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The Journal of the Irish Dental Association:
- is the only dental publication produced in Ireland;
- is Irish dentists’ own Journal of record.

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February/March 2011
VOLUME 57 (1)
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Time for change

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

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

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

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

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

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

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

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

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

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

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

Election 2011 – Dental Health for All
We now know that the long-awaited General Election will take place on February 25. The IDA is undertaking a major campaign to bring our members’ concerns, and those of our patients, to the attention of the political parties at national level, to local candidates on the doorsteps, and to the media.

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

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

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

There are many ways in which to refresh your knowledge of all aspects of dentistry throughout the year. The Journal of the IDA always contains excellent scientific and practice management advice for readers. The IDA Annual Conference takes place in Cavan from May 12 to 14, and will have a great line-up of speakers. Be sure to mark the dates in your diary! IDA branch meetings, which are free to all members, offer an excellent opportunity to obtain good advice. You will find a full list of upcoming events on the last page of this journal and I encourage you to check out the events listed for your area and, indeed, in areas near you. The Celtic Tiger road network makes everywhere accessible.

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

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

Dr Billy Davis
IDA President
New President-Elect

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

Time to renew – reduced IDA subscription rates 2011

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

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

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

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

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

Applications are invited for the position of Honorary Editor

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Clinical position papers
Position papers on amalgam, dietary guidelines and oral diseases, and paediatric dentistry are to be prepared and published by the Association. The move to publish these position papers is intended to bolster the Association’s position as an advocate for both dentists and their patients, and follows recommendations to this effect in the Association’s strategic plan. Mr Paddy Fleming has accepted an invitation to Chair the group that will draft the position paper on paediatric dentistry, and nominations are also being sought from the General Practitioners Group, HSE Dental Surgeons, and the Irish Society of Dentistry for Children.

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

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

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

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

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

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

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

We are not just one of the options for Ireland; we are THE option for Ireland. And we offer more than simply a dental plan administration service. We offer a host of services including consultancy, marketing advice, business support and our unique quality management system.

Due to our recent growth we have strengthened both our back-office team and our field based team to offer an excellent level of customer service. Indeed you may already know some of our Irish team from the many years they have spent in the Irish dental profession.

We would be delighted to visit your practice and carry out an assessment of how a dental plan could help increase your profitability. Call us on 01 526 2556 to arrange an appointment. We are not just a dental plan, we are THE Dental Plan.

T: 01 526 2556   E: info@thedentalplan.co.uk   W: www.thedentalplan.co.uk
Focus on business development

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

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

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

Ray Gordon is the IDA’s public relations consultant and spoke on raising your profile. He stressed that the fragmentation of media (there are 113 newspapers and 48 radio stations in Ireland) offers an opportunity in its own right, as well as the increased interest from media in lifestyle issues, including oral health. One of his main tips was that the provision of aggregate information is always of interest to media. For example, a dentist might report to the local media...
that there was a 20% increase in caries recorded in adult patients in the last six months at his or her practice.

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

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

David McCaffrey is an accountant who formed MedAccount with Steven Lynch and together they have in excess of 100 dental practices on their books. He stressed that every single practice is unique but that there are certain common threads running through all practice accounts at the moment. He observed that cash flow is absolutely critical, and can cause a lot of stress, and that it is vital to get patients into the chair. David advised that leaflet drops and using the local papers are effective at generating interest, as is creating an occasion (e.g., a Valentine’s Day promotion).

Sheila Scott is qualified in psychology, marketing couselling and training, and has been helping dentists in the UK to achieve success and profit for the past 20 years. She is now working in Ireland and says that the dentists she is working with are keeping their patients. Sheila says the key to good business lies in making sure that patients see the importance of dentistry. Dentists, she says, should find out what patients want and communicate and prove the value of dentistry with confidence. And on that very point she is campaigning for her dentists to change the language of dentistry to health, and is developing a 14- to 17-point dental health check with those dentists.

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

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

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

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

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

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

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

Updates will be sent to IDA members by email.

