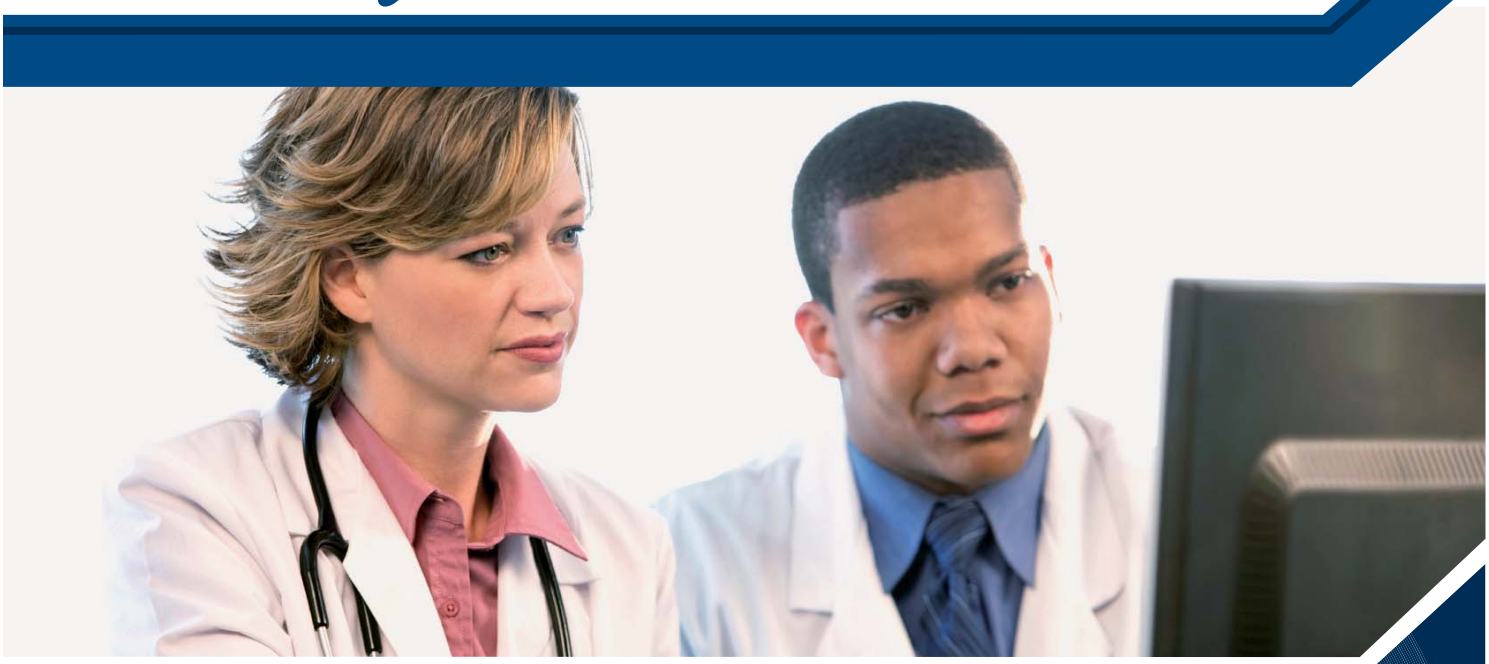
The IDA Council is delighted to announce that Colgate Total has now been accepted for accreditation.

Colgate Total is the first Colgate brand to be accredited by the IDA. IDA accreditation indicates the acceptance of certain products after a very comprehensive assessment by a scientific panel appointed by the IDA.

Diary & Directory 2009

The new 2009 *IDA Diary & Directory* will be sent to all members in November this year. Once again, this valuable publication contains a listing of members and trade suppliers, and will be an essential addition to any dental practice. The Association would like to thank all advertisers for their continued support for all IDA publications.

QUINN-*life*



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AIDI/BDTA joint meeting

A joint meeting of the Association of the Irish Dental industry (AIDI) and the British Dental Trade Association (BDTA) took place at the Killashee House Hotel in Naas this summer. Presentations were made to members of both organisations, including a joint session presented by Norbert Orth of the European Dental Dealers Association.

At the AIDI AGM, Tony Anderson of Henry Schein (Ireland) Ltd was elected President in succession to Seamus O'Neill of DMI. The previous day, the members of the AIDI played for the Annual AIDI Cup over the Citywest Lakes Course. Aidan McCormack of DMI emerged as the clear winner with an outstanding score.

Tony Anderson is congratulated on his election as President of AIDI by his predecessdor, Seamus O'Neill.

President of the BDTA, Simon Gambold, with then AIDI President Seamus O'Neill, at the Gala Dinner.

Winner, Aidan McCormack of DMI (centre left), receives the AIDI Cup from Paul O'Grady of the Journal of the Irish Dental Association *(centre right), who sponsored the prizes. Competitors included (from left) Seamus O'Neill, DMI; Tommy Maguire of Kerr; Pat O'Brien of DMI; David Greham of 3M ESPE; Christy Canavan of Odontological Supplies; Anne O'Flaherty of the AIDI; and, Tony Anderson of Henry Schein (Ireland) Ltd.*

Colgate survey – Brad Pitt and Jessica Alba top poll amid major inflation in tooth fairy money!

As the sixth Colgate Oral Health Month was taking place in September, an Irish survey discovered some fascinating results! Commissioned for Colgate Oral Health Month, the survey of over 500 people discovered that over 60% of those surveyed don't always feel that they have done their best to keep their mouth healthy.

However, when asked which was most important to them from a health point of view, almost 44% said that having good oral health was more important than a healthy diet (39%) and regular exercise (17%). Given that more and more research is uncovering a possible association between oral health and overall general well being, this is an encouraging statistic. When people consider their health, they tend to focus on exercise and healthy eating, with oral health not as high on the agenda. During September, Colgate and the Irish Dental Association worked together to highlight the long-term benefits of good dental practice with the message 'a healthy lifestyle includes looking after your mouth'.

Other intriguing results from the survey include the fact that almost 45% of women surveyed believe that they make a concentrated effort on a daily basis to keep their mouth healthy, compared to only 34% of men. Alarmingly, 17% of those surveyed only brush their teeth out of habit rather than being aware that an overall healthy lifestyle includes looking after your mouth. Astonishingly, 6% of those surveyed admitted that they only take care of their teeth and mouth when they remember, with 3% admitting that they don't look after their teeth at all.

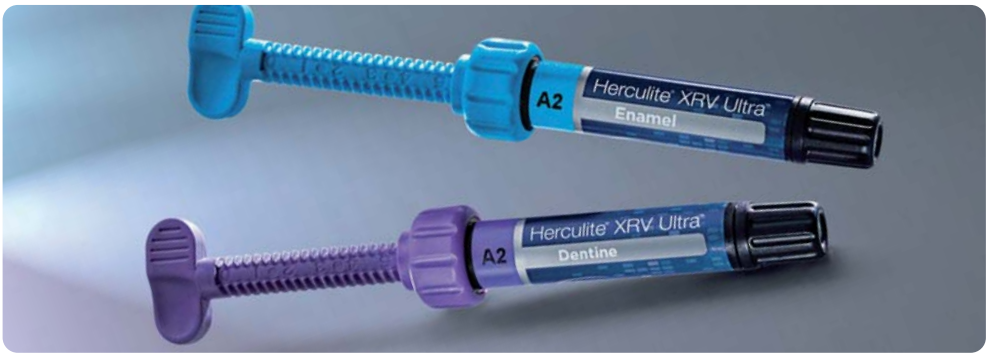
From a beauty perspective, having healthy teeth topped the polls at 44%, followed by shiny hair (14%) and glowing skin (12%). And despite all the recommendations from dental professionals, only 14% of those surveyed believe that flossing is important, with less than 12% citing the use of mouthwash as an essential part of their dental routine.

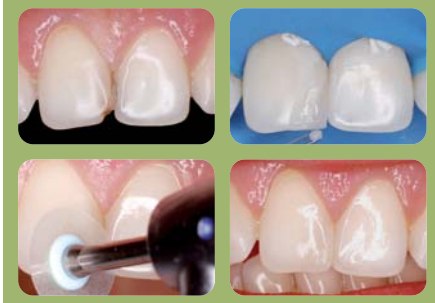
The survey also uncovered the extent of inflation in tooth fairy money. Some 28% of those surveyed said they would have received no more than the equivalent of €1 from the tooth fairy when they were growing up. However, when asked what that figure is now, 68% said that they believed it was at least €2, with 25% estimating that the going rate was now €4 or more.

Among the men surveyed, almost 35% voted Jessica Alba as the international celebrity they would most like to leave money under their pillow. This was followed closely by Angelina Jolie (32%), Gisele Bundchen (15%), Eva Mendez (10%) and Scarlett Johannsen (8%). Of the women surveyed, Brad Pitt topped the poll at 27%, followed closely by Will Smith (24%), Tom Cruise (20%) and Denzel Washington (20%). Justin Timberlake was least popular at just 9%.

Colgate Oral Health Month, which is aimed at promoting awareness of the benefits of good oral health, has gone from strength to strength over the last five years. The programme for this year consisted of a nationwide oral health educational road show. Visitors to the road show were invited to bring along their old toothbrush and exchange it for a shiny new Colgate 360° toothbrush free of charge on the day.

Herculite® XRV Ultra™ | Kerr, making history *again*.





Herculite® XRV Ultra™ evolution on the move

Herculite® XRV has been the industry standard for dental composites for 20 years. True to the Kerr legacy of developing innovative, quality products for dentistry, Kerr makes history again by launching another new addition to the Kerr composite family: Herculite® XRV Ultra™ nanohybrid composite. Based on the latest nanofiller technology, in addition to offering improved handling, polishability and wear resistance, Herculite® XRV Ultra™ delivers an improved lifelike appearance to final restorations by replicating the opalescence and fluorescence of the natural tooth.

Herculite XRV Ultra standard kit

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Herculite XRV Ultra MINI kit

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Accessories: Premise Flowable A2, 10 Flowable applicator tips, OptiBond Solo Plus bottle 5ml, Gel Etchant 3g, 10 Gel Etchant syringe tips, Optidisc Sample Kit with OptiDiscs 12.6mm: 15 x Extra-Coarse, 15 x Medium-Coarse, 15 x Fine, 15 x Extra-Fine, 25 Mixing Wells, 50 Applicator tips

33856 - Herculite XRV Ultra standard syringe

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33857 - Herculite XRV Ultra standard unidose

£134.95 €175.45

FREE

Purchase Herculite XRV Ultra standard syringe kit or unidose kit
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Syringe and Unidose Intro Kit (6 syringes/unidose)

The package contains 6 syringes 4g each or 6 Unidose boxes 10 x 0.2g in shades: Enamel A1, A2, A3, A3.5, D2, Dentine A2

Accessories: Premise Flowable A2, 10 Flowable applicator tips, OptiBond Solo Plus bottle 5ml, Gel Etchant 3g, 10 Gel Etchant syringe tips, OptiDisc Sample Kit with OptiDiscs 12.6 mm: 15 x Extra-Coarse, 15 x Medium-Coarse, 15 x Fine, 15 x Extra-Fine, 25 Mixing Wells, 50 Applicator tips

33858 - Herculite XRV Ultra intro syringe

£139.95 €181.95

33859 - Herculite XRV Ultra intro unidose

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Syringe and Unidose Mini Kit (3 syringes/unidose)

The package contains 3 syringes 4g each or 3 Unidose boxes 10 x 0.2g in shades: Enamel A2, A3, Dentine A2, OptiBond Solo Plus 5ml, Gel Etchant 3g, Applicator tips, Etchant syringe tips

33860 - Herculite XRV Ultra MINI syringe

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BUSINESS NEWS

Judges announced for dental competition

The judges for the Sensodyne Sensitive Dentist of the Year Competition have been announced. The competition will be judged by: Dr Barry Harrington (Chair); Dr Seton Menton; and, Dr Anne Crotty (Public Dental Surgeon). Dr Harrington is a GDP, a former President of the Association, and lectures part-time in the Dublin Dental Hospital. Dr Menton, also a GDP, last year received a 'Lifetime Achievement' award from the Metropolitan Branch of the IDA and he lectures in the Dublin Dental Hospital. Dr Crotty is an orthodontist who is well known through her recent term as President of the Public Dental Surgeons Group of the Irish Dental Association. The *Journal of the Irish Dental Association* will be represented on the panel of judges by Paul O'Grady.

Entries have already begun to flow into the organisers, and dentists and patients are reminded that the closing date is November 1. The patient that nominates the winning dentist will win a family holiday in Florida. Winners will be announced in the November/December edition of the Journal.

The painful truth about mouth ulcers

Some 1-2% of the population suffers from repeated and persistent mouth ulcers and, according to a recent survey on www.mouthulcer.com, there were 281 causes of mouth ulcers among the 210,737 respondents. However, the predominant causes are: stress; being run down; and, a lowering of the immune system, and the same top three are listed as triggers that exacerbate symptoms. Also high on the list was oral trauma caused by the fitting of orthodontic braces. Of more concern, persistent mouth ulcers that take longer than three weeks to heal are the number one symptom listed by The Mouth Cancer Foundation (source: www.mouthcancerfoundation.org).

Healthcare experts suggest that a balanced microflora in the mouth is essential for good oral health; however, when this is disrupted the protective balance is altered and pathogenic bacteria thrive, leading to mouth ulcers and other oral health problems. Many dentists recommend that patients use an oral probiotic to treat mouth ulcers and, in particular, a probiotic adapted to living in the whole digestive tract, including the oral cavity, and that can competitively exclude disease-causing organisms and stimulate the immune system, such as GUM PerioBalance.

