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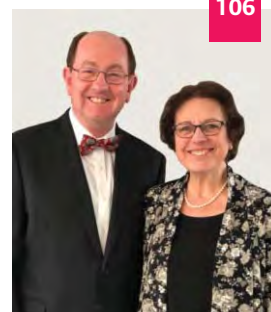
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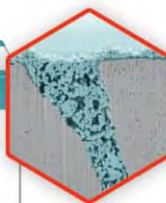
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References: 1. Nathoo S, et al. J Clin Dent. 2009;20(Spec Iss):123-130. 2. Docimo R, et al. J Clin Dent. 2009;20(Spec Iss):17-22. 3. Hines D, et al. Accepted poster, July 2018 IADR. Colgate-Palmolive Company 2018.



Dr Ciara Scott
Honorary Editor

Opportunity knocks

We have an opportunity now to collectively build a framework based on the new national oral health policy, supported by evidenced-based dentistry.

Policy: *A course or principle of action adopted or proposed by an organisation or individual.*

My first experience of general dental practice was as a vocational trainee (VT) in a village practice outside Southampton. My principals were very dedicated to high standards and this created a wonderful learning environment. I was eager to make a good impression and so found it difficult when many of my new patients were disappointed to see me! "You're not the dentist I saw last time" or "I'm so disappointed the last dentist has left, she was the best dentist I've ever had". And so it went on. Anyone who has taken over a dental list will relate to this, but it was the first time I really understood the importance of that professional relationship in dentistry and continuing care from the patient's perspective. Over the years, advertising and media reports of dentistry seem increasingly transactional; how much is a filling, or a crown or braces, failing to recognise differences in materials or techniques or training and most importantly, the professional relationship we build to engage and empower our patients and how important this is for so many patients. Our Colgate Caring Awards are a testament to this.

As a dentist, I do not fully understand the complexities of public policy, in the same way that others may not fully appreciate the complexities of our profession. I was interested to learn that a policy is a document of intent; a proposed action. The publication of *Smile agus Sláinte* offers the opportunity to now collectively build a framework that preserves, promotes and progresses our profession and how we deliver oral health services in a way that shares both our professional knowledge and technical skills with patients and other health professionals.

Evidence-based dentistry

With this in mind, I was delighted that Dr Derek Richards agreed to be interviewed for this issue. Over his career, Derek has been instrumental in establishing evidence-based dentistry, and developing and implementing

policy and evidenced-based practice through his work on The York Review for water fluoridation, the UK's National Institute for Health and Care Excellence (NICE) dental recall guidelines and Scottish Intercollegiate Guidelines Network (SIGN) guidelines on the prevention of caries in children. He also writes for the Dental Elf blog, sharing new evidence in very accessible critical appraisals. In this issue he shares his wisdom on the benefits of prevention in policy and how, in the same way that patients do not always change their habits to improve their health, we as practitioners can also be slow to change our habits in response to new evidence.

Shared knowledge

We also have professional links further afield with Drs Robin Foyle, Nuala Carney and Jane Renehan representing Irish dentistry at European (CED) and world (FDI) level. I'm thankful to Nuala for taking the time to feed back from this forum and share their learning with us in this edition.

It was wonderful to meet so many colleagues, speakers and exhibitors at the Annual Conference in Galway and I enjoyed and learnt much from many of the excellent presentations and all the casual conversations over the three days! I'm also grateful to Dr John O'Keefe for sharing his professional journey with us in this issue before heading back to Canada.

Musculo-skeletal pain can be a cause of early retirement from dentistry, so I was very interested to read Eamon Ó Muircheartaigh's tips in this issue on improving our ergonomics and preventing pain and injury in our practising lives.

In this issue, we also have two case reports in our peer-reviewed section. I thank both lead authors Drs Conor O'Gorman and Brian Martin and their colleagues for sharing these very different and unusual case reports. They have reported them in a way that we can all learn more about the investigations, diagnosis and management used when a patient presents with something uncommon. Writing and publishing should be a great learning experience for both authors and readers. I thank all the peer reviewers who support this process for our *Journal* and encourage more readers to consider publishing.

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Prof. Leo Stassen
IDA President



Constructive approach needed

How we approach and respond to the proposed new National Oral Health Policy is critical to the future of our patients' health.