Metro Branch ASM

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

IDA website upgrade

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

IDA nominations

The IDA has nominated Professor Brian O’Connell and Dr Marielle Blake as its nominees to the Board of the Dublin Dental School & Hospital.
**Dr. Paul A. Tipton**  
B.D.S., M.Sc., D.G.D.P., U.K.  
Specialist in Prosthodontics

**Presents a 10 days (5 weekends) hands-on practical cosmetic and restorative dentistry course using state-of-the-art Phantom Heads**

**Commencing: March 2011**  
**Location: Tallaght, Dublin 24**

**5 weekends between March and June 2011**  
€1,190.00 per weekend plus materials on the day.

The level 2 Practical Restorative Dentistry (Phantom Head) course is designed for dentists seeking a competitive edge, better results for their patients and/or a move into a private practice. The course will build the clinical skills and confidence to prepare and restore teeth for basic and advanced restorative procedures.

**Course Content**
- Tooth preparation techniques
- Anterior bonded crowns
- Procera, Inceram, Empress
- Porcelain veneers
- Posterior bonded crowns
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- Partial porcelain veneers
- Gold posts and cores
- Carbon fibre posts/composite cores
- Adhesion and bonding techniques
- Anterior composites
- Posterior composites
- Anatomical carving for composites
- Staining posterior composites
- Amalgam bonded restorations
- Nayar amalgam cores
- Maryland bridge preps
- Gold crowns, onlays and 3/4 crowns
- Bridge design and preparation
- Grooves and box preps for bridges
- Two-handed tooth preparation
- Temporisation procedures
- New materials

“This course has proved to me how much there is to learn in dentistry—larn excellent course, providing me with the clinical skills and confidence to realise my dentistry potential.”

*Dr Caroline Ingamells, Lake District.*

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

*Dr Stephen J Legg, Derbyshire.*

**Bookings**

For further details on the course and a course brochure please contact Ralf Sander,  
TG Medical (Ireland), Telephone: 01-452 4818 or email: ralf@tgmedical.net.

To book a place, a non-refundable deposit of €1,000.00 is required (this will be offset against last days course fee). The course contributes 65 verifiable hours for CPD.
The Dental Plan offers experience and support

A year after the cuts in dental healthcare funding, many practice principals may be wondering how they can make their businesses more sustainable, and continue to offer the highest possible standards of care to all their patients. The Dental Plan is well placed to help dentists grow their bottom line, while also providing a way to offer patients affordable access to dental care.

In addition to their individually tailored membership plans, the Dental Plan can also provide expert business advice to help you:
- grow your practice and enhance its worth;
- build patient loyalty and grow your customer base;
- develop efficient accounting, clinical and health & safety systems;
- handle tricky staffing issues and provide quality training; and,
- brand and market your practice more effectively.

Dentist-owned and managed, The Dental Plan team brings the best business guidance as well as unparalleled levels of administrative support. What’s more, you’ll actually own a stake in the company and benefit from cash rebate payments bi-annually.

DeCare launches waiting room magazine

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

RCSI FACULTY OF DENTISTRY
POST-GRADUATE DENTAL EDUCATION PROGRAMME

Three Saturday morning modules of post-graduate dental education, with a strong focus on practice issues, and in preparation for membership examinations, have been organised by the Faculty of Dentistry. These will take place at the RCSI on St Stephens Green, Dublin 2, on the dates mentioned below. They will start at 9.00am and feature six 40-minutes presentations up to 2.00pm.

Saturday March 26
Head and neck anatomy; pain control; diagnostic imaging; oral pathology; oral cancer; and radiation safety

Saturday April 16
Dental anatomy; composite restorations; endodontics; paediatric dentistry; cracked tooth syndrome; and, practice management.

Saturday May 7
Craniofacial development; removable dentures; orthodontics; periodontics, including systemic factors; and, adhesive dentistry.

Cost: €80 per module, or €200 for all three modules.