GUM PerioBalance is the first and only probiotic specifically patented for oral care and endorsed by the British Dental Health Foundation. Clinical trials have found that it is side effect free and can be safely used in all categories of patients, from those who have compromised immune systems to pregnant women and children. Probiotics can be used even in extremely sore and dry mouths, where normal brushing can be limited by pain.

According to the manufacturers, PerioBalance has been found to reduce the inflammation of gingivitis, stabilise periodontitis, and reduce cariogenic activity. It binds to the mucosal epithelium, producing a more beneficial biofilm, as well as producing inhibitors to pathogenic growth, thus preventing or limiting the undesirable effects of pathogens and stimulating the immune system. Where the natural healthy bioflora of the mouth has been altered by oral cancer therapy a probiotic will seek to rectify any imbalance produced by restoring the healthy microflora balance.

Sunstar GUM has developed a wide range of oral care products in collaboration with dental professionals to help improve oral health. More information about Sunstar and the GUM range is available on www.sunstargum.co.uk.

BUSINESS NEWS

Solpadeine capsules – new pack size

GlaxoSmithKline Consumer Healthcare (Ireland) Ltd has announced that Solpadeine Capsules are now available in an additional pack size – 32s. This new pack size is reimbursed under the GMS scheme.

A nice day for a whiter wedding

A leading London aesthetic dentistry practice has reported a dramatic rise in women having cosmetic dentistry treatments for their big day. Lead clinician Dr Anoop Maini says he has noticed an increase of almost double in the run-up to summer, with many women opting for whitening or veneers to give them the perfect wedding day smile.

Hawo Impulse Heat Sealers – quick and cost effective barrier sealing

General Medical has announced that it has been appointed UK dental distributors for Hawo Impulse Heat Sealers, including the new 'Generation Easy' HD 320 MS-8, which are significantly cheaper per unit than using autoclave bags, at just a few pennies each.

Using conventional self-sealing pouches, it is virtually impossible to obtain a 100% seal. Consequently, micro-leakage inevitably results in re-infection of apparently sterile instruments, especially if they are stored for any length of time.

According to the company, the HD 320 MS-8 represents the state of the art in heat-sealing units for barrier products prior to autoclaving. Featuring an electronic sealing time, it is extremely easy to operate and ensures that instrument packages are completely sealed prior to autoclaving, so that their contents can be sterilised effectively and remain so until the moment they are required. It is the smallest unit in the Generation Easy range, making it ideal for use in dental practices. CE certified, it satisfies all the criteria of EN 868-4/5 and DIN 58953-7 for sealing barrier products. General Medical also supplies the HD 260 MS-8 heat sealer and a wide range of tube film rolls for use with both units.

Another knockout success for Denplan

Denplan staff take part in 'It's a Knockout' for charity Dentaid.

Friday July 25 saw over 100 Denplan staff make their way to the Winchester Rugby Club for their charity event 'It's a Knockout'. Based loosely around the original TV game show, Denplan managed to raise over £3,000 for Dentaid.

Denplan Ltd., part of the AXA Group, is the UK's leading dental plan provider, with an approximately 80% market share. Denplan also provides a range of professional services for its member dentists, including the Denplan Quality Programme, Denplan Excel accreditation programme and Denplan Training.

Biotene offers solutions for dry mouth

Research has shown that more than 10% of adults suffer from dry mouth (xerostomia). Dry mouth adversely affects the sufferer's quality of life and is a common cause of gum disease, bad breath, tooth caries and excess plaque.

According to the manufacturers, Biotene Oral Care products protect against dry mouth by boosting the mouth's natural defence systems against gum disease, bad breath and tooth decay, while relieving discomfort. All Biotene products are free of SLS (sodium lauryl sulphate, a foaming/drying agent) and alcohols, which compound tissue dryness.

The Biotene range is available from pharmacies nationwide and includes: mouthwash; toothpastes; oral balance gel; chewing gum; and, oral balance moisturising liquid.

Biotene is made in Ireland at Europharma Concepts Ltd., Clara, Co. Offaly.

Listerine Stay White. The simple new name for Advanced Tartar Control.

We've changed the name of Listerine Advanced Tartar Control to the more patient-friendly Listerine Stay White. That's the only thing we've changed. Inside is the same effective formula containing Zinc Chloride, which is clinically proven to reduce calculus build up by up to 21%[1].

Not that your patients are motivated by science. Most of the 73% of the population with visible calculus[2] want results they can see, and that means teeth that stay naturally white. So to encourage people to practice advanced tartar control daily, we've kept the same unique formulation, but given it a simple new name; Listerine Stay White.

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

LISTERINE® CLINICAL
SUPPORTING DENTAL PROFESSIONALS

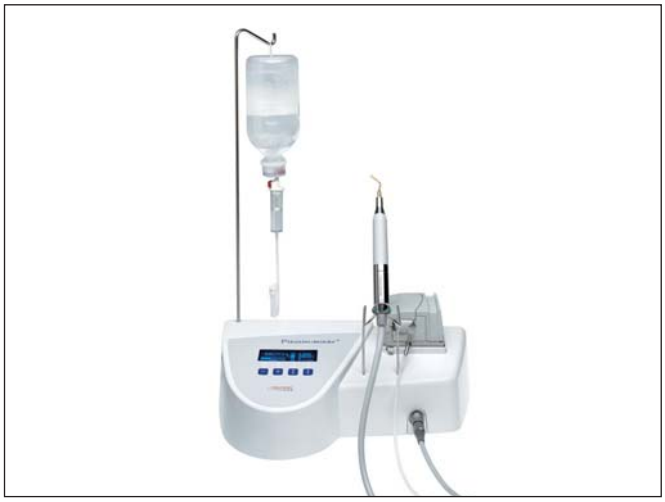
BUSINESS NEWS

New President for Irish Society of Dentistry for Children

Dr Patrick Quinn has taken over from Dr Evelyn Crowley as President of the Irish Society of Dentistry for Children (ISDC) following the Society's recent Annual Scientific Meeting in Cork. The ISDC was founded in 1971 as the Irish Paedodontic Society, with its stated objective: "to further the knowledge relating to the dental health of children". The Society, which is affiliated to the International Association of Paediatric Dentistry, currently has in the region of 90 members from public dental service, general practice, specialist practice and academic backgrounds. The Society hosts a number of meetings throughout the country each year, culminating in an Annual Scientific Meeting in May. This year's programme will commence on September 5 with a day seminar on the subject of conscious sedation, which will be held in the Dublin Dental Hospital.

Anybody interested in finding out more about the Society or becoming a member should contact Dr Eleanor McGovern, ISDC Membership Secretary, Email: eleanormcgovern@hotmail.com.

Mectron Piezosurgery II – the safe way to cut bone



According to the company, the Mectron Piezosurgery II from General Medical is the safe way to cut bone and other mineralised tissues without any risk to adjacent soft tissues. It has built-in programmes for bone surgery (bone types D1 – D3 plus "special") together with one-touch power settings for perio and endo inserts, variable fluid control and an automated cleaning cycle.

Piezosurgery II has the widest range of insert tips for all types of bone cutting and harvesting. It can be used in oral surgery, implantology, surgical orthodontics, endodontics and periodontology. Its modulated ultrasonics ensure that no damage occurs to soft tissue, increasing the safety level of intra-oral surgery in such procedures as sinus lifts and nerve transpositions, as well as in less complex cases.

Competitively priced, it can be sterilised up to 135°C and has a two-year warranty.

General Medical procedure packs

General Medical offers a range of sterile procedure packs containing high quality disposable gowns, drapes and accessories to meet all requirements.

According to the company, the Universal Pack for minor oral surgery and periodontal procedures offers excellent value for as little as £6.50 per pack, while the Basic Implant Pack contains everything for implant procedures and more advanced oral surgery, and periodontal cases, for as little as £18.95 per pack. The Deluxe Pack contains a full range of components for all procedures and is similarly competitively priced.

General Medical also offers custom packs to individual specifications at excellent prices. They enable surgeons to specify the precise combination of disposable gowns, drapes and accessories to meet their individual requirements and save a considerable amount of money.

All General Medical components are available as separate items including gowns, drapes, plastic covers, masks, hats in various styles, suction tubing and tips, plus much more.

OsteoBiol for total conversion

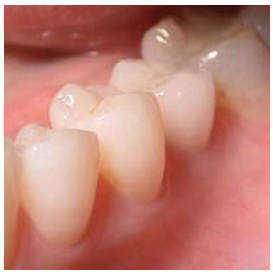
General Medical is the distributor for the complete range of OsteoBiol bone graft materials and membranes. According to the company, OsteoBiol bone graft materials and membranes are a revolutionary innovation in biomaterials, providing all the necessary elements for quick, efficient and complete bone regeneration. Supported by 10 years of scientific research and proven efficacy, they contain collagen, which:

- attracts the osteoblastic precursors in the bloodstream;
- accelerates the physiological activity of osteoblasts by up to two to three times, resulting in similarly faster bone regeneration;
- provides a vital substrate for platelet activation and aggregation; and,
- optimises the tissue healing process.

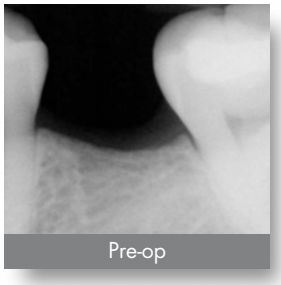
Dental Protection lectures

Dental Protection, in association with the IDA, will run two seminars later this year focusing broadly on the themes of risk management and communication skills. The first event will take place on Wednesday November 5, at the Clarion Hotel, Dublin Airport, and the second on Thursday December 4, at the Kingsley Hotel, Cork.

See www.dentist.ie for further details.



Confidence of lasting natural aesthetics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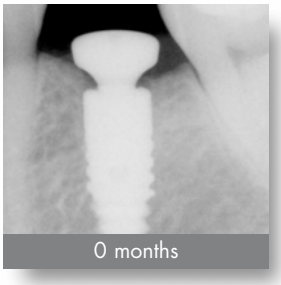
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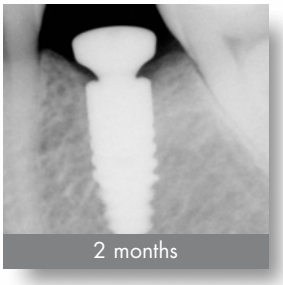
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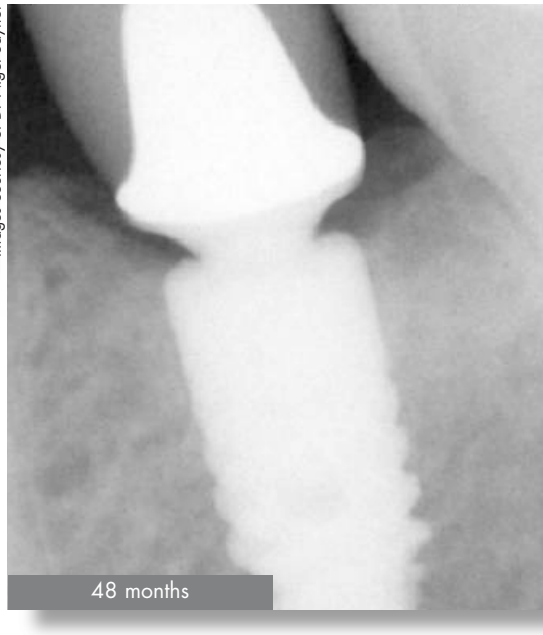

48 months

Images courtesy of Dr Nigel Saynor

"I have been placing Ankylos implants since 1999, after using numerous other 'top brands'. But, nothing compares to the performance and long term aesthetics found with Ankylos".

Dr Nigel Saynor
Bramcote Implant Centre

"The morse taper connection forms a gas tight junction that the body then sees as 'one piece', thus allowing repositioning of the biologic doughnut causing bone to grow up and over the head of the implant".

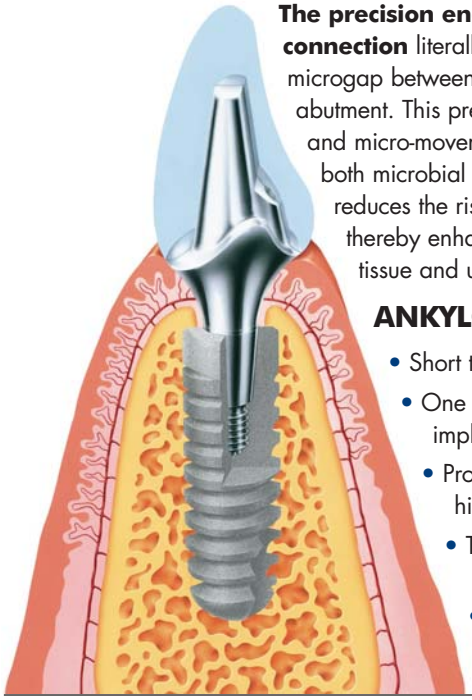
Dr Phil Bennett
Lyme Bay Dentistry

"The system is very accurate to work with and offers an extensive range of abutments. With Ankylos it is easier for the dentist to achieve a precise impression, and abutments are always a positive fit".

Steve Taylor
Taylor Dental
Technology Centre

Precision engineered for outstanding clinical performance

The lasting natural aesthetics and long term stability of ANKYLOS implants result from the system's unique taper connection. The exact fit between the implant and the abutment helps maintain healthy supporting tissues and reduces the risk of implant failure.



The precision engineered conical connection literally eliminates the microgap between the implant and the abutment. This prevents microbial leakage and micro-movement. The avoidance of both microbial and mechanical irritation reduces the risk of inflammation, thereby enhancing recovery of soft tissue and underlying bone.