The publication of a new National Oral Health Policy, entitled *Smile agus sláinte*, is to be welcomed. The Association has been calling for such a publication for many years now. Indeed, we anticipated a new policy in early 2008.

Smile agus sláinte marks a significant development for our profession. Whatever its contents (which we are currently assessing), it brings a very welcome Government focus on oral health. We have a framework now to work with and see how we can make it work for our patients. So even though we may be aggrieved at the lack of consultation with us in advance of its publication, there is no doubt that it is a document that deserves our most serious consideration and comparison to our own task force document *Towards a Vision for Oral Health* that we submitted to Minister Harris. Let us put aside our grievance and proceed in a constructive spirit from here on.

This constructive approach is vital if we are to ensure that the Government puts the resources into oral health necessary to achieve worthwhile goals. Our current work is in assessing the contents of the Policy and I invite all sections of dentistry to contribute their views and analyses to the Association. Dentistry in all its areas, general practice, specialist practice, HSE dental surgeons and dentists in the hospitals must remain collegiate in our approach to help define the needs and how we can best provide this new oral health strategy. Working together, accepting and respecting our different needs, is the only way.

To facilitate this collaborative assessment, the Association is holding a major national meeting, with all members welcome. It will take place at the Crowne Plaza Hotel in Santry, Dublin 9, on Saturday, May 11 next. In advance of our meeting, both *Smile agus sláinte* and *Towards a Vision for Oral Health* can be found and read on the Association's website, www.dentist.ie.

In many ways, this is the most important meeting of dentists in 25 years. How we react to this publication will define how we influence the success or failure of its contents. We need, therefore, to carry out accurate analyses of its proposals and see where we can add value to its contents, or identify any flaws if they exist. I remind members that our mission statement states that we exist

to "...promote the well-being of our country's population through the attainment of optimum oral health". Every interest within dentistry needs to get involved in this work and we will actively seek out contributions from those with specific expertise.

Annual Conference

This meeting on May 11 comes hot on the heels of a highly successful Annual Conference in Galway. Every aspect of the Conference was a success. Before we even opened the Pre-Conference Courses, the support of the suppliers to the dental profession in taking stands at the Trade Show and sponsoring presentations ensured that we had a sustainable financial base from which to build our programme. We remain grateful to those companies and individuals that support our Association and seek to support them as fully as possible in return. Thank you to all those delegates who visited the trade: it was a win-win situation for everybody.

Our Pre-Conference Courses were fully booked and the presentations on the Friday and Saturday were excellent. The attendance was strong and the social aspects, including the Gala Dinner, were very well supported. Of course, a huge event like that cannot happen without superb advance planning, and great management. I am personally grateful to all the members of my Scientific Organising Committee, chaired by Dr Dermot Canavan, and to all our Association executives, especially Elaine Hughes and Aoife Kavanagh, for their tremendous work. It is appropriate also to congratulate them on their great success – it was highly professional in every sense.

To all members, I say thank you for the great honour of electing me as your President. I promise to work to the best of my ability for our common good and that of our patients.

On my own and all our behalves, I thank Dr Kieran O'Connor for his fantastic work as President over the last 12 months and I look forward to seeing as many of us as possible together on Saturday, May 11 next.



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Inaugural clinical pledge ceremony at UCC



Pictured are the BDS3 class, who had just taken the clinical pledge, along with staff (from left): Prof. Helen Whelton; Dr Gerry McCarthy; Dr Christine McCreary; Prof. Patrick O'Shea; Prof. John O'Halloran; and, Prof. Chris Lynch.


The inaugural clinical pledge ceremony was held at University College Cork (UCC) on December 6, 2018. This event was held to mark the development of the third-year BDS (BDS 3) students as future dental professionals. Addresses were made to the students by Prof. Patrick O'Shea (UCC President), Dr Gerry McCarthy (President, Dental Council) and Dr Christine McCreary (Dean, Cork

University Dental School & Hospital). The event was convened by Prof. Chris Lynch (BDS 3 Year Lead), who invited the students to recite the clinical pledge. The event was also attended by Prof. John O'Halloran (Deputy President and Registrar, UCC) and Prof. Helen Whelton (Head, College of Medicine & Health).