To register contact the Faculty of Dentistry at RCSI by telephone on 01 402 2239, or by email at facultydentistry@rcsi.ie

Alternatively, application forms can be download from the RCSI website at: http://dentistry.rcsi.ie

Development of Training Pathways
“A new Diploma of Primary Dental Care (subject to approval by the Dental Council) is being finalised to replace the existing MCDS Part 1. This Diploma will be a stand-alone qualification taken after a minimum of two years post-qualification experience. It will also entitle those who wish to do so the possibility to continue towards the MGDS and the FGDS.”
Dr Patrick J. Byrne, Dean.
Updates on amalgam and tooth whitening

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

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

Amalgam

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

There were some interesting comments from Member States:

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

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

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

Changes in funding for dentistry

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

- Hungary: Continuing problems were reported because of reduced government expenditure for dental care and restrictions on items covered.
- Ireland: Decreases in per-patient funding and restrictions of items covered under the Dental Treatment Services Scheme (DTSS) were reported, as were restrictions under the Dental Treatment Benefit Scheme (DTBS).
- Lithuania: A fixed rate for payments by health insurance for prosthetic services was introduced; the difference for more sophisticated treatment is paid by the patient. There was a decrease of 11-14% in allocations from the Patient’s Fund compared to 2008.
- The Netherlands: Rates for orthodontics decreased by 34%, effective January 1, 2011; there was strong opposition from the NMT.
- Poland: Expenditure of the National Health Fund lowered in 2010; the majority of dentists are now operating exclusively on the private market, outside of the general insurance scheme.
EU news

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

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

The Commission has not yet enforced the current regulation (under the Cosmetics Directive), which establishes 0.1% as being the maximum authorised concentration of H₂O₂ in finished products. This concentration is too low for tooth whitening; however, higher concentrations are not allowed, and any use of them, including by dentists, is illegal.

The Commission wants to see the whole tooth-whitening issue resolved; otherwise, it will start infringement procedures against Member States in order to enforce the current regulation. It now has a new proposal, namely that:
- under the 0.1% concentration, H₂O₂ would be freely available;
- between 0.1% and 6% H₂O₂, first use is permitted by a dentist only, and the product should be supplied only by a dentist; and,
- H₂O₂ is illegal above 6%.

This new proposal would provide clear regulation and would help those Member States that had no specific provisions against the use of tooth-whitening products by hairdressers and beauticians. It would also render the bleaching process legal for the first time, and dental practitioners would be in control of the product. There were advantages in that the CED would be helping to improve regulation (bleaching would be legal up to 6% H₂O₂ and dentists would be the only ones that would supply this material), and the CED would be seen to be working positively with DG SANCO – a political advantage.

The CED supports the new proposal of the EC to regulate sterile dental handpieces. Among these, Denmark reported that it also has binding guidelines and recommendations, and the Latvian Dental Association reported that it classified all dental handpieces as critical items that must be sterilised after each patient.

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

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

Directive on the application of patients’ rights in cross-border healthcare
On December 21, 2010, the Council approved the compromise text of the cross-border directive prepared on the basis of trialogue consultations (the Council, the Parliament and the Commission), which concluded on December 15, 2010, in Strasbourg. The compromise is in line with CED expectations and generally also with CED proposals set out in the September 2010 position paper. Specifically, CED concerns about including healthcare professionals in national contact points, and in assessment of healthcare technologies, and that national contact points should also provide information to healthcare professionals, are all included.

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

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

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

Questionnaire from the Czech Republic – sterile dental handpieces
A recent questionnaire from the Czech Dental Association contained the following question:
“Is there any obligation (legal or otherwise) in your country requiring the use of sterile dental handpieces in every procedure by all persons involved?”
A total of 17 replies were received: 16 from CED members and one from a CED observer.
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- Mercury & chemical spill kits
- Segregations posters to assist staff with waste handling
- Annual dental waste management contract

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


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

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

Results: At the re-evaluation, the mean age of the patients was 62 years (36.2-83.4). One hundred and seventy-five FDPs were seated (82 FDP-tt, nine FDP-ii, 20 FDP-ti, 39 cFDP-tt, 15 cFDP-ii, 10 cFDP-ti). The mean observation time was 11.3 years; 21 FDPs were lost, and 46 technical and 50 biological complications occurred. Chances for the survival of the three groups of FDPs with end abutments were very high (risk for failure 2.8%, 0%, 5.6%). The probability to remain without complications and/or failure was 70.3%, 88.9% and 74.7% in FDPs with end abutments, but 49.8-25% only in FDPs with extensions at 10 years.