ANKYLOS®

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EU NEWS

Directive negotiations to shape the future of cross-border healthcare

Honorary CED Treasurer TOM FEENEY gives a summary of recent developments on European issues.

CED Board Meeting venue – CNSD Headquarters (French Dental Association), Paris.

CED meeting with EU Health Commissioner

A CED delegation including President Orlando Monteiro da Silva met with EU Health Commissioner Vassiliou on July 14 to discuss matters relating to the new draft Directive and other matters of common interest. The meeting proceeded in a positive atmosphere and the new Health Commissioner was well prepared and knowledgeable on the issues. The Commissioner requested the CED's help in disseminating the layman's versions of the Scientific Committee's opinions on amalgam and tooth-whitening products in Member States, which will be available in the course of the summer/early autumn in English, French and German. With regard to the draft Directive on the Application of Patients' Rights in Cross-border Healthcare, the Commissioner insisted that the Directive is not intended to actively promote patient mobility. She also claimed that it would not open the door to harmonised professional liability insurance, and that Member States will decide for themselves on quality standards. The CED representatives also reiterated the importance of oral health as part of general health in the framework of the EU Health Strategy. In addition, the Green Paper on Health Professionals was discussed, with the CED raising the importance of greater focus on prevention and continuing professional development.

New EU framework for cross-border healthcare

The new draft Directive on the Application of Patients' Rights in Cross-border Healthcare is likely to take up much CED time and analysis over the coming couple of years. Because of its wide-ranging implications, especially for government budgets, it is expected that aggressive lobbying will occur, which could cause considerable delays in the legislative process.

At a recent CED Task Force meeting it was felt that the Directive's proposals contained many positives. Codification of the existing Court of Justice jurisprudence would help to reduce the need for further judgements on the issue of reimbursements for cross-border healthcare by the Court. The Court is generally biased towards upholding freedom of movement principles, while not recognising the specificity of the health sector. The inclusion of principles specifying that healthcare is to be provided according to the legislation of the Member State where it takes place was seen as positive. Also praised was mention of recognition of professional qualifications and other relevant pieces of existing legislation. Compulsory liability insurance in all EU Member States, which might result from the Directive, was not seen as necessarily negative as it meant safety for both patients and dentists. Concerns were raised that it might encourage a monopoly of insurance companies and fail to balance insurance amounts with number and size of claims, thus unnecessarily raising prices – for health professionals and for patients – and so decreasing healthcare affordability. Additionally, mandating compulsory insurance because of the 1% of patients who cross borders to seek healthcare elsewhere was seen as disproportionate. Certain parts of the draft Directive were seen as good in principle but likely to be problematic in implementation, particularly specific provisions related to the European reference networks (risk of introducing new EU criteria for dental practice and limiting the right to provide certain specialised treatments to such networks) and national contact points (lack of capacity to provide more than very general information, including information on problems and risks associated with seeking healthcare abroad, to patients).

Commission consultation on the EU workforce for health

The EU Commission is expected to issue a Green Paper at the end of the year, launching consultations on the challenge of dealing with the health needs of an ageing population. The goal behind the initiative is to increase Commission competencies in the health field, and the rationale

is to respond to the challenge of ageing populations, decreasing numbers of healthcare professionals and a brain drain in certain Member States. From the CED perspective, more attention should be given to prevention, good basic training, creating a good regulatory environment, teamwork of professionals at individual country level, and ethical recruitment. The draft of the paper was discussed at the Gastein European Health Forum on October 2, 2008, where the CED President sat on a panel with the presidents of other European organisations of health professionals.

Cross-border healthcare – round-table discussion

The round-table 'High Quality Healthcare in Europe' discussion, organised jointly by the Council of European Dentists (CED) and the Standing Committee of European Doctors (CPME) on September 11, 2008, in Brussels, provided one of the first opportunities for stakeholders to discuss the Commission's recent proposal for a Directive on Patients' Rights in Cross-Border Healthcare. The event, under the patronage of Othmar Karas MEP, brought together Commission officials and MEPs to exchange views with the main organisations of European health professionals and patients on the proposed Directive, as well as on the wider institutional and political framework for cross-border healthcare in

Filipa Marques, lawyer at the Portuguese Dental Chamber; and, Orlando Monteiro da Silva, President, CED.

EU NEWS

Europe. Mr Fintan Hourihan represented the Irish Dental Association. EU Commissioner for Health and Consumers, Androulla Vassiliou, opened the debate with a keynote presentation. She confirmed the continued commitment of the Commission to dialogue and co-operation in the process leading to the adoption of the proposed Directive on Patients' Rights in Cross-Border Healthcare with those most directly affected by it: health professionals and patients.

During the debate, all representatives – those of health professionals as well as patients – welcomed the Directive and reiterated the need to enshrine patients' rights of access to safe and high quality healthcare throughout the EU in a legal document.

CED President Dr Orlando Monteiro da Silva noted that quality is definable but very difficult to measure: "We must focus on the three main principles of strategy, high quality and efficiency – doing the right thing right". CPME President Dr Michael Wilks pointed out, among other issues, the necessity of good information systems for both patients and physicians that support cross-border care.

The moderator, Dr Matthias Wismar of the European Observatory on Health Systems and Policies, concluded that there is a consensus among the panellists on the need for this Directive. Othmar Karas MEP (EPP) played a lead role in negotiating an agreement between the European Parliament and the Council under the Austrian EU Presidency in 2005, leading to the exclusion of health services from the Services Directive. Other speakers included DG SANCO Head of Unit Bernard Merkel, MEPs Bernadette Vergnaud (PES) and Holger Krahmer (ALDE), and Dr Anders Olauson, President of the European Patients' Forum.

From left: Claudia Ritter, head of CED office; Dr Jean Claude Michel, President, CNSD; Francoise Grossetete, MEP; Dr Orlando Monteiro da Silva, President, CED; and, Dr Tom Feeney, Treasurer, CED.

Meeting with Francoise Grossetete MEP

At the CED Board Meeting at the CNSD Headquarters in Paris on September 12, 2008, Ms Francois Grossetete MEP was invited to attend with a view to discussing matters relevant to dentistry in the EU, in particular in the context of the new draft Directive. Ms Grossetete is a member of the Group of the European People's Party (Christian Democrats) and of the European Democrats. She is a member of the Committee on the Environment, Public Health and Food Safety (ENVI) and also has a history of involvement with the Services in the Internal Market Directive. Ms Grossetete summarised French Government priorities during the current French EU Presidency as: i) how to cope in the event of an EU-wide pandemic; and, ii) how to bring a French plan to better deal with Alzheimer's disease to a European level.

On the question of dental tourism, Ms Grossetete was very well informed. She was robustly reminded that in Ireland the dental tourism question has serious patient safety issues. While everybody accepts the right of any patient to travel across borders, there is a need for the Commission to build into the new Directive better methods of informing patients of the risks of overseas treatment. It is the continuing Irish experience that there are many cases of over-treatment, complex treatment plans being contracted into very short time frames, and lack of continuity of care.

Ms Grossetete accepted that there was a need to regulate patient information at both EU and national level. The question of follow-up treatment is also very relevant. Ms Grossetete would welcome suggestions in this area from any individuals or organisations at francoise.grossetete@europarl.europa.eu.

Dental Council publishes communications code

The Dental Council of Ireland has published its Code of Conduct Pertaining to Public Relations and Communications. JIDA summarises the main points.

The Code sets out guidelines for dental professionals in their dealings with members of the public, whether in private practice, or via the media. The aim of the guidelines is to enable the public to make judgements based on relevant, adequate and accurate information.

Public relations

Dentists may communicate appropriate professional information to the public. A dentist is permitted to:

- clearly indicate the location of his/her practice; and,
- provide appropriate information on services offered, provided such information is:
  - truthful;
  - legal and decent;
  - factual;
  - relevant; and,
  - accurate.

Information should not:

- mislead the public;
- impugn the professional reputation or integrity of his/her colleagues;
- bring the profession into disrepute; or,
- exploit or take advantage of:
  - patients' physical and emotional state; or,
  - the public's lack of knowledge of dental subjects.

The legal position

Under the provisions of Section 49 of the Dentists Act 1985 a dentist may only use the description dentist, dental surgeon or dental practitioner. An exception is made in the case of dentists whose names are registered in the Register of Dental Specialists. A dentist may not claim any title or qualification that he/she does not possess; this applies to all literature, signage and other media.

Dentists should be aware that this provision prohibits them from making public claim to membership of associations or societies or to display qualifications that are not registered on their behalf in the Register.

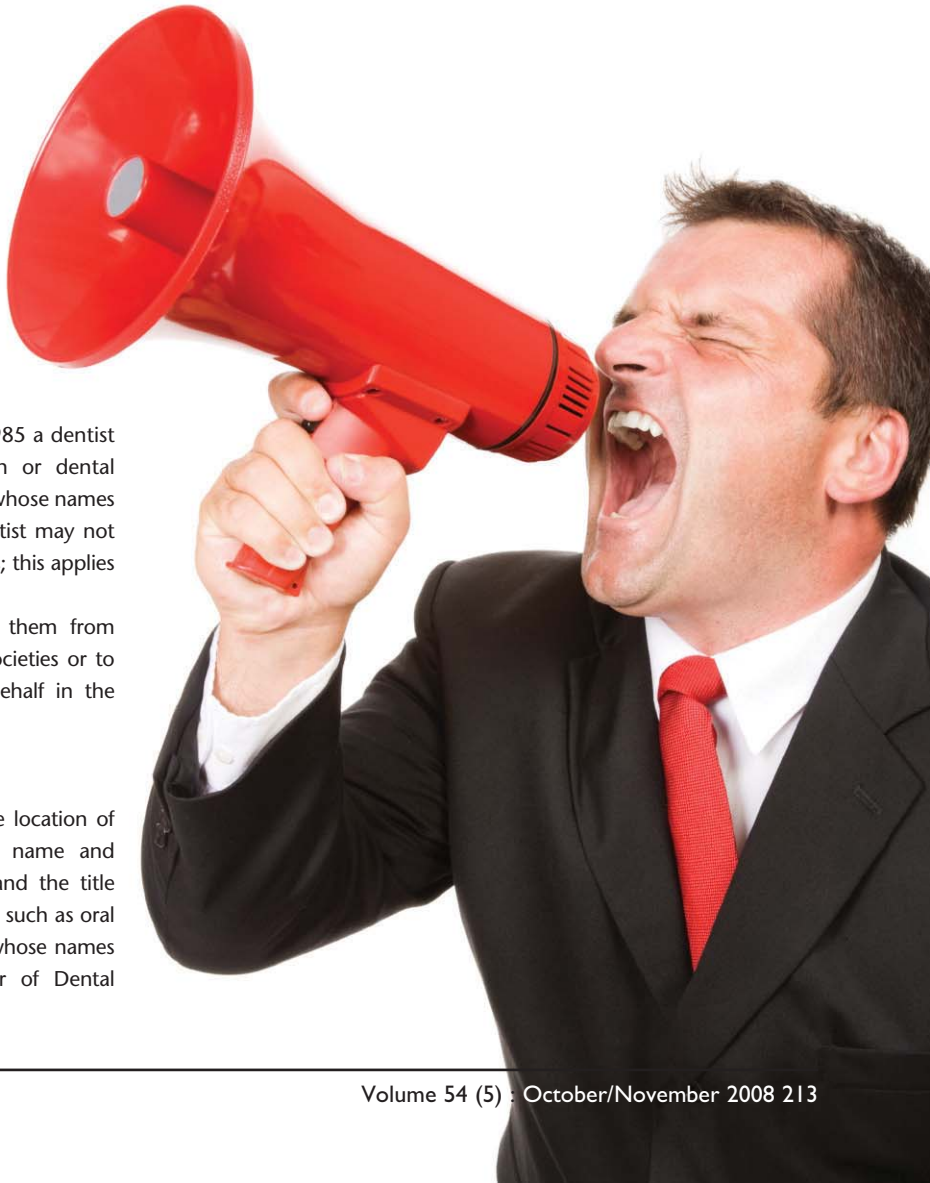
Signs and professional plates

A dentist may display a professional plate to indicate the location of his/her practice. This plate may exhibit the dentist's name and qualifications (as recorded in the Register of Dentists) and the title dentist, dental surgeon or dental practitioner. Descriptions such as oral surgeon and orthodontist may only be used by dentists whose names are registered in the relevant division of the Register of Dental Specialists.

Dentists may also display:

- days and hours of attendance;
- availability of an emergency service;
- practice telephone number;
- availability of treatment under State schemes;
- website address; and,
- fee structure.

The identity and registered qualifications of all dentists practising on the premises must be displayed and accessible to the public. When a dentist ceases to practise at that location, his/her name must be removed within one month. All signs displayed at a practice location should comply with relevant local authority planning regulations.



Stationery

The names of all registered dentists and auxiliary dental staff who work in a practice should be included on practice stationery.

No status, qualifications, titles or memberships may be included on practice stationery other than those that are recorded in the Register of Dentists. Statements of "a special interest" in a particular aspect of dentistry are not permitted.

Practice brochures

It is recommended that dentists publish a practice brochure to provide information to the public. Brochures should be available to everyone who attends the practice and to all other persons who request them.

A brochure could give a short history of the practice and provide details of the persons employed there, including dentists, dental hygienists, dental nurses, dental technicians and clerical/administrative staff.

Information on services including, if necessary, a brief explanation of the treatments that are available, may be provided.

Days and hours of attendance, plus telephone numbers including access details in the case of any emergency, should be included. A website address may be given.