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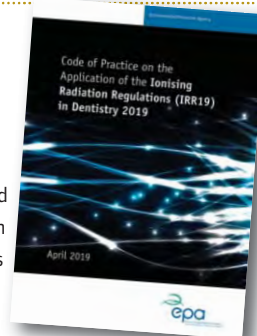
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Ionising Radiation Regulations Code of Practice

Dr Jane Renehan at Dental Compliance Ltd recommends the new Environmental Protection Agency (EPA) Dental Code of Practice as essential reading for all dentists and dental team members. Jane was the dental technical expert on the EPA working group that wrote this code.

The EPA holds regulatory responsibility for workers and members of the public, and this new code of practice is a helpful, practical guide setting out the requirements of the national regulator.

Jane advises that EPA's remit, as legislated for in S.I. No. 30 of 2019, should not be confused with HIQA's radiation regulatory responsibilities. HIQA was designated as the competent authority for medical ionising radiation (patients) under S.I. No. 256 of 2018. Refer to www.HIQA.ie for information and relevant publications. Irish legislation provides for two separate competent authorities to act as regulators in oral radiology. Their individual remits are summarised in the table below.



Protection remit	Regulation	Competent authority/regulator
Protection of those who work with radiation and members of the public	Ionising Radiation Regulations S.I. No 30 of 2019 (known as IRR 19)	Environmental Protection Agency (EPA)
Protection of patients undergoing dental radiological procedures	Medical Exposure Regulations S.I. No. 256 of 2018	Health Information and Quality Authority (HIQA)

You can download the EPA's Code of Practice on <https://bit.ly/2Upi63n>.

Irish Inter Professional Association lunch



Pictured at the Irish Inter Professional Association (IIPA) Spring Lunch on March 8 are (from left): IDA CEO Fintan Hourihan; Dr Martin Holohan; Mr Justice Peter Kelly, President of the High Court; Dr Jennifer Collins; and, Dr Sean Ó Seachnasaí. The IDA is a member of the IIPA, which is an informal umbrella organisation whose members include the Irish Medical Organisation, Irish Pharmacy Union, The Bar of Ireland, the Law Society, Engineers Ireland, and the Irish Tax Institute. Fintan Hourihan is the current Chair of the IIPA. At this year's Spring Lunch, which took place in the Benchers' Room at King's Inn, guest of honour Mr Justice Peter Kelly spoke on the topic of 'Trust and the Professions'.

Retirement Day

Considering retiring from dentistry? All you need to know, from selling your practice to looking after your health, will be covered in our day-long seminar on Friday, September 27, at the Crowne Plaza Hotel, Santry. Further details to follow.

New graduates/young dentists

Following on from the success of our inaugural day designed for new graduates/young dentists in 2018, we are hosting the event again this year. The date for your diary is Saturday, September 28, at the Crowne Plaza Hotel, Santry. The event will be sponsored by KBC Bank. Further details to follow.

Nominations for Colgate Caring Dentist of the Year 2019 are open

Nominations are now open for the Colgate Caring Dentist/Dental Team of the Year. These awards are the only dental awards in Ireland that are chosen by your patients. Nomination packs will be sent out to all dental practices, and patients can also log on to www.colgatecaringawards.ie.

Date for your diary: Colgate Caring Dentist Awards Ceremony, December 7, Clayton Hotel, Leeson Street. You don't want to miss it!

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Quiz questions

Submitted by Dr Eimear McHugh



Questions

1. This OPG is from a 45-year-old lady of African descent who presented with generalised symptoms of mild discomfort in her jaws. What is the most likely diagnosis?
2. What is the most common presentation?
3. What is the usual management for this diagnosis?

Answers on page 101.

Diary of events

APRIL

- 26 Introduction to Dental Sleep Medicine with Dr Dermot Canavan**
Northbrook Clinic, Dublin 6, 3.00pm-7.00pm

MAY

- 14 Dental Sedation Teachers Group (DSTG) Symposium 2019**
Western Gateway Building, UCC, 9.00am-4.45pm
- 16 Irish Society of Dentistry in Children Annual Scientific Conference**
Midlands Park Hotel, Portlaoise, Co. Laois
- 17 Hands-on endodontic course with Dr Patrick O'Driscoll**
Fota Island Resort, Cork
- 18 Basic life support and medical emergencies**
Rochestown Park Hotel, Douglas, Cork

OCTOBER

- 10-11 HSE Dental Surgeons Seminar**
Midlands Park Hotel, Portlaoise, Co. Laois

Putting gum health in the spotlight




"Healthy gums, beautiful smile" is the slogan chosen for European Gum Health Day 2019, which will be celebrated on May 12 across Europe, to raise public awareness of the importance of gum health and the growing threat that gum diseases imply for general and public health.