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


An alternative impression technique for individuals with special care needs

Topouzelis, N., Kotsiomiti, E., Arhakis, A.

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

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

A retrospective study of 889 injured permanent teeth

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

The aim of this study was to investigate pre-injury factors, causes of dental injuries and healing complications after traumatic injuries to permanent teeth. The analysed sample comprised 889 permanent teeth of 384 patients, who were treated in the Dentistry Department in the Faculty Hospital in Pilsen. Enamel-dentin fractures (233 teeth [26.2%]) and lateral luxations (207 teeth [23.3%]) were the most frequent injuries. The age of the patients at the time of injury varied between seven and 65 years. Predominantly, children were affected.
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(587 injured teeth [66%]). The most frequent causes of injuries in patients older than 11 years were various sport activities, predominantly bicycling. Pulp necrosis was observed in 239 teeth (26.9%). It was the most frequent post-traumatic complication in all types of dental traumas. Teeth with a completed root formation demonstrated a higher prevalence of pulp necrosis than teeth with an incomplete root formation in all types of luxation injuries. External root resorption was observed in 144 teeth. The rate of inflammatory resorption differed between the various types of luxation injuries (extrusive luxation 5.6%, lateral luxation 11.6%, intrusive luxation 33.3%). Following avulsion and replantation, active inflammatory resorptions were diagnosed in 13 (26.5%) of 49 replanted teeth, and ankylosis/replacement resorptions were observed in 21 (42.9%) of 49 replanted teeth. After avulsion, primarily, immature teeth were affected by these complications. Within the observation period of five years, 39 teeth (4.4%) had to be removed (16 teeth with root fractures, 19 avulsed and replanted teeth, three luxated teeth, and one tooth with crown-root fracture).


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

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

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

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

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

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

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

Quiz answers (questions on page 20)

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

References and further reading
The cyclooxygenase-2 inhibitor celecoxib and alveolar osteitis

Abstract

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

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

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

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

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

Introduction

The cyclooxygenase-2 (COX-2) inhibitors widen the spectrum of pharmacological management of pain and inflammation for many patient groups. Prior to the introduction of COX-2 inhibitors, patients were exposed to harmful side-effects associated with the long-term use of non-selective non-steroidal anti-inflammatory drugs (NSAIDs), such as gastric ulcer bleeding and perforations, or the risk of addiction with the long-term use of narcotics. COX-2 inhibitors offer greater safety in conjunction with comparable efficacy, compared to simpler NSAIDs, in managing pain, including acute dental pain. COX-2 inhibitors are the medication of choice for use in patients with gastric disease for both prophylactic or post-treatment analgesic pain management. Until recently, COX-2 inhibitors were gaining more popularity for pain relief in general. In fields such as oral surgery, there has been an increase in the prescribing of COX-2 inhibitors. The use of the traditional NSAID...
Ibuprofen had been challenged by these 'promising' COX-2 inhibitors. However, in the last few years interest in the cardiovascular effects of the relatively selective COX-2 inhibitors has been intense. In October 2004, rofecoxib was withdrawn from world markets after a randomised placebo-controlled trial found that doses of 25mg/d increased rates of cardiovascular events in patients with colorectal polyps. The results were confirmed by several large pharmaco-epidemiological studies. Celecoxib continues to be widely used, despite meta-analyses of randomised controlled trials showing an increased risk of myocardial infarction. The differences between rofecoxib and celecoxib appear important from both a clinical and regulatory standpoint. Based on the randomised data, celecoxib appears to be unsafe in doses of 400mg or more. However, at doses of 200mg or less there is no convincing evidence of an increased risk of cardiovascular events with celecoxib, which remains on the market. These results seem to point to different dose–effect gradients in the vascular compartment across the ranges of doses of celecoxib and rofecoxib that were used in clinical practice.