The brochure should provide full information on private fees and should give details of the provisions of the DTSS, PRSI and other schemes operated by the practice.

Advice on what to do in the case of post-treatment complications or emergencies should be included.

All information contained in a practice brochure must be factually correct and must be relevant. Care must be taken not to mislead the public and no status, qualifications, titles or memberships must be claimed other than those that are recorded to the dentist's credit in the Register of Dentists. Statements that the dentist has a "special interest" in particular aspects of dentistry are not permitted.

Price lists

The Council advocates greater transparency in fees, and a list of private fees should be prominently displayed in dental practices. The Council accepts that dentists can only give a detailed estimate of the cost of treatment following a full oral examination, but it should be possible to give an indication of the fees charged by the practice for routine procedures.

Websites

Dentists are permitted to use websites to give information to the public. These can contain any or all of the information available in the practice brochure. Links to other websites should be relevant and factually correct.

Newspaper articles, television and radio broadcasts, lectures to lay audiences

Dentists have the right, and indeed a civic duty, to initiate and become involved in public debate. However, dentists should avoid personal publicity whether in press, radio, television or other media where such publicity could result in their gaining professional advantage. The Council understands the difficulties in this area, but dentists who engage in private practice, when being interviewed on radio or television, should make every effort to avoid linking name, profession and address. Similarly, in letters or articles for the lay press, the dentist should ensure that his/her name, profession and practice address are not published simultaneously.

Dentists may adopt a collective approach to the promotion of dental health in local media. The names of individual dentists, however, should not be disclosed.

A dentist giving lectures to lay audiences should ensure that such lectures do not result in his/her personal practice being promoted.

Copies of this Code must be made available in practice waiting rooms.

Non-adherence to these guidelines may result in the dentist facing a charge of professional misconduct.

The Code of Conduct is available in full from the Dental Council website – www.dentalcouncil.ie.

Renal disease and chronic renal failure in dental practice

Abstract

Patients with renal diseases are increasingly common in dental practice. This is due to advances in medicine, and the increasing life expectancy of western populations. Chronic renal failure is a serious condition that general dental practitioners may see in their practice. This article discusses the functions of the kidney, and the causes and medical management of chronic renal failure, as well as considerations in the dental management of these patients. Common complications such as infection and bleeding are discussed. General recommendations are made, based on current evidence with respect to prescribing of medications.

Journal of the Irish Dental Association 2008; 54 (5): 215-217.

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Introduction

Patients with renal diseases are increasingly common in dental practice. This is due to advances in medicine, and the increasing life expectancy of western populations. The most serious condition seen by the dental practitioner is the patient with chronic renal failure.

Chronic renal failure is the slow, progressive loss of kidney function, usually over a number of years, resulting in permanent kidney failure requiring renal support.[1]

This condition may develop over several years and is often undiagnosed until the later stages of the disease. It can have significant repercussions for dental practitioners treating these patients. The dental management of patients with this condition can be carried out in the general practice setting, as long as the practitioner is aware of the specific precautions that are necessary.

The purpose of this article is to educate the dental practitioner in the necessary precautions, and in the effective management of these patients.

Functions of the kidney[2]

1. Maintains homeostasis: The kidney maintains the balance of several substances, including water, sodium, potassium, glucose and urea. It has a very important role in acid–base balance.
2. Endocrine: The kidney produces:

- erythropoietin – stimulates the bone marrow to produce red blood cells;
- active vitamin D – important in calcium and bone metabolism; and,
- renin – an important hormone in the renin–angiotensin–aldosterone system, which is involved in blood pressure control.

Causes of chronic renal failure[3]

1. Glomerulonephritis (25% of cases).
2. Diabetes mellitus.
3. Severe pyelonephritis.
4. Hypertension.
5. Polycystic kidney disease.
6. Drugs, e.g., non-steroidal anti-inflammatory drugs (NSAIDs).
7. Connective tissue diseases such as systemic lupus erythematosis and polyarteritis nodosa.
8. Renal stones.

Classification[4]

Chronic renal disease is classified according to the patient's glomerular filtration rate (GFR: normal GFR: >90ml/min/1.73m^2):

Stage 1: Normal GFR (>90ml/min/1.73m^2) with other evidence of chronic kidney damage.

Stage 2: Mild impairment – GFR 60-89ml/min/1.73m^2 with other evidence of chronic kidney damage.

Stage 3: Moderate impairment – GFR 30-59ml/min/1.73m^2.

Stage 4: Severe impairment – GFR: 15-29ml/min/1.73m^2.

Stage 5: Established renal failure (ERF) – GFR <15ml/min/1.73m^2 or on dialysis.

Medical treatment[1]

1. Lifestyle modification:

- smoking cessation – controls blood pressure and reduces risk of renal cell carcinoma;
- low protein diet – protects the kidneys by reducing the protein load filtered;
- weight loss if obese – aids blood pressure control; and,
- regular exercise.

2. Blood pressure control: antihypertensive medications are used to reduce the risk of vascular damage.

3. Dialysis (peritoneal or haemodialysis) is used in later stage disease.

4. Transplant in severe disease – this requires immunosuppression, with associated increased risk of infection.

Considerations in the general dental practice

The major oral findings include:[1]

1. Gingival hyperplasia in patients receiving cyclosporin (an immunosuppressant used in transplant patients) or nifedipine (an antihypertensive medication). A combination of both drugs can act synergistically.
2. Uraemic stomatitis gives a 'lemon tinge' appearance to the oral mucosa.
3. Recurrent candidal and herpes infections in post-transplant patients due to immunosuppression.
4. Swollen salivary glands with reduced saliva production.
5. Oral ulceration and generalised purpura (decreased erythropoietin production leading to reduced platelet production).
6. Enamel hypoplasia in children.
7. Halitosis (uraemic fetor).
8. Giant cell lesions of bone due to secondary hyperparathyroidism (osteitis fibrosa cystica).
9. Bone changes on x-ray, including loss of the lamina dura and osteolytic lesions.
10. Slate grey appearance.
11. Signs and symptoms of anaemia.

Principles of management

A full history is necessary to properly treat these patients. Patients with renal disease are likely to be under the care of a specialist team for management of their condition, so dental management should be co-ordinated with this specialist team.[5] Pre-transplantation patients should have a full assessment and aggressive treatment of any dental conditions before surgery. The main concerns identified in managing these patients are:

Local anaesthetics and sedation

Local anaesthetics are safe to use. The normal maximum safe dose of lignocaine with adrenaline is considered to be seven cartridges (2.2ml) in a healthy adult. Some consideration should be given to reducing the adrenaline content if the patient is hypertensive.[1] Hypertension is a common problem in renal disease, as the role of the kidneys in regulating blood pressure is reduced. The use of self-aspirating cartridges reduces the risk of intravascular adrenaline administration, which is highly important in patients with hypertension.

IV sedation is safe to use when titrated clinically to the appropriate dose by dentists with the appropriate postgraduate training. Consideration should be given to dose reduction. Patients receiving dialysis may have an arterio-venous (A-V) fistula. This is a merger of an artery and vein, which is used for haemodialysis. IV lines should not be placed in the same arm as the A-V fistula, as to do so may damage the venous system.[1]

Bleeding[1,5]

Platelet defects are commonly found in patients with chronic renal failure. This causes a prolonged bleeding time, the aetiology of which is poorly understood, but is thought to be related to high urea levels altering the platelet function, as well as decreased number of platelets. Therefore, patients undergoing dialysis require heparin therapy on dialysis days. They should not have dental treatment on the same day as dialysis, as heparin will prolong the bleeding time further and increase the risk of postoperative bleeding. The effect of heparin is short and treatment may be carried out in the days following dialysis. Consultation with the specialist team is necessary to identify any bleeding problems before treatment is started. Oral surgery may be carried out once the above criteria are met, and the practitioner should proceed with the utmost care. Teeth of dubious prognosis should be identified before transplantation. Extraction of teeth of poor prognosis is important to prevent postoperative infection in the immunosuppressed patient. Before commencing with extractions, options for the replacement of missing teeth should be discussed with the patient and planned. Meticulous haemostatic measures such as firm pressure, packing sockets with haemostatic gauze (e.g, Surgicel), suturing sockets and topical haemostatic agents such as tranexamic acid, may be used. Arrangements can be made to treat patients with severely abnormal bleeding in a specialist setting.

Infections[1,6]

Odontogenic infections require aggressive management, since phagocyte function is often impaired. This can lead to the spread of infection locally and systemically. Patients who have received renal

transplants are treated with cyclosporin to reduce the risk of rejection. This causes immunosuppression, leading to increased susceptibility to infection. Antibiotic prophylaxis should be considered when carrying out procedures that are likely to produce bacteraemia for dialysis and post-transplant patients. Consultation of the recent literature is advised before commencing treatment.

Prescribing[1,7]

Many drugs are cleared from the body by the kidneys. In renal failure, this ability is reduced. This can affect several drugs that are prescribed in dental practice. Recommendations on these medications are made below:

Avoid:

- aminoglycosides, e.g., erythromycin, in transplant patients (interferes with cyclosporin metabolism);
- NSAIDs, e.g, ibuprofen, diclofenac;
- tetracycline;
- cephalosporins; and,
- gentamicin.

Reduced dosage recommended of:

- amoxicillin (e.g., Amoxil) and co-amoxiclav (e.g., Augmentin);
- clindamycin (e.g., Klacid);
- codeine; and,
- midazolam, diazepam.

Safe:

- metronidizole (e.g., Flagyl).
- doxycycline;
- paracetamol; and,
- lignocaine (consider using reduced adrenaline dose).

Conclusion

Renal disease is a common condition that is encountered in practice. Through application of the principles of management outlined above, the treatment of these patients can be carried out safely and effectively in a dental practice setting.

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SCIENTIFIC

The selection of adhesive systems for resin-based luting agents

Abstract

The use of resin-based luting agents is ever expanding with the development of adhesive dentistry. A multitude of different adhesive systems are used with resin-based luting agents, and new products are introduced to the market frequently. Traditional adhesives generally required a multiple step bonding procedure prior to cementing with active resin-based luting materials; however, combined agents offer a simple application procedure. Self-etching 'all-in-one' systems claim that there is no need for the use of a separate adhesive process. The following review addresses the advantages and disadvantages of the available adhesive systems used with resin-based luting agents.

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Resin-based luting agents

Methyl methacrylate resin cements have been available since the early 1950s for cementation of indirect restorations.[1] Resin-based luting agents are low viscosity, lightly filled or unfilled variants of resin-based composites. Their function is to cement and thus retain restorations, prevent/reduce leakage, protect the pulp, and re-enforce the tooth and restoration, as well as filling in the space between tooth and restoration. They are often described as 'active' luting agents, as they are intended to bond to both the tooth structure, by use of an enamel/dentine bonding agent, and to the restoration, by treatment of its ceramic or metal surface. Their advantages lie in cementing restorations where there is minimal preparation and limited retention.

Resin-based luting agents may be light or chemically activated (amino peroxide). They may be activated by a combination of both techniques (dual-cured). Light and dual-cured resins give more control to the operator.

Examples of resin-based luting agents

- Crown and Bridge Metabond/Superbond (chemically-activated methyl methacrylate/4-META/TBO);
- Panavia Ex (chemically-activated, resin-based composite);
- Panavia F (dual-activated, resin-based composite with adhesive system);
- Variolink (dual-activated, resin-based composite with adhesive system);
- Calibra (dual-activated, resin-based composite with adhesive system);
- Nexus (dual-activated, resin-based composite with adhesive system);
- RelyX Unicem (dual-activated, self-adhesive resin-based composite); and,
- Maxcem (dual-activated, self-adhesive resin-based composite).

The adhesive system

The adhesive system plays an important role, providing a chemical bond between the cement and the substrate to be cemented. Traditional adhesive systems require a multiple step process prior to luting with a resin (**Table 1**). Some contemporary systems are described as 'self-adhesive', as they no longer require separate etch, prime and bonding stages.[2,3,4] Manufacturers' laboratory testing of luting agents, and their adhesive systems, can be confusing and may not always accurately predict clinical performance.[5]

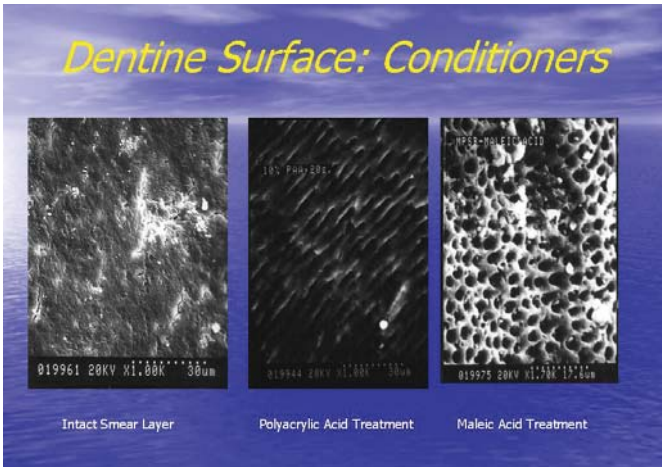

FIGURE 1: Dentine surface: conditioners.

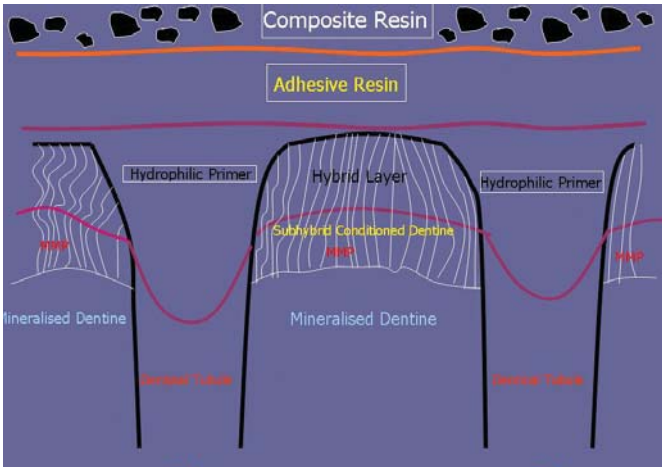

Figure 2: Diagrammatic representation of the 'hybrid layer'.