European Gum Health Day 2019 is organised by the European Federation of Periodontology (EFP) in partnership with the EFP-affiliated Irish Society of Periodontology (ISP). The event will be highlighted among dental professionals and to the public.

"This highlights the need for patients to visit their dental practice regularly to monitor their gum health and prevent gum disease," commented Dr Peter Harrison, ISP President.


"Gum Health Day 2019 aims to remind people that gum health is a key factor for general health and well-being throughout life, and that gum disease is a relevant public health concern as it is linked to very serious conditions, including heart disease and stroke" says Lior Shapira, co-ordinator of Gum Health Day 2019.

The EFP is a leading voice on gum health and gum disease, focused on improving periodontal science and practice in Europe and around the world. For more information on gum health and European Gum Health Day 2019, go to www.efp.org.



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Easolief Duo 500 mg/150 mg film-coated tablets Each tablet contains paracetamol 500 mg and ibuprofen 150 mg.
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Contraindications: Severe heart failure, known hypersensitivity to paracetamol, ibuprofen, other NSAIDs or to any of the excipients, active alcoholism, asthma, urticaria, or allergic-type reactions after taking acetylsalicylic acid or other NSAIDs, history of gastrointestinal bleeding or perforation related to previous NSAID therapy, active or history of recurrent peptic ulceration/haemorrhage, severe hepatic failure or severe renal failure, cerebrovascular or other active bleeding, blood-formation disturbances, during the third trimester of pregnancy. **Warnings and precautions:** This medicine is for short term use and is not recommended for use beyond 3 days. Clinical studies suggest that use of ibuprofen, particularly at a high dose may be associated with a small increased risk of arterial thrombotic events. Patients with uncontrolled hypertension, congestive heart failure, established ischaemic heart disease, peripheral arterial disease and/or cerebrovascular disease should only be treated with ibuprofen after careful consideration and high doses should be avoided. Careful consideration should be exercised before initiating long-term treatment of patients with risk factors for cardiovascular events. The use of paracetamol at higher than recommended doses can lead to hepatotoxicity, hepatic failure and death. Patients with impaired liver function or a history of liver disease or who are on long term ibuprofen or paracetamol therapy should have hepatic function monitored at regular intervals. Severe hepatic reactions, including jaundice and cases of fatal hepatitis, though rare, have been reported with ibuprofen. Paracetamol can be used in patients with chronic renal disease without dosage adjustment. There is minimal risk of paracetamol toxicity in patients with moderate to severe renal failure. Caution should be used when initiating treatment with ibuprofen in patients with dehydration. The use of an ACE

inhibiting drug, an anti-inflammatory drug and thiazide diuretic at the same time increases the risk of renal impairment. Blood dyscrasias have been rarely reported. Patients on long-term therapy with ibuprofen should have regular haematological monitoring. Like other NSAIDs, ibuprofen can inhibit platelet aggregation. GI bleeding, ulceration or perforation, which can be fatal, has been reported with all NSAIDs at anytime during treatment. Combination therapy with protective agents (e.g. misoprostol or proton pump inhibitors) should be considered. Use with concomitant NSAIDs including cyclooxygenase-2 selective inhibitors should be avoided. NSAIDs may lead to onset of new hypertension or worsening of pre-existing hypertension and patients taking antihypertensive medicines with NSAIDs may have an impaired anti-hypertensive response. Fluid retention and oedema have been observed in some patients taking NSAIDs. NSAIDs may very rarely cause serious cutaneous adverse events such as exfoliative dermatitis, toxic epidermal necrolysis and Stevens-Johnson syndrome. Products containing ibuprofen should not be administered to patients with acetylsalicylic acid sensitive asthma and should be used with caution in patients with pre-existing asthma. Adverse ophthalmological effects have been observed with NSAIDs. For products containing ibuprofen aseptic meningitis has been reported only rarely. NSAIDs may mask symptoms of infection and fever. **Interactions:** Warfarin, medicines to treat epilepsy, chloramphenicol, probenecid, zidovudine, medicines used to treat tuberculosis such as isoniazid, acetylsalicylic acid, other NSAIDs, medicines to treat high blood pressure or other heart conditions, diuretics, lithium, methotrexate, corticosteroids. Refer to summary of product characteristics for other interactions. **Fertility, pregnancy and lactation:** Easolief Duo is contraindicated during the third trimester of pregnancy. **Driving and operation of machinery:** Dizziness, drowsiness, fatigue and visual disturbances are possible after taking NSAIDs. If affected patients should not drive or operate machinery. **Undesirable effects:** Dizziness, headache, nervousness, tinnitus, oedema, fluid retention, abdominal pain, diarrhoea, dyspepsia, nausea, stomach discomfort, vomiting, flatulence, constipation, slight gastrointestinal blood loss, rash, pruritus, alanine aminotransferase increased, gamma-glutamyltransferase increased, abnormal liver function tests, blood creatinine increased and blood urea increased. Refer to Summary of Product Characteristics for other adverse effects. **Pack size:** 24 tablets. **Marketing authorisation holder:** Clonmel Healthcare Ltd., Clonmel, Co. Tipperary. Marketing authorisation number: PA0126/2947. Medicinal product not subject to medical prescription. For retail sale through pharmacy only. A copy of the summary of product characteristics is available upon request. **Date prepared:** March 2018. 2018/ADV/EAS/036H.