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

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

Patients and methods
This randomised, double-blind, placebo-controlled, prospective clinical trial was conducted at Euro-Oral Hammaslääkärikeskus in Helsinki, Finland, over an eight-month period. Participants were randomly allocated to receive a standard oral dose of 200mg celecoxib, 400mg ibuprofen, or a placebo containing lactose, pre-emptively, one hour before surgery. The doses were selected based on the product labelling and other currently available product information. Each patient was given a prescription for 1,000mg of paracetamol as a rescue medication in case the study medication did not provide sufficient pain relief. Each patient was prescribed amoxycillin 500mg three times per day postoperatively for seven days. Patients were not prescribed any postoperative analgesia apart from paracetamol as a rescue medication.

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

The participants were given standardised participant information sheets, and written informed consent was subsequently obtained from the participants prior to the commencement of the study. The institutional review board approved the protocol and the informed consent document. For the analysis of differences in frequencies of postoperative complications, including alveolar osteitis, in various patient groups, the Chi-square test was applied, defining p<0.05 to be a significant difference. Statistical analysis was performed using the software SigmaStat 3.0 (SPSS Inc., USA).

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

Safety profile
No persistent or unexpected adverse events were reported. The most common adverse events were nausea (occurring in 22%, 13.3% and 18.1% of placebo, celecoxib and ibuprofen patients, respectively), headache (13.1%, 10.2% and 9.7%), and vomiting (10.3%, 3.3% and 4.1%). Vomiting occurred more frequently in placebo patients.
than in celecoxib patients (p<0.05). None of the other between-group differences in nausea or headache were statistically significant (p>0.05).

A total of 13% of the patients who took ibuprofen had severe pain two to three days postoperatively. This was diagnosed as alveolar osteitis, which is in line with the universally accepted outcome for the surgical extraction of mandibular molar teeth. Alveolar osteitis occurred more frequently in placebo patients (21.1%). None of the celecoxib patients developed alveolar osteitis postoperatively. The ibuprofen group had a significantly higher alveolar osteitis incidence than the celecoxib group (p ≤ 0.05) and the placebo group (p ≤ 0.05).

The use of the celecoxib resulted in a significant decrease in the occurrence of alveolar osteitis (Table 1).

**Discussion**

The selective COX-2 inhibitors have been found to exert significant opioid-sparing effects after dental, gynaecologic, orthopaedic, and other non-cardiac surgical procedures, apparently without causing serious adverse effects. Recently, studies of the long-term administration of COX-2 inhibitors have aroused concern regarding their potential to increase the risk of thromboembolic events after vascular surgery. COX-2 inhibitors not only lack the antiplatelet effects of aspirin; by inhibiting the production of prostacyclin, they also disable one of the primary defences of the endothelium against platelet aggregation, hypertension and atherosclerosis. COX-2 inhibitors also promote an imbalance in favour of vasoconstriction. These biologic actions suggest that COX-2 inhibitors might increase the risk of clot formation. While this might have a harmful effect in patients undergoing vascular surgery, it might have a beneficial effect in stabilising the blood clot in the alveolar socket following dental extraction. Stabilising the blood clot would ultimately decrease the incidence of infection and alveolar osteitis postoperatively.

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

<table>
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<th>Tooth number</th>
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<th>Number of dry socket</th>
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<tr>
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<td>Ibuprofen group</td>
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pain and alveolar osteitis in patients undergoing surgical dental extractions.

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

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

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

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

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

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

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

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

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

Social history

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

Introduction

A logical and well organised approach should be followed to record a patient’s medical history. As the population continues to age, dentists are now more likely to be faced with an increasing number of patients with complex medical problems. Dental patients more frequently undergo local anaesthesia, sedation and more advanced dental procedures. Studies have shown that medical emergencies do occur in medically compromised patients attending general dental practice.1-3

Within the Departments of Oral & Maxillofacial Surgery and Oral Medicine, and the Accident and Emergency (A&E) Unit, there are currently three different medical history systems in operation:

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

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

Aim

The objectives of this audit were to produce a standardised medical history, to identify any differences or discrepancies between each of the
methods, and to determine if one method was superior to the others. The results will be used to recommend a method for obtaining a thorough health history for practitioners.