Classification of adhesive systems

The most common classification of adhesive systems is based on the time of their release onto the dental market; typically, four to seven generations are described. This chronological classification is misleading in that it implies that each successive 'generation' is an improvement on the previous ones: this may not be true! For this paper the author felt that it would be more appropriate to classify adhesive systems based on the number of clinical application steps, and their interaction with dentine.[6]

1. 'Etch and rinse' adhesives

Three-bottle systems

These are the most clinically reliable and durable systems, but also the most technically complex. They are comprised of:

a. acid etchant (conditioner), which removes the smear layer, removes smear plugs of dentinal tubules and demineralises the intertubular dentine to a depth of 5-10µm, leaving hydrated collagen bundles. This conditioner is rinsed away;

TABLE 1: Traditional adhesive systems require a multiple step process prior to luting with a resin.

Conditioning (Figure 1)	Priming	Adhesive resin bonding
Conditioners are acidic solutions or gels. They cause chemical alteration of the dentine surface by acid, with removal and solubilisation of the smear layer, leading to decalcification of surface intertubular dentine, exposing a microporous scaffold of collagen fibrils.	Primers are hydrophilic monomers dissolved in organic solvents, such as acetone, ethanol, or water. They may contain hydrophilic properties with an affinity for exposed collagen fibrils, and hydrophobic properties for copolymerisation with the adhesive resin. They act as an adhesion-promoting agent that can change the chemical nature of dentine to overcome repulsion between hydrophilic dentine and hydrophobic resin.	Bonding agents are fluid resins. They contain hydrophobic monomers, such as bis-GMA and UDMA, and more hydrophilic monomers, such as TEG-DMA, to regulate viscosities, and HEMA as a wetting agent. They may be filled or unfilled, and of variable thickness. They act as a bridging resin, with both hydrophobic and hydrophilic properties. They join the primed, penetrated dentine (hybrid layer) to the restorative composite resin (**Figure 2**). They may also act as a barrier to water movement from the dentine to the composite resin interface.

b. hydrophilic primer resins (usually in a solvent), which are intended to seal the tubules and penetrate the demineralised intertubular dentine (forming the 'hybrid layer'), and intratubular resin tags. Several layers may be needed; and,
c. adhesive or 'bond', which bridges the resin-based composite or resin-lute to the hybrid layer.

Three-step etch and rinse adhesives have demonstrated excellent bond durability both *in vitro* and *in vivo*. Their success has been attributed to optimal enamel interlocking and dentine hybridisation, demonstrated in several ultra-morphologic interface analyses, and use of a filled adhesive acting as a shock absorber during polymerisation and functional loading.

Two-bottle systems

Two-bottle systems are comprised of:
a. identical conditioner (usually 30-40% phosphoric acid), which is rinsed away after 15-30 seconds; and,
b. combined primer and adhesive (usually in solvent). Although this idea seems attractive, the components often separate out (phase separation) and form an incomplete layer unless several coats (at least two) are applied and allowed to penetrate the dentine. Many researchers have questioned the durability of this group of adhesives.

Two-step etch and rinse adhesives perform clinically less favourably than conventional three-step etch and rinse adhesives.[2,8]

2. Self-etching systems

Self-etch adhesives (SEAs) are classified, depending on the etching aggressiveness, as mild, intermediary or strong.[2]
Strong SEAs contain highly acidic adhesive monomers (pH1 or less), and they completely remove the smear layer and hydroxyapatite from the surface dentine, causing deep hybridisation of 0.5-3µm. Examples include Adper Prompt-L-Pop (3M/ESPE), Etch and Prime (Degussa) and Xeno V (Dentsply).[24] The strong self-etch adhesives produce similar interfacial characteristics in dentine as etch and rinse adhesives; however, although the etching aggressiveness of self-etching systems can be used to predict the depth of demineralisation of tooth structure and hybrid layer thickness, these factors do not necessarily correlate to bond strength.[7] Strong self-etch adhesives were often found to have relatively low bond strengths, especially to dentine, as high initial acidity is found to weaken the bond; also, residual solvent may remain within the adhesive interface.[8,9] Further study is required to investigate the long-term stability of the strong self-etch approach.
Mild self-etch adhesives use acidic monomers of approximately pH2, and form a submicron thin hybrid layer of 0.5-1µm; hydroxyapatite remains partially around exposed collagen. Examples of mild SEAs include Clearfil Liner Bond 2, Clearfil SE Bond (Kuraray) and Unifil Bond (GC). Despite a thin hybrid layer, the effectiveness of the bond to dentine was found to be quite stable, with suggestions that the hydroxyapatite preserved may serve as a receptor for additional chemical bonding.[25,10,11] Mild self-etch adhesives, although improving, displayed a relatively low bond strength to enamel.
Newer two-step SEAs, such as AdheSE (Ivoclar Vivadent) and Optibond

TABLE 2: Comparison of etch and rinse adhesives.

Etch and rinse smear layer removing agents	Three-step	Two-step ('one-bottle' adhesive)
Advantages	■ Proven effectiveness of adhesion to enamel and dentine; ■ high bond strength; ■ most durable bond; and, ■ consistent, predictable results when used according to manufacturer's instructions.	■ Basic features of the three-step systems; ■ application procedure simpler with one less step; ■ possibility of single dose packaging; and, ■ relatively durable bond *in vitro*.
Disadvantages	■ Time-consuming: separate application of conditioner, primer and adhesive resin – added complexity; ■ technique sensitive – open to operator error; ■ risk of over etching; ■ post-conditioning rinsing required; ■ sensitive to over moist dentine; ■ sensitive to desiccated dentine; ■ dual-cure adhesives could accelerate resin cement set, e.g., all bond 2 – need for additional components; ■ thick layers of adhesive may interfere with seating restoration; and, ■ evaporation of acetone solvent, altering viscosity and permeability.	■ Application not substantially faster – multiple layers are required; ■ technique sensitive (multiple layers); ■ risk of too thin bonding layer, reducing bond durability; ■ risk of over etching dentine; ■ post-conditioning rinsing required; ■ dentine wetness sensitive; ■ insufficient long-term clinical results for some simplified strategies; ■ should be light-activated or additional self-cure components needed; ■ phase separation may compromise adhesion to dentine; ■ evaporation of acetone solvent, altering viscosity and permeability; and, ■ poorer durability *in vivo* compared to three-step.

Solo Plus self-etch, are described as intermediary strength; with self-etch primers of pH1.5 they typically produce better micromechanical interlocking than mild SE adhesives, especially to enamel.[6]

Two-bottle systems

These are comprised of:

a. acidic resin primers to etch and prime the enamel. The pH of the primers ranges from under 1 to over 2. They will etch dentine and instrumented enamel (the latter to a varying degree). These are not rinsed away but form the hybrid layer with the intertubular dentine; and,
b. a separate 'bond' or adhesive resin to bridge the hybrid layer to the resin-based composite or resin luting cement.

These systems should be used with caution when combined with chemically or dual-cured activated cements, as acidic primer may inhibit amine catalyst of the luting resin. If correctly used, the adhesive layer seals the hybrid layer and protects the catalyst system.

All-in-one adhesive systems

These acidified resin systems are intended to fulfil the three functions of the traditional three-bottle systems. These materials contain significant amounts of water and form incomplete layers, allowing the passage of fluids through the adhesive. The acidity is likely to inhibit the set of resin luting cements and the intrinsic water/transudated liquid inhibits the resin polymerisation and aids in its degradation. These materials are not recommended for use with resin luting cements.

Self-adhesive cements

The most recent additions to the armamentarium of resin-based cements are the so-called 'self-adhesive' cements. The manufacturers claim a complex setting reaction, going from a low pH, aqueous type cement to an impermeable resin-based cement. There is little clinical evidence for the durable adhesion of these types of cement, and laboratory studies indicate a weak interaction with the smear layer and surface dentine, with little independent evidence of the formation of a durable hybrid layer.

These cements are attractive because they need no conditioning, involve a single cementation stage, and are rarely associated with post-cementation sensitivity. Very limited clinical trials indicate inferior adhesion to conventional resin-based cements/adhesive systems, and the question of adhesive durability has not been addressed, as long-term clinical data and evidence of their effectiveness is currently unavailable.[12] An additional question is whether they absorb moisture, leading to expansion, which would exclude their use with low strength ceramics. Self-etching luting agents, by eliminating the need for a separate adhesive, are heavily marketed currently (e.g., RelyX Unicem [3M ESPE] and MAXCEM [Kerr]), with claims of favourable physical and bonding properties *in vitro*,[12,14,15,16] low post-operative sensitivity, low de-bond rates (0.1% in 4,820 cases), and ease of manipulation/handling. Self-etch adhesive cements have been found to have a low sensitivity with regard to the conditions of the dentine surface (dry, wet, moist, etc). Their bond strength is improved by separate etching of enamel, and they should always be applied with some pressure, to ensure adequate contact with dentine. RelyX Unicem has been found to have the lowest extent of dentine demineralisation of all self-etching luting agents and demonstrated no detectable hybrid layer.[17]

TABLE 3: Comparison of self-etching adhesives.

Self-etching Adhesives	One-step	Two-step (self-etch separate resin bond)
Advantages	■ Low technique sensitivity; ■ time-saving application procedure; ■ simultaneous conditioning and resin infiltration; ■ no post-conditioning rinsing; ■ not sensitive to dentine wetness, desiccation; ■ possibility of single-dose packaging, hygienic application; ■ constant stable composition; and, ■ reduces need for difficult procedure of etch and bond in post spaces or pin holes.	■ No post-conditioning rinsing; ■ minimise difficulty in keeping dentine moist, not sensitive to dentine wetness; ■ low incidence of post-operative sensitivity; and, ■ bond strengths approaching the current gold standard with predictable retention over one year.
Disadvantages	■ Lower bond strength than total etch systems; ■ questionable bond durability; ■ contain significant volumes of water and are permeable to transduction of dentinal fluid (water trees); may compromise adhesive to resin cement adhesion; ■ insufficient long-term clinical research; ■ adhesion potential to enamel yet to be clinically proven; ■ low bond strength to enamel so not indicated for resin-retained bridges/veneers; and, ■ low pH will inhibit the set of chemically cured or dual-cured composite material. They inhibit the catalyst system (amine catalyst), which initiates polymerisation of auto-polymerising (self- or chemical-cure), or dual-cure resin composite luting materials.	■ Separate self-etching step; ■ often requires extra application of primer (multiple layers); ■ acidic primers may inhibit dual- or chemical-cure resin; ■ water movement may damage primer/adhesive bond over time; ■ variable etch of enamel; ■ delay in placement of adhesive/bonding layer may be detrimental to adhesion, as the self-etching primer resin allows water movement to the primer/adhesive interface; and, ■ questionable long-term bond durability.

Conclusion

The use of traditional etch and rinse smear layer removing adhesives with resin-based luting materials, remains the gold standard with regard to achieving predictable and durable bond strengths; however, additional components may be necessary to maximise polymerisation of the resin cements. Meticulous clinical procedure and moisture control is crucial in order to obtain a successful bond with the traditional two- and three-step etch and rinse adhesives.

Self-etching adhesive systems show promise for the future with anecdotal reports of less post-operative sensitivity, reduced technique sensitivity and a time-application procedure. Two-step self-etch adhesives can achieve acceptable bond strengths approaching that of traditional adhesives. The one step, 'all-in-one' adhesives still lack clinical evidence of their long-term durability, and have been found in some cases to interact with chemically or dual-cured resins. Their inability to prevent liquid transudation from the dentinal side casts doubt on the structural durability of the adhesive or adhesive luting agent. Further *in vitro* and *in vivo* and, especially, longitudinal trials, are necessary before their general acceptance can be advocated.

Novel self-adhesive cements have become popular since their recent introduction due to manufacturers' claims and favourable handling properties. Available evidence seems to indicate relatively low adhesion to tooth structure and questionable long-term bond durability. It seems prudent to avoid their use in combination with low strength ceramics and where maximum adhesion is desirable for the restoration.

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ABSTRACTS

Obstructive sleep apnoea therapy

Hoekema, A., Stegenga, B., Wijkstra, P.J., van der Hoeven, J.H., Meinesz, A.F., de Bont, L.G.M.

In clinical practice, oral appliances are used primarily in obstructive sleep apnoea patients who do not respond to continuous positive airway pressure (CPAP) therapy. We hypothesised that an oral appliance is not inferior to CPAP in treating obstructive sleep apnoea effectively. We randomly assigned 103 individuals to oral appliance or CPAP therapy. Polysomnography after 8-12 weeks indicated that treatment was effective for 39 of 51 persons using the oral appliance (76.5%), and for 43 of 52 persons using CPAP (82.7%). For the difference in effectiveness, a 95% two-sided confidence interval (CI) was calculated. Non-inferiority of oral appliance therapy was considered to be established when the lower boundary of this interval exceeded -25%. The lower boundary of the CI was -21.7%, indicating that oral appliance therapy was not inferior to CPAP for effective treatment of obstructive sleep apnoea. However, subgroup analysis revealed that oral appliance therapy was less effective in individuals with severe disease (apnoea–hypopnoea index >30). Since these people could be at particular cardiovascular risk, primary oral appliance therapy appears to be supported only for those with non-severe apnoea.