Navigating our Future

While the newly launched National Oral Health Policy dominated discussions at this year's Annual Conference, there was plenty of cutting-edge research on display, and plenty of time to relax and socialise.



Pictured at this year's Past Presidents' lunch were: Back row (from left): Drs Gerry McCarthy, Tom Feeney, Vincent O'Connor, Joe Lemasney, PJ Byrne, John Barry, Charles O'Malley, Robin Foyle, Tom O'Connor, and Brian O'Loughlin. Front row (from left): Dr Barry Harrington, Dr Anne Twomey, Prof. Leo Stassen, Dr Kieran O'Connor, and Dr Seán Ó Seachnasaí.

The theme of this year's conference, in the familiar surroundings of Galway's Galmont Hotel, was 'Navigating our Future', and a fantastic range of courses and lectures helped delegates to do just that. As ever, Thursday was pre-Conference course day, and attendance was excellent at all of the courses. Dr Pat Cleary took attendees through endodontic and restorative treatment, and Dr Ian Cline covered posterior composites. With the regulatory requirements facing dentists increasing all the time, Drs Eamon Croke and Nick Armstrong gave a timely and informative course in achieving compliance, aided by Chairperson Dr Jane Ranehan. Dentistry is evolving all the time, and so is the technology available to the dental team. Dr Brian Franks introduced the idea of facial aesthetics treatments such as botulinum toxin in his course, while Drs Maurice Fitzgerald and Alastair Woods covered everything attendees needed to know about making the transfer to digital dentistry.

Thursday's proceedings ended with the IDA/IDU AGM, where Prof. Leo Stassen took on the role of President of the Association for the coming year from Dr Kieran O'Connor. This was followed by the very popular annual Trade Show Party, a great opportunity for delegates to meet and socialise in the trade show area, where the very best of dental products and technology were on show throughout the conference.

A full programme

Friday and Saturday were filled with a programme of fantastic lectures from the very best of Irish and international speakers.

Dr Claire Healy gave excellent advice on oral mucosal disease, and on what the general dental practitioner should refer for specialist assessment, and what can be treated in general practice. Using images of common and no-so-common oral conditions, Claire outlined the diagnosis and recommendations for each. She emphasised the importance of taking a good history; many oral conditions are linked to chronic physical illnesses, which can make treatment complex, while others are a sign of underlying malignancy, requiring urgent referral.

Dr Frank Lobbezoo from Amsterdam gave two fascinating presentations that put a new slant first on the emerging discipline of dental sleep medicine, and then on bruxism. The definition of dental sleep medicine has broadened considerably in recent years, and now goes beyond snoring and sleep apnoea to cover a range of conditions such as orofacial pain, gastro-oesophageal reflux, and mandibular movement disorders. The lecture also included an update on research comparing continuous positive airway pressure (CPAP) with newer mandibular advancement devices in the treatment of snoring and sleep apnoea.

Challenging times ahead

There was a good attendance at this year's GP Meeting on Friday, April 5, where, unsurprisingly, the new Oral Health Policy took centre stage. Outgoing GP Committee Chair Dr John Nolan wondered if the Policy would be "another false dawn in the landscape of dentistry in Ireland", and outlined members' concerns regarding the proposed care pathways and the role of general practice in offering these, and the proposed funding, which falls far below what is required.