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

Results
One hundred and fifty patient charts were audited. The patient population was 61% female and 39% male. The age distribution was 5-87 years for females and 3-85 years for males. The mean age was 45 years for females and 42 years for males. The study found that all three types of health history assessment addressed life-threatening conditions like heart problems (146), chest problems (138) and allergies (142). The next most common topics included bleeding (121), epilepsy (128), diabetes (134), liver problems (138) and current medications (122). The least mentioned subjects were previous hospitalisations (116), pregnancy (44) and use of the oral contraceptive pill (OCP) (42) (Figure 3). Information on infectious diseases like AIDS and hepatitis B, and the use of recreational drugs, was not often requested. Considerable discrepancies were noted between the verbally administered questionnaire and the electronic questionnaire. There was a wide variation between the three different questionnaires in the type and frequency of questions asked. Topics that were asked most frequently were questions relating to heart problems, chest problems and allergies. The written pro forma questionnaire combined with verbal verification was the most accurate method, with heart problems, chest problems and allergies asked in 100% of cases. The electronic questionnaire on Salud also proved to be an efficient method with heart problems asked in 100% of patients, chest problems in 96% and allergies in 98%. The verbal dialogue history was the least efficient method, with 92% of patients being questioned on heart problems, 80% on chest problems and 86% on allergies. In relation to bleeding, the written patient-administered pro forma questionnaire was the most efficient with 98% of patients interrogated. The electronic questionnaire followed at 92%. The verbal enquiry requested this information in only 52% of patients (Figure 4).

In questions relating to epilepsy, diabetes, jaundice and hepatitis the written pro forma questionnaire combined with verbal verification was superior, with queries made regarding epilepsy in 98% of charts, diabetes in 100% and jaundice/hepatitis in 100%. The dentist-administered electronic questionnaire combined all these topics as a single question and this was asked in 94% of cases. Again, the verbal enquiry proved to be the least efficient, with values obtained for epilepsy, diabetes and jaundice/hepatitis being 64%, 74% and 82%, respectively. The study demonstrated that 58.7% of patients were taking medication on a daily basis. However, there appeared to be a huge
discrepancy within all three questionnaires in relation to this topic. The verbal questionnaire in the oral medicine clinic achieved the greatest result with 100% of patients knowing the name of the drug and 52% knowing the dosage. However, this is based on the clinician researching the British National Formulary (BNF) and adding to the list. The Salud system also performed well, with 100% recalling the name, but only 40% recalling the dosages. The written pro forma questionnaire alone performed quite poorly. Only 70% of patients knew the name and 15% knew the dosages. However, this value did increase after verbal enquiry in the clinic with these values increasing to 81% and 36%, respectively.

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

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

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

The oral medicine clinic patient-administered questionnaire was the most consistent method for recording this information, with 92% and 72% of patients providing information on their GP and GDP, respectively. Only 30% of patients were asked for GP details and 54% for GDP details on Salud. A mere 24% of patients were questioned on their GP details and 68% on their GDP details in the verbal enquiry questionnaire (Figure 6). The study revealed considerable variation between questionnaires in the type of questions asked. Topics more frequently asked in the verbal dialogue in the oral medicine clinic, but not the other two, included kidney problems (54%), GIT (50%), musculoskeletal (28%), neurological (22%), endocrine (18%), family history (18%), dermatological (12%) and anaemia (6%) (Figure 7). OMFS patients were further questioned on arthritis (100%) and previous steroid use (94%). In the A&E electronic record, enquiries were made into topics such as slimming medications (28%), sickle cell disease (40%), human growth hormone (66%) and previous steroid use (94%).
general anaesthesia (50%). These questions were frequently skipped by the majority of examining dentists in the A&E clinic.

Discussion

The medical/social history is an essential part of patient care. It is incumbent on the clinician to obtain relevant patient history for the safe practice of dentistry. If the questionnaire/discussion is considered difficult to use or time-consuming, for example the EMRRH questionnaire, the clinician might miss important patient information. Any medical problem that is missed might be of importance for the dental treatment. Indeed, reports have confirmed that medical emergencies occur in medically complex patients attending general dental practice. It was apparent that the patient-administered pro forma questionnaire, combined with verbal verification by the dentist, has proved to be the most useful method for detecting medical problems in dental patients. The verbal enquiry alone by the clinician showed more inconsistencies than the other two methods.