J Dent Res 2008; 87 (9): 882-887.

Tooth avulsion in children: to replant or not

Andreasen, J.O, Malmgren, B., Bakland, L.K.

Replanting avulsed teeth with a doubtful long-term prognosis due to unfavourable extra-alveolar conditions has recently been questioned by Kenny and Barrett. Many factors, however, still favour replanting such teeth. First of all, the reliability of failure predictors has not yet been tested in prospective studies. Secondly, preservation of even resorbing replanted teeth may offer significant long-term advantages in preparation for definitive treatment. Also, for psychological reasons, replantation can significantly reduce the anxiety and despair of both the injured child and the parents. Furthermore, decoronation of a resorbing anterior tooth will allow it to serve as a matrix for alveolar bone formation and preserve an otherwise resorbing alveolar process, thereby leaving an environment of bone and soft tissue that is optimal for both single implant insertion or fixed prosthesis. Finally, replantation and subsequent decoronation, if indicated, appear to be cost-effective in comparison with non-replantation combined with subsequent repeated prosthetic tooth replacements, owing to vertical alveolar growth of adjacent ridge areas with eventual definitive implant placement or a fixed prosthesis. (Copyright © 2008 Blackwell Munksgaard.)

Endodontic Topics 2008; 14 (1): 28-34.

Dentine hypersensitivity: preventive and therapeutic approaches to treatment

West, N.X.

Many individuals are affected by the oral pain condition of dentine hypersensitivity. For the majority of sufferers the pain is episodic and, although sharp in nature, is short in duration, and hence annoying but bearable. Measures such as avoiding cold running water when tooth cleaning, and taking care when breathing in air on cold, frosty winter mornings, are often adopted. For less fortunate individuals the pain is far more severe, lasts for hours or days, and interferes with day-to-day activities and pleasures.

One of the earliest citings of dentine hypersensitivity dates back to Blum in 1530; however, it was not until 1700 that this oral pain condition was more extensively investigated. Data documented in the UK Adult Dental Health Survey of 1998 showed increasing life expectancy of the western population who have a functional natural dentition, which will be prone to tooth wear. It is not unreasonable to suggest that dentine hypersensitivity is therefore likely to become a more frequent dental finding in the future. This is supported by Zero & Lussi, who state that, following the decline of tooth loss in the 20th century, the increasing longevity of the teeth with tooth wear in the 21st century will be far more demanding on the preventive and restorative skills of dental professionals. Similarly, the continued high prevalence of periodontal disease in a population retaining their teeth for longer is likely to lead to greater numbers of teeth with recession

as a result of both disease and treatment. Thus, it would not be surprising if general dental practitioners noted an increase in cases of dentine hypersensitivity and a rise in requests for treatment in the foreseeable future.

Periodontology 2000, 2008; 48: 31-41.

Who is at risk? Periodontal disease risk analysis made accessible for the general dental practitioner

Cronin, A.J, Claffey, N., Stassen L.F.

The use of odds ratio (OR) in risk analysis is considered a useful means of cross-comparing the risk factors by which a disease is influenced. This article outlines the interpretation of reported ORs with respect to periodontal disease, highlighting those factors that are most deserving of consideration. The claim that periodontal disease is implicated in some serious systemic diseases is investigated with respect to the evidence.

Data retrieval was carried out, focusing primarily on ORs for factors shown to be positively correlated with the incidence of periodontal disease. Using the available data, a risk evaluation scoring system was proposed (the Cronin/Stassen BEDS CHASM scale). The results of the evaluation support the view that hygiene therapy, smoking cessation and control of the glycaemic state offer the largest and most easily achieved reductions in risk with respect to attachment loss. The literature on systemic diseases indicates that the mechanisms with which periodontitis may interact seem biologically plausible, compellingly so in the cases of coronary heart disease and diabetes mellitus. However, statistical evidence to confirm these suggested interactions is equivocal, with the data retrieved in some instances being less than decisive. Further investigation is recommended.

British Dental Journal 2008; 205: 131-137.

Answers to quiz *(from page 200)*

Symptoms/signs

Duration, change with time, change with food, pain or not, other lumps, altered mouth opening, taste, sensation, hearing or facial nerve movement.

Size, shape, characteristic, level of lump, surface, tender, pulsatile (direct or transmitted), fluctuant, trans-illumination, other lumps, Nerves V, VII, VIII and XII.

Diagnoses

1. Parotid mass (80% benign PSA)
2. Neck node
3. Cyst

Investigations

FNAC/US/biopsy in the form of an excision biopsy (superficial parotidectomy) with preservation of the facial nerve.

Impact of the economy on dental practice income

DAVID McCAFFREY looks at how the economic downturn is impacting dental practices.

In a previous article in the *Journal of the Irish Dental Association* (JIDA; Summer 2007) we reviewed how costs impact dental practices and the importance of reviewing prices of treatment offered. In this follow-up article, we look at how the downturn in the economy is impacting dental practices.

Setting the stage

2008 is certainly turning out to be a challenging year for the Irish economy. Unemployment is rising, consumer spending is weakening, house prices are still falling and house building activity remains very weak.

Economic forecasts have become increasingly pessimistic, with the Economic and Social Research Institute now indicating a 0% growth rate in the Irish economy in 2008. As the year rolls on the level of the economic slowdown appears to be increasing. Most forecasts are predicting that it will be 2010 at the earliest before the economy improves, and only once house prices have bottomed out.

In the seven months to July 2008 general inflation in the Irish economy is running at 4.4% (**Figure 1**), with electricity/gas inflation at 9.7% (predicted to rise to 18% due to ESB price increases), and health inflation at 6.2%, with dental services inflation increasing to 5.8%. Wages and salaries for dental employees are increasing at around 5.5%.

Consumer confidence and retail sales growth (**Figure 2**) are also falling as the economic downturn moves out of the construction sector into the wider economy. It is the speed with which the economy has retracted that has caught many by surprise. Consumer confidence is being eroded by a combination of factors. These include:

- higher interest rates;
- falling house prices;
- falling equity markets;
- the ongoing sharp increase in the cost of living;
- deterioration in labour market conditions;
- a more uncertain fiscal background; and,
- restriction of credit.

It is clear that the consumer is now moving into a period of much more subdued spending activity. Personal borrowing will decline, helped by tighter credit conditions, and an attempt will be made to mend personal balance sheets. There is nothing inherently wrong with this, as the consumer borrowing and spending growth of the past decade could not be sustained indefinitely.

Impact on dentists

The first six months of 2008 have been difficult for many dental practices. It is not uncommon to come across dental practices where income is down by up to 20% when comparing the first half of 2007 with 2008. In particular, those practices where turnover comprises a high level of private patients availing of elective cosmetic treatment are being impacted by a reduction in consumer spending.

The previous article in the *JIDA* of Summer 2007 stated that single-handed practice overheads were averaging €180,000 in 2007, with the majority of the costs being fixed, i.e., the costs do not vary with the number of patients being treated.

Figure 3 sets out the practice costs, with projected inflation rates included. As can be seen, the cost of running the practice has increased by an average of 3.6%. This is a lower average than we would have expected given the level of inflation in the economy for two reasons:

a) the cost of leasing equipment is fixed and therefore is not impacted by changes in interest rate movements. Where practice equipment has been purchased on variable bank loans, then there will be an impact on repayments each month; and,

b) property leases are fixed for five-year terms and are not impacted by short-term interest rate movements. When leases are renegotiated at the end of the lease term it is important to understand the impact the new lease will have on practice profitability. Where the premises is owned by the dentist and financed by a variable mortgage, then there will be an impact on monthly repayments due to interest rate rises.

Where it is noticed that an element of overhead expenditure has increased, a review should be carried out to identify the drivers of the cost and alternatives considered, and outstanding patient balances reviewed.

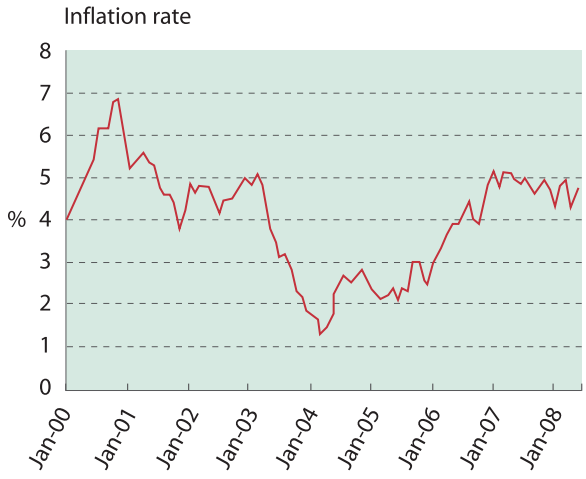

FIGURE 1: General inflation in Ireland. (Source: CSO.)

FIGURE 2: Retail sales growth in Ireland. (Source: CSO.)

Practice costs	2007 €	Inflation	2008 €
Dental consumables	32,000	5%	33,600
Staff wages (incl. PAYE/PRSI)	70,000	5.5%	73,850
Energy costs	3,000	18%	3,540
Property lease/insurance	40,000	0%	40,000
Promotional costs	3,000	4.4%	3,132
Equipment lease	16,000	0%	16,000
Office expenses	5,000	4.4%	5,220
Waste disposal	1,500	6%	1,590
Depreciation	10,000	0%	10,000
Total costs	**180,500**	**3.6%**	**186,932**

FIGURE 3: Practice running costs with projected inflation rates.

When we look at practice profitability for 2008 in the scenario below, where income is flat we can see that inflation has driven practice income down from €110,000 to €101,000, a movement of 7.4%:

	2007 €'000	2008 €'000	% change
Turnover	320	320	
Lab costs**	30	32	5.5%
Fixed costs	181	187	3.6%
Income	110	101	-7.4%

If practice income were to fall by 10% due to a decrease in patient numbers or income per patient, and overheads increase, then practice profitability will fall by 34%:

	2007 €'000	2008 €'000	% change
Turnover	320	288	-10.0%
Lab costs**	30	28	-5.1%
Fixed costs	181	187	3.6%
Income	110	73	-33.7%

***Lab bills are flexed for reduced turnover and inflation of 5.5%.*

If dentists have not been maintaining quarterly accounts then the first signs of lower practice income in 2008, besides gaps in the appointment book and deferred treatment plans, will usually occur at this time of year. Funds in the bank will be lower than expected when the tax bill has to be paid and pension contributions made.

In the practice scenarios above, the dentist would expect to be paying a tax bill of €36,000 on income in 2007. With preliminary tax for 2008 being 100% of the 2007 liability, the total due to Revenue would be €72,000, which is nearly 100% of 2008 income. When tax is paid in 2009 there will be a refund due of €12,000, as the final liability for 2008 will be €24,000. There is an option to pay 90% of 2007's taxation liability as preliminary tax but this is always risky when you are not sure what the practice income is in 2008. If you do not make sufficient preliminary tax payment, then interest penalties will be applied by Revenue. In the past some dentists have borrowed to cover tax bills. In 2008 the level of finance available from financial institutions has been reduced due to the credit crunch.

The banks have also tightened up their criteria for the measurement of risk as required by a new European banking accord, the Basel II Accord. This has removed a lot of the flexibility that local bank managers had to sanction loans and increased the criteria required in order for loans to be approved. A further concern is that bank funding will not be available to creditworthy businesses wanting to expand. This may impinge on practices' long-term growth potential.

Conclusion

Financial awareness and planning are becoming increasingly important as we head into 2009. Those dentists who rely on past performance as a predictor of the future may be lulled into a false sense of security. It is recommended that dentists prepare timely accounts in order to keep on top of how their practices are performing. If a dentist's gut feeling is that practice income has reduced, then immediate action should be taken to investigate and not get caught out in the last quarter of the financial year when taxation and pension contributions are due.

David McCaffrey MBS, ACMA, is a partner with specialist dental accounting practice MedAccount.

Take more control of your pension savings

As dentists make contributions to their pension funds in the coming weeks, JOHN O'CONNOR discusses some of the pitfalls, and what to be aware of when adding to your pension fund.

Very few of us want to work forever, and as a result it would be nice to know that the savings we put into our pension funds will provide us with a good income when we want to retire.

Some of the questions that continually arise in my discussions with dentists regarding their pensions are:

- what age will I be when I can retire?;
- how much will my pension savings be worth then?;
- have I put enough in my pension funds to allow me to retire?;
- are my funds invested wisely?; and,
- can I have more control of my pension funds?

My experience to date in dealing with dentists has been that many have been making contributions to pension funds primarily motivated by reducing their tax bill rather than actually using their pension fund as a method of retirement. While reducing your tax bill is very important, it should not be the foremost motivation for investing in a pension. You should have a clear focus on what kind of income your pension will provide to you. After all, we will all be reliant on our pensions to continue the lifestyle achieved while we were working. We all spend more money during our free time and it would be nice to have the reward of a good income when we retire rather than being anxious about the cost of living.

Investing wisely

I have also noticed that many dentists have a vast array of different pension policies with different companies invested in many different ways. For example, I have come across some dentists with more than 20 different policies that have been taken out on a once off basis over many years. This type of 'scattered investing' creates confusion on two different levels. Firstly, it makes it complicated to assess the overall valuation of the funds, and secondly, it makes it difficult to ascertain where the funds are invested and what the overall risk rationale of the funds is.

Attitude to risk

Another area of difficulty I have encountered is that many dentists' pensions are invested in much riskier funds than they realise, or than they should be. Recently, I have come across a number of dentists who are close to retirement, and who should have had their funds moved out of the stock markets and into more secure investments. Some 10-20% of a dentist's pension fund should be moved to secure investments during the last five to 10 years of his or her career. In many cases, this is just not happening.