IDA CEO Fintan Hourihan said that the Policy contains serious flaws, but that it is important to acknowledge that now that there is a policy, the Association can begin to formulate a response, and ultimately to negotiate on behalf of members. He updated those present on a range of issues relevant to general

practice, from new legislation and regulation, to the Association's continuing efforts to achieve restoration of fees for dentists as part of the unwinding of FEMPI legislation. He strongly recommended that relevant dentists should register with HIQA, which has taken on a regulatory role in respect of radiation protection. He said that the Association's work around areas such as recruitment and professional indemnity is also continuing.

When the discussion was opened to the floor, members returned to the Oral Health Policy and their very understandable concerns. Fintan Hourihan invited them to attend the IDA's very important meeting to discuss the Policy on May 11 at the Crowne Plaza Hotel in Santry. He said that it is extremely important that IDA members make their voices heard in the coming months and years. He was joined in this by the members of the GP Committee, who talked about the importance of strengthening the Association's branch structure, and working together to get the best deal for dentists and patients.



Drs Maurice Fitzgerald and Alastair Woods delivered an excellent course in digital dentistry.

Frank's second lecture was entitled 'Bruxism: friend or foe', and he endeavoured to prove that, contrary to popular belief, it might be more the former than the latter. He outlined research suggesting a positive association between bruxism and cognition in elderly patients and those with dementia. New research is also pointing to a possible protective effect against upper airway collapse in



Prof. Leo Stassen with BDA President Dr Susie Sanderson, who was presented with Honorary Membership of the IDA at this year's Annual Dinner.

obstructive sleep apnoea. Given its possible protective effects, he recommended that if bruxism is not having severe negative consequences for a patient, it might be better not to treat it!

On Friday evening, delegates came together for the final two lectures of the day. Dr Ciara Doherty, a general medical practitioner and specialist in occupational

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* Source: Mehl et al, Accuracy studies at University of Zurich, Int J Comput Dent. (publishing date: March 2019)



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PJ O'Brien of KBC with IDA President Prof. Leo Stassen.



Shane O'Neill (left) and Pat O'Brien of DMI with President Prof. Leo Stassen.



The President of the Association, Prof. Leo Stassen, with some of the standholders at the IDA Annual Conference in Galway. From left: Sandra Joyce, Irish Dental Hygienists Association; Phoebe Campbell, BF Mulholland; Pamela Killilea, PameX; Tim Horwood, GC; Peter Morris, Morris Dental; Etain Kett, Dental Health Foundation; Jambaldorj Machlay, Karma Dental; Jim Way, Henry Schein; Vincent Clifford, Henry Schein; Sandra Byrne, Dental Health Foundation; Tom Fahy, Handpiece Harry; Colm Moore, Moore Wealth Management; Murray Walker, BF Mulholland; Jonathan Singh, NSK; Kieran Moore, Moore Wealth Management; Catherine Waldron, Wrigleys; Sviatlana Anishchuk, Irish Dental Hygienists Association; Prof. Leo Stassen; Paddy O'Sullivan, Karma Dental; Lizelle Mills, BF Mulholland; Mark Barry, ESM; David McCaffrey, MedAccount; Paul Hogan, HDMS; Nick McKelvie, McDowell and Service; Jesse Morrow, McDowell and Service; Declan Egan, Omega; Dermot Smyth, DTS; Gráinne Miskelly, BF Mulholland; Mike Mulholland, Omega; Joe Biesty, Braemar Finance; Stephen Holmes, Dentawealth; Nicola Jones, Tepe; Jo Ryan, Dentawealth; Stephen Wilson, Southern Dental Implants; Nicola Mellotte, PameX; Greg Cunningham, Dentawealth; Donna Paton, Irish Dental Hygienists Association; Angela Glasgow, NSK; Ian Caffrey, Irish Dental Nurses Association; Helen Farrelly, Irish Dental Nurses Association.

health, tackled the difficult topic of challenging consultations. She argued that the patient consultation is at the heart of both medicine and dentistry, and that work-related stress has become an increasingly important issue for these professions. She feels that better consultation and communication skills could help to reduce workplace stress. She discussed the importance of acknowledging when a consultation is challenging, looking at why it's going badly, and setting boundaries, while continuing to support the patient. Self