The pro forma questionnaire alone was not sufficient. Ten out of the 50 questionnaires had blank answers, highlighting the need to personally verify blank answers in the clinic. Patients do not always provide accurate or complete health information. The patient may not understand the terminology or may judge some conditions as unimportant or fail to recall significant facts at the time the questionnaire is completed. Brady and Martinoff in 1980 found that 32% of patients did not answer self-administered questionnaires correctly. Scully and Boyle in 1983 and Fenlon and McCartan in 1992 found that self-administered questionnaires revealed significant discrepancies. The use of written patient-administered pro forma questionnaires is beneficial and may encourage more truthful responses to sensitive questions. They can be filled in privately by the patient prior to the clinic or face to face with the clinician. The clinician can expand on any area that needs exploration. Although the verbal history makes it possible to explain questions and provide a good insight into patients’ responses, it is time-consuming and relies on the clinician’s memory, time and alertness. Within the Oral Medicine clinic, there was no systematic recording of relevant medical history and this was wholly dependent on the operator’s preference. Important topics were frequently missed. Handwriting was also illegible in many charts. An advantage of using the electronic or patient-administered pro forma questionnaires is to avoid illegible handwriting issues.

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

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

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

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

Although the patient-administered pro forma questionnaire is the most useful, efficient method of carrying out a preliminary screening for medical conditions, it should be combined with verbal enquiry into
FIGURE 8: Proposed medical pro forma questionnaire.

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

Conclusion

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

References


Consent to treatment for children and adults with learning difficulties

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

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

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

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

There are four specific components to valid consent:
1. Capacity.
2. Information.
3. Voluntariness.
4. Authority.

The test of capacity currently applied in the Irish courts is the ‘C Test’, which derives from the English case of ‘Re C’. The test is in three parts, all of which have to be fulfilled for a patient to be deemed competent to make the decision they are being asked to consider:
1. Does the patient comprehend and retain treatment information?
2. Does the patient believe that information?
3. Does the patient weigh that information, balancing risks and needs to reach a decision?

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

Children

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

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

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

While, in the vast majority of cases, consent will be provided by a parent, or indeed a competent child, there are occasions where others can provide consent on behalf of a minor. A summary of who can act in this capacity is:
- the child’s mother;
- the child’s father, if married to the mother before or after the birth, or with court approval;
- legal guardians/testamentary (appointed in a will);
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foster carers and health boards in specific circumstances (Consent to Medical Treatment for Foster Children, November 6, 1999), (Childcare (Amendment) Act 2007, Section 43(A)); health boards with a court order; and, the courts.

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

**Forthcoming changes**

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

**Adults with learning difficulties**

There are obviously similarities between adults with learning difficulties and children under the age of 16 in that the clinician has to make the decision as to whether the patient has capacity. Assessing a person’s capacity or lack of it should follow a proper examination and assessment, to include conveying information to the patient, discussing it with them to gauge their understanding and then asking open questions about salient points to see if they have been grasped. At present, only the courts can consent to treatment on behalf of an incapacitated adult. However, this should not deny patients treatment, and there should be consultation between the clinician, the patient’s relatives and any carers, in order to agree that a particular treatment is in the patient’s best interests. Further opinion from a colleague can also be sought and the treatment provided should be the minimum to achieve the result required.

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

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

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

**James Foster LLM BDS MFDS(GDP)(UK)**

James is an experienced general practitioner with extensive experience of the vocational training of recently qualified dentists. He is also a trained mentor and has a certificate in clinical education. James is a dento-legal adviser who frequently handles cases for members of Dental Protection practising in Ireland.
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 March 7, 2011, by cheque made payable to the Irish Dental Association. If a box number is required, please indicate this at the end of the ad (replies to box number X). Classified ads placed in the Journal are also published on our website www.dentist.ie for 12 weeks.

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Classifieds

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Experienced dentist available for locum positions in January/February 2011. Tel: 087-269 3381.

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Associate required for start-up dental surgery in Athlone area. For more information please Tel: 085-786 6614, or Email: nicolalennon25@gmail.com.

South East. Part-time associate required to replace associate who was with practice for 10 years. OPG, computerised, etc. Tel: 087-250 6484, or Email CV to: murber@eircom.net.