Organisation

In a lot of cases, organisation is the solution to the problems that dentists have with their pensions. Making monthly contributions with a target retirement amount in mind would help greatly in creating clarity. Also, using one pension company to manage it all by means of a self-directed vehicle can give the stability and the variety of investment options that is required.

Aiming to have at least €1.5 million in your pension fund

I would suggest that a 40-year-old today should aim to have at least €1.5 million in their pension fund at retirement. When you retire, Revenue will allow you take 25% of your pension fund out tax free. You will be allowed to invest the balance in retirement funds to provide an income. If a person takes an income of 6% of the remaining €1,125,000, this will amount to a pension of €67,500 per annum. Admittedly, family costs may well have reduced, and mortgages, etc., will probably be gone at that stage, but this is still a significant drop from most dentists' current income.

Research among the professions shows that, as with society at large, a high proportion of self-employed people do not have adequate pension arrangements in place. My reasoning behind recommending a self-directed pension fund to the self-employed is that it allows people to invest the funds as they see fit in whatever asset they like.

Self-directed pensions – take control of your fund

The self-directed pension scheme was designed to give the self-employed much greater levels of control and influence on how their funds are invested. For example, some people may wish to select particular companies in the stock market, or indeed to purchase property within their pension fund. Since the launch of this pension product, we have had a very large response and there are a number of key areas that seem to be attracting people's interest.

Investing in property

Although property markets are currently uncertain both here and in the UK, purchasing an investment property is still very attractive, particularly using pension funds. An individual can purchase a property in Ireland or the UK and mortgage up to 75% of it. The rental income receivable is paid into the member's retirement fund and is used to pay off the mortgage, which has a maximum term of 15 years. It is a very attractive concept for many people to think that they could have a property within their pension that is completely paid off after 15 years.

Moving existing pension funds

We have also experienced a very large number of enquiries from members who have existing pension funds invested in a variety of locations. These have been either in Ireland or the UK, and many members are confused about the best course of action for them to take. The good news is that both Irish and UK funds can be moved into this pension, and they can then be invested as the individual sees fit.

Is pension investment worth it?

Apart from saving for your retirement, investing in your pension fund is one of the most tax efficient things you can do. Depending on age, an individual can invest between 15% and 40% of their income in a pension and receive tax relief on it.

With the annual tax deadline fast approaching, pensions will have a very high profile again. As well as contributing to reduce their tax bill, I would recommend that members review their overall retirement funding, and where it is invested, to give them an idea of what their fund will be worth and when they can retire.

John O'Connor is Managing Director of Omega Financial Management, an independent firm offering pension solutions.

My pension portfolio

Deposits		
Standard Life cash fund		€100,000
Funds		
UK Smaller Companies Fund		€50,000
Indian Equity Fund		€50,000
Shares		
AIB		€25,000
CRH		€25,000
Property		
15 The Gallops	€350,000	
Less mortgage	(€250,000)	
Net equity		€100,000
Total in pension fund		€350,000

FIGURE 1: Example of a pension portfolio.

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Classified advert procedure

Please read these instructions prior to sending an advertisement. On the right are the charges for placing an advertisement for both members and non-members. Advertisements will only be accepted in writing via fax, letter or email (fionnuala@irishdentalassoc.ie). Non-members must pre-pay for advertisements, which must arrive no later than Monday, November 3, 2008, by cheque made payable to the Irish Dental Association. If a box number is required, please indicate this at the end of the ad (replies to box number X). Classified ads placed in the Journal are also published on our website www.dentist.ie within 48 hours, for 12 weeks.

Advert size	Members	Non-members
up to 25 words	**€75**	**€95**
26 to 40 words	**€90**	**€110**

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

Only if the advert is in excess of 40 words, then please contact:
Think Media
The Malthouse, 537 North Circular Road, Dublin 1.
Tel: 01-856 1166 Fax: 01-856 1169 Email: paul@thinkmedia.ie

POSITIONS WANTED

UCC graduate returning after 10 years working in the UK. Looking for part-time associate position with or without a view in Cork area. Available from October. Tel: 0044 7776 300 665, or Email: corkdentist@googlemail.com.

Part-time dentist, 20 years experience, seeking part-time work in the Cork City area. Saturdays and one afternoon/evening. Tel: 083 359 5600.

POSITIONS VACANT

Full-time associate dentist to take over from departing colleague in September 2008. Naas, Co. Kildare. Busy three-dentist, two-hygienist practice. Fully computerised, air-conditioned surgeries. Digital OPG and intra-oral. Zoom Whitening. Tel: 087 947 1088 after 7.00pm, or Email: martinflynn87@hotmail.com.

Part-time associate wanted, Co. Waterford. Fully computerised. Contact Brid, Tel: 086 820 4247, after 8.00pm.

Locum/associate dentist (long-term position, if desired) in Athlone. Maternity leave until February 2009. OPG, digital x-rays, computerised. Tel: 087 206 8020, or Email: dentalvacancy@hotmail.com.

Associate required to join busy private practice in Waterford. Fully computerised, digital OPG/x-rays, hygienist, visiting implantologist/periodontist, intra-oral camera, Diagnodent, air abrasion, rotary endodontics, Zoom Whitening. Tel: 086 818 0388 after 6.00pm, or Email: dental.practice@live.ie.

Part/full-time associate wanted, immediate start. Must be friendly and comfortable with aesthetic dentistry. Busy, modern, purpose-built, two-surgery practice in Dublin 15 area. Digital OPG/intra-oral. Excellent support staff. Email: oaklanddental@yahoo.ie.

Part-time dental associate required for Dublin 2 practice. Tel: 01 678 7322, or 087 232 2384.

Superb opportunity Carlow Town – full-time associate wanted in modern practice. New surgery and equipment, fully computerised, four-handed dentistry. Friendly, skilled staff, PRSI/private only, OPG, hygienist, orthodontist. Tel: 087 266 6524, or Email: rmulhall@pembrokedental.ie.

Associate required for mixed PRSI/Medical Card/private practice in South Dublin in September. Brand new surgery and equipment in Main Street location with established patient list. Computerised with digital camera and x-ray. Email: jen@glenvilledental.ie.

Associate dentist required to join busy family practice in South East County Galway. Modern surgeries, full chair-side and clerical support, OPG, Ozone, etc. Please Tel: 086 809 5809, or Email: rothwellauct@eircom.net.

Associate wanted for busy Dublin general dental practice (multiple). Dynamic, digital, and ethical. Great conditions. Email CV to: emmet@smiles.ie.

Experienced associate required to replace colleague in busy, high-spec, South Dublin practice. Please Tel: 087 223 9743, or Email: tfoley@iol.ie.

Associate position available immediately in busy, modern Galway City Centre dental practice. Excellent conditions. Email your CV to: emmet@smiles.ie.

Dental associate required for an immediate start in a busy Dublin dental practice. Please Email: fiachloir@live.com.

Associate (with a view) required for full-time position in busy group practice with OPG, digital x-ray, computerised, full-time hygienist, and practice manager. Location: North Munster. Contact Box No. J508.001.

Busy Northside Dublin practice requires part-time dental associate for two days a week to replace departing colleague. Fully computerised, digital OPG, hygienist and modern equipment in long-established surgery. Please Tel: 086 2364375, or Email: banded@iol.ie.

North central Dublin. Associate required from mid-September, two to three days per week to include Fridays (full-time available 12/08). Busy, well-run practice, mix of private/SW/MC. Fully computerised. Tel: 087 772 1828, or Email CV to: rodandcatherine@hotmail.com.

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Associate required Stillorgan practice, at least three years experience – satellite practice. Fluent English essential, highly motivated capable dentist would suit; keen interest in advanced procedures, ability to build trust and effective communication skills would be advantageous. Please email CV to: peterddwyer@eircom.net.

Friendly associate required (full-time) for a very busy practice in Nenagh, Co. Tipperary. OPG and laboratory on site. Tel: 087 686 6180.

Associate required for Coole Dentist, Co. Westmeath (between Mullingar and Longford). Modern, progressive, computerised, digitalised practice, OPG, hygienist, rapidly expanding. Contact Dr Mulrooney, Tel: 044 966 1777, or Email CV to: drmulrooney@yahoo.com.

Associate dentist required to replace departing colleague for practice in attractive south Kerry tourist town. Modern equipment, OPG, friendly staff, computerised. Tel: 087 983 1290.

Associate required for general dental practice in Ashford, Co. Wicklow. Applicants ideally should have good communication skills, experience in general practice and a knowledge of the national dental schemes. Please Email CV to: apolloniadent@gmail.com.

Castlebar, Co. Mayo. Associate required for five-surgery practice from September 2008. Modern equipment, fully computerised, digital OPG, intra-oral camera. Full book. Excellent remuneration. 25% commission paid for in-surgery hygiene referrals. New graduates welcome! Tel: 086 600 1719, Email: hilda@tobindental.com, or visit: www.tobindental.com.

County Kerry – part-time associate required to take over an existing position in very busy practice. Three days at present. Private and DTSS only. Apply to Box Number J508.002.

Full-time and part-time dental associates required for a busy Clonee and Lucan practice. Excellent support staff, package and prospects. Immediate start. Please contact Maria/William, Tel: 01 610 5022, or Email: maria.kavanagh@primacare.ie.

Associate dentist sought for immediate start in busy North Cork dental practice. Tel: 063 81088 (day), or 087 767 1515.

South West Dublin. Experienced associate required to join top class general practice with visiting consultants. City centre 30 minutes. High gross earning practice. Candidates should have interest in prosthetics (lab on site), endo, implants. Buy-in option available. Tel: 086 807 5273.

Midlands. Progressive associate required for top class, long-established stable practice – two hours from Dublin. Very busy, full book. Excellent back-up services. Good modern surgeries. Implants, strong crown and bridge work, endo all on site. Tel: 086 807 5273.

South Dublin. Progressive dynamic associates/principals/franchisees required. Unique practices, superb locations. Fantastic well tested support system. Fully computerised. Top class equipment. Walk-in-able wow factor practices. Total clinical independence. High earnings possibility. Buy-out option two/four years. Tel: 086 807 5273.

Full-time associate required for busy North Dublin practice replacing departing colleague. Full book. Private, PRSI and Medical Card, GMS. Dublin 3 and Dublin 13 areas. Tel: 085 771 3677, or Email: 1casana@eircom.net.

Associate required (full-time) for a very busy practice in Nenagh, Co. Tipperary. OPG and laboratory on site. Tel: 087 686 6180.

Dental associate required for very busy modern practice in Carlow. Fully computerised, digital x-ray, hygienist and hard working friendly staff. Must have fluent English. Tel: 087 299 8930, or Email jsel@eircom.net.

DSA required to join pleasant, modern, Glasnevin (Dublin 9) practice. Details on application. Please fax CV to: 01 857 2120, or Email to: rcahill@cahilldental.net.

Dental surgeon required for busy family practice, Ballyhaunis, Co. Mayo. Full book, good public/private mix, clinical freedom. Tel: 094 963 0315, or 086 822 0297.

Two dental surgeons required for immediate start for a very busy Carlow practice. Two surgeries fully staffed with modern equipment, including OPG. Great conditions. Tel: 087 926 8050, or Email CV to: amadden@eurocareinternational.ie.

Experienced dental surgeons required to help deliver our Urgent Care Dental Service at the new VHI Swiftcare Clinic in Cork, opening October 2008. Initial hourly rate guaranteed. Submit CVs to: andrewcox@iol.ie.

Full-time/part-time dental surgeon required for busy modern dental practice 15 minutes from Galway city. Fully computerised, digital x-ray, i/o camera. Excellent friendly staff and practice manager. Please Tel: 091 558944, or 086 170 9210 after 6.00pm.

Locum required for three to four weeks for South Dublin practice in November. Possibility of part-time associate position afterwards. Please Email CV to: tomthedentist@hotmail.com.

Locum dentist wanted for busy, friendly Cork dental practice. Part-time to cover maternity leave from November. Tel: 087 221 9890.

Part-time dentist required, Dublin 2/Grafton Street. Private/PRSI, fully computerised and digital radiographs. Forward your CV to: dpgal@eircom.net.

Dentist with minimum four years post-qualification experience and preferably with postgraduate qualification wanted to replace long-standing colleague in a busy private practice one hour from Dublin. State-of-the-art facilities and every equipment mod con. Email CV to: abbeydentalcare@gmail.com please.

Busy Mayo practice requires full-time dentist to replace associate in long-established surgery. Computerised, digital x-ray, OPG, hygienist, etc. Excellent future prospects. Tel: 086 856 2423.

Orthodontist – opportunity for orthodontist to join long-established general/orthodontic practice. Experienced team. Current orthodontist scaling down. Might suit practitioner starting up. Please Tel: 01 833 7405, or 085 7146992 (evenings).

Endodontist required – surgery available for sessions in Dublin 2 general practice. May suit newly qualified specialist looking to establish in Dublin. Please Tel: 087 693 8947.

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Days available for specialist, periodontist, endodontist, oral surgeon in Swords and Dublin 2. Orthodontic practice. Fully equipped, computerised, several chairs, x-ray facilities. Email: tony.coughlan@iol.ie.

Implantologist/periodontist/oral surgeon wanted for a few sessions every month. Fine four-surgery practice within reach of Dublin. Fully computerised, OPG, hygienist, orthodontist, etc. IV sedation available. All patients private/PRSI. Buy-in possibilities. References required. Email: conor.irwin@ratoathdental.ie.

Specialists required: implantologist, periodontist, endodontist and oral surgeon wanted for sessions in modern Limerick clinic. All private patients. Contact Ailish, Tel: 061 490710, or Email: info@no8.ie.

Lab technician required – immediate start. Coole Dental Lab, Co. Westmeath. Tel: 044 966 1777, or Email: drmulrooney@yahoo.com.

Experienced dental hygienist required part-time for a busy, modern dental practice in Galway City. Fully equipped and computerised, full assistance provided (digital x-ray, OPG, Cavitron, etc.) Please Tel: 087 803 4514, or Email CV to: lisatuohy2006@yahoo.ie.

Hygienist wanted. Part-time. Busy, comfortable four-surgery practice close to Dublin. Fully computerised, OPG, etc. Happy place to work! Email: conor.irwin@ratoathdental.ie.

Dental hygienist required for modern dental practice in Galway City. Start from end of September and two to three days per week. Fully computerised, digitial radiography and good support staff. Tel: 087 997 2877.

Galway City Centre dental practice requires hygienist for existing book of private and DTBS patients. One to two days per week starting from September. Fully computerised, digital radiography. Contact Nora, Tel: 091 531531, or Email: reception@galwaydentist.com.

Dental hygienist required for part-/full-time position in busy dental practice in Limerick City. Modern surgery, computerised, OPG, digital x-ray, full admin assistance. Tel: 087 853 7313, or Email: cornmarketdental@eircom.net.

Locum dental hygienist required for busy general dental practice in Drogheda. Two to three days per week. To cover maternity leave from late November 2008 to the end of May 2009. Please Tel: 041 983 0586, or 086 858 3366, evenings only.

Dental hygienist required part-time for busy modern dental practice near Galway city. Fully computerised, digital x-ray, OPG. Good support staff and nurse available. Tel: 091 558944, or 086 170 9210.

Part-time (two days) dental receptionist required. Northside dental practice. Experience essential. Tel: 087 934 8007, or Email: eimear2t@yahoo.com.

Full-time receptionist required in small expanding practice. Experience essential. Email CVs to: cromey1@hotmail.com.

EQUIPMENT FOR SALE

Panara dental software. Developed for Irish practice by an Irish dentist. Clinical charting, accounts, notes, recalls, private/PRSI/Medical Card, claims, SMS, word processing, integrates with Kodak, Vistascan, etc. Comprehensive data conversions from Bridges and XLCR. Tel: 087 239 6281, or visit www.panara.ie.

PRACTICES FOR SALE/TO LET

Great opportunity for dental/orthodontic practice. 30,000 sq ft primary care centre in Mitchelstown. Designed to full dental specification including x-ray room and three treatment rooms (sound proofing, piping, electrics, etc., to dental specs.). Contact Eamonn, Tel: 058 42211.

Established modern practice for sale. Two surgeries, Limerick City. Replies in writing to James Byrne & Co, Bank Place, Mallow, Co. Cork.

For sale or to let. New office unit in Sandyford with planning for medical use to suit dental practice. Unit 101 Q House comprises 158 square metres with three car spaces. Contact HWBC, Tel: 01 775 0500, or Email: pscannell@hwbc.ie.

For sale, South Dublin. City centre two miles. Very busy location with good footfall. Good equipment. Room for expansion plans available. At present expense sharing, overheads, rent low. No Medical Card. Good figures. Competitively priced. Immediate sale. Tel: 086 807 5273.

For sale – Dublin City Centre. Superb location. Long established. Very busy. General practice. Approximately 1,900 sq ft, with rent return. Two reasonably equipped surgeries. Good capital allowances transferable. 50% private. Large new patient numbers. Good profits. Price seriously reduced. Tel: 086 807 5273.

For lease/sale – Dublin City Centre, adjacent to Merrion Square. High-profile building, excellent footfall. Full planning permission/part medical complex. Fully-kitted, walk-in-able new surgery. Ripe for expansion, extra rooms. Plans available. Superb opportunity, long lease/flexible options. Immediate occupancy. Tel: 086 807 5273.

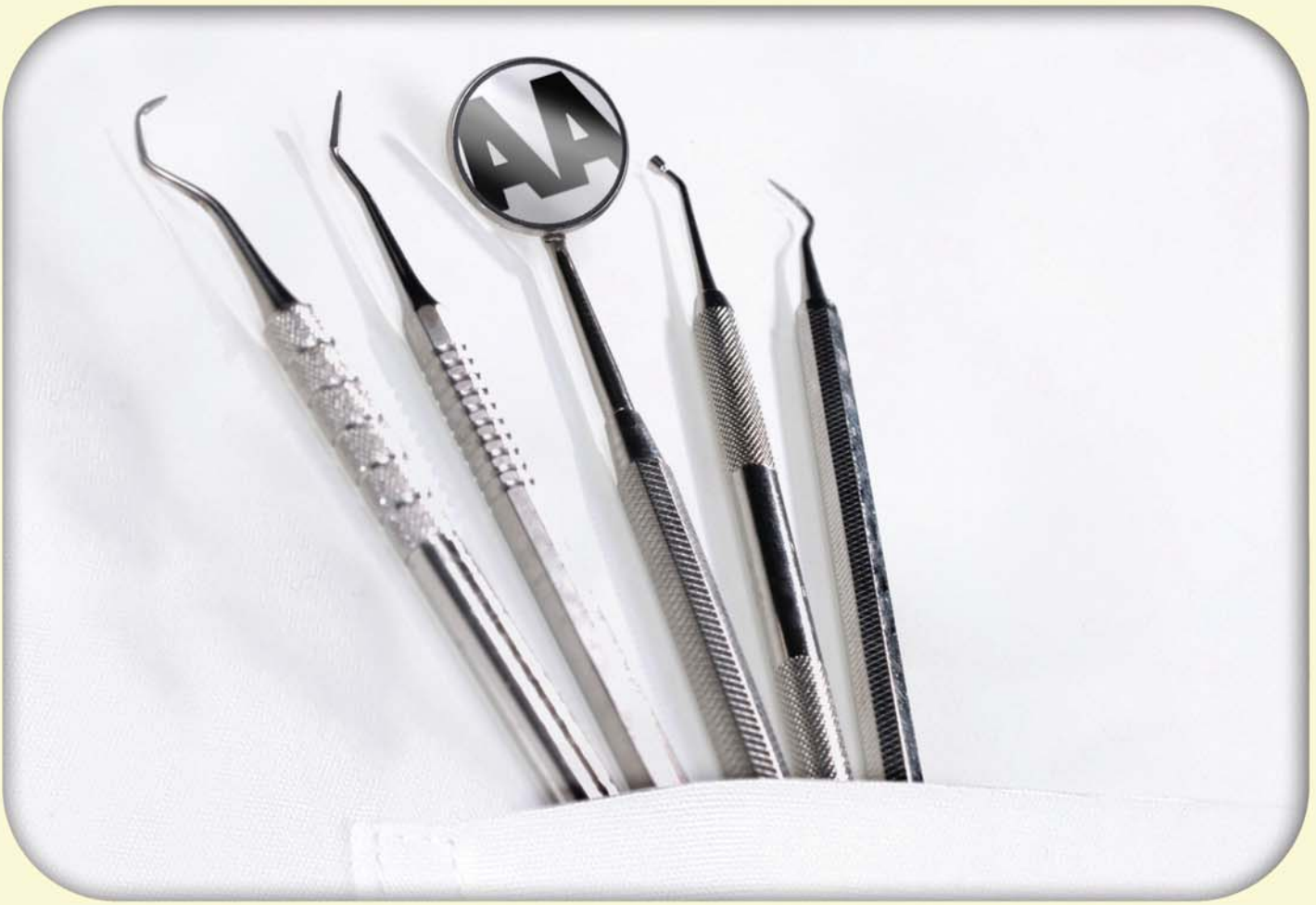
For sale – South Dublin. City centre four miles. Top class location with high passing trade. Two surgeries, excellent equipment. Ripe for expansion, extra room available. No medical card, great staff. Good figures. Competitively priced. Immediate sale. Tel: 086 807 5273.

For sale – Co. Kerry. Long-established, very busy. High profile, good passing trade. Two surgeries, well equipped. No Medical Card. Excellent staff. Large expansion possible. Established hygienist. Excellent quality practice. Principal can stay as associate. Tel: 086 807 5273.

For sale – Galway City. Excellent location. Two surgeries. Progressive busy practice. High footfall. Room to expand. Good modern equipment – OPG, camera. Computerised. Good staff. Low Medical Card. Good figures. Principal available for transition. Tel: 086 807 5273.

For sale – Dublin South. Good location. Long established in the area. Very busy, high profits. Principal retiring from general practice. Two surgeries, hygienist. Room for expansion. Good equipment – OPG. Plentiful parking. High C and B element. Property flexible options. Tel: 086 807 5273.

DENTAL PRACTICE INSURANCE



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DIARY OF EVENTS

OCTOBER 2008

Irish Dental Association – Public Dental Surgeons Seminar
October 1-3 Knightsbrook Hotel, Trim, Co Meath
For further information contact the IDA, Tel: 01 2950072, or Email: elaine@irishdentalassoc.ie.

Irish Dental Nurses Association (IDNA) Meeting – 'The Way Forward'
October 4 Clontarf Castle Hotel, Castle Avenue, Clontarf, Dublin 3
For further information, visit www.idna-ireland.com.

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

Metropolitan Branch IDA – Scientific Meeting
October 16 Hilton Hotel, Charlemont Place, Dublin 2
Speakers are Dr Sabine Maguire on 'Child protection – what has this got to do with dentists?', and Dr Billy Fenlon on 'What's new in paediatric dentistry?'

Irish Dental Hygienists Association (IDHA) Meeting
October 17-18 Cavan Crystal Hotel, Dublin Road, Cavan
For further information, visit www.irishdentalhygienists.com.

Irish Endodontic Society Meeting
October 23 Dublin Dental Hospital, 7.30pm
Speaker: Dr Stephen Flint

November 2008

Irish Dental Association – Council Meeting
November 8 IDA House, Leopardstown

Metropolitan Branch IDA – Scientific Meeting
November 20 Hilton Hotel, Charlemont Place, Dublin 2
Speakers are Drs Jacobs and Woolfe, who will jointly present a smorgasboard of problems and solutions within implant dentistry, with cases undertaken in clinical practice.

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

Irish Endodontic Society Meeting
November 27 Dublin Dental Hospital, 7.30pm
Speaker: Dr Hal Duncan (new Endodontic Consultant, DDH).

Metropolitan Branch IDA – Christmas Party: "Jungle Boogie"
November 29 Minerva Suite, RDS, Ballsbridge, Dublin 4

December 2008

Irish Dental Association Golf Society – The Christmas Hamper
December 5 Royal Dublin Golf Club

2009

January 2009

Metropolitan Branch IDA – Scientific Meeting
January 15 Hilton Hotel, Charlemont Place, Dublin 2
Speaker is Prof. Brian O'Connell on 'Improving your outcomes in prosthodontics – something old, something new', and a joint presentation from postgraduate prosthodontic students at DDH.

Irish Endodontic Society – Annual Scientific Meeting
January 22 Hilton Hotel, Charlemont Place, Dublin 2

Irish Endodontic Society Meeting
January 23 Dublin Dental Hospital, 9.00am
Speaker: Dr Christine Sedgley

Irish Dental Association – Council Meeting
January 24 IDA House, Leopardstown

February 2009

Irish Endodontic Society Meeting
February 26 Dublin Dental Hospital, 7.30pm
Case studies

Metropolitan Branch IDA – Retired Dentists' Dinner
February 26 Hilton Hotel, Charlemont Place, Dublin 2
Dinner at 6.00pm. All dentists, whether retired or not, are very welcome to attend and have a chat with our colleagues who have 'been there' and 'done that'.

Metropolitan Branch IDA – Informal dental evening
February 26 Hilton Hotel, Charlemont Place, Dublin 2, 8.00pm

Metropolitan Branch IDA – Annual Scientific Day: 'Mastering technology'
February 27 Hilton Hotel, Charlemont Place, Dublin 2
Short presentations, a multidisciplinary dental team presentation, table discussions and trade show.

March 2009

Irish Dental Association – Council Meeting
March 7 IDA House, Leopardstown

Metropolitan Branch IDA – Scientific Meeting and Metro AGM
March 19 Hilton Hotel, Charlemont Place, Dublin 2
Speaker is Dr Paul Averley on 'Conscious sedation: a primary case perspective'.

The Dental Nursing and Dental Hygienists Seminar
March 21 Cork University Dental School and Hospital
Further details available nearer the time.

Irish Endodontic Society Meeting
March 26 Dublin Dental Hospital, 7.30pm
Speakers: Drs Derek Duggan, Sile Lennon and Eoin Mullane

Irish Dental Association Golf Society – Metropolitan Branch outing
March 29 Woodenbridge Golf Club

April 2009

Irish Dental Association Golf Society – President's Prize
Date and venue to be confirmed.

Irish Dental Association Annual Conference – 'Skilkenny 2009'
April 22-26 Hotel Kilkenny
For further details, contact the IDA, Tel: 01 295 0072, or Email: elaine@irishdentalassoc.ie.

Irish Dental Association – Annual General Meeting
April 23 Hotel Kilkenny

May 2009

Irish Dental Association Golf Society – Lyttle Cup
May 22 Baltray Golf Club

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ORBIT Complete helps reduce plaque

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[1] Söderling E, Mäkinen KK, Chen C-Y, Pape HR, Loesche W, Mäkinen P-L (1989) Effect of sorbitol, xylitol and xylitol/sorbitol chewing gums on dental plaque. Caries Res 23: 378-84

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