Experienced dental associate required for a busy, modern dental practice in Galway City, Ireland. Fully equipped and computerised (digital x-ray, OPG, hygienist, etc.) Please Email: dental.practice1@yahoo.ie.

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Diary of events

JOURNAL OF THE IRISH DENTAL ASSOCIATION

FEBRUARY 2011

Metropolitan Branch, IDA Annual Scientific Day
February 18
Hilton Hotel, Dublin 2
Speakers are Professor Robin Seymour on ‘Oral health and systemic diseases, where are we now?’, Professor St John Crean on ‘Recognising medical conditions in the dental patient’, Dr Gary Heavey on ‘Marketing – the most effective bang for your buck’, and Dr Ashley Latter on ‘Ethical sales and communication’.

Munster Branch, IDA – Scientific Meeting
February 22
Maryborough House Hotel
Speaker is Prof. John Whitworth on ‘The wise man built his house … concrete foundations and soggy bottoms in endodontics’.

MARCH 2011

Head and Neck Reconstructive Surgery Conference
March 4
St Vincent’s University Hospital, Education & Research Centre
For further information, contact Aongus Curran, Tel: 01-221 4277.

Metropolitan Branch, IDA – Scientific Meeting and AGM
March 24
Hilton Hotel, Dublin 2
Speakers are: Dr Jason Owens on ‘Location, location location – site consideration in implant placement’, and Dr Raphael Bellamy on ‘100% – X the challenge of endodontic success’.

Kerry Branch, IDA – Scientific Meeting
March 24
Brehon Hotel, Killarney, 8.00pm.
Speaker is Dr Stephen Fennell, Radiological Institute of Ireland, on ‘Update on radiological licensing requirements and code of conduct for Irish dentists’.

The International Dental Show (IDS) 2011
March 22-26
Cologne, Germany
For further information see www.ids-cologne.de.

APRIL 2011

The IDA Golf Society, Christmas Hamper Outing
April 1
Royal Dublin Golf Club
Tee reserved from 8.00am.

Kerry Branch, IDA – Scientific Meeting
April 7
Meadowlands Hotel, Tralee, 8.00pm.
Speaker is Dr Denise MacCarthy, Consultant Periodontologist at the Dublin Dental Hospital, on ‘Oral care for oncology patients’.

Orthodontic Society of Ireland – Meeting
April 15-16
K Club, Co. Kildare
Speaker is Dr Hugo De Clerck. See www.orthodontics.ie for more details.

MAY 2011

IDA Annual Conference 2011
May 11-14
Slieve Russell Hotel and Country Club, Ballyconnell, Co. Cavan
For further information contact IDA House, Tel: 01-295 0072.

Irish Society of Dentistry for Children – Annual Scientific Meeting
May 19-20
Limerick

SEPTEMBER 2011

The 24th Annual Meeting and Refresher Course of the European Society of Head and Neck Radiology (ESHNR)
September 8-10
Congress Center Oud Sint-Jan, Bruges, Belgium
More information on the programme can be found on the website – www.eshnr2011.be.

OCTOBER 2012

21st Congress of the International Association for Disability and Oral Health
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Sydney, Australia.
For further information see www.iadh2012.com.
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Wide variety of prosthetic options with maximum function and fit.

High stability with only four implants.

Reduced need for vertical bone augmentation.

Maximum bone-to-implant contact and preservation of vital structures.

All-on-4 was developed to provide clinicians with an efficient and effective restoration using only four implants to support an immediately loaded full-arch prosthesis. Final solutions include both fixed and removable prostheses such as NobelProcera Implant Bridge Titanium or Implant Bar Overdenture. The tilted posterior implants help avoid relevant anatomical structures, can be anchored in better quality anterior bone and offer maximum support of the prosthesis by reducing cantilevers. They also help eliminate the need for bone grafting by increasing bone-to-implant contact. All-on-4 can be planned and performed using the NobelGuide treatment concept, ensuring accurate diagnostics, planning and implant placement.

Nobel Biocare is the world leader in innovative and evidence-based dental solutions. For more information, call +44 (0)208756 3300 (UK), 1800 677306 (Ireland) or visit our website.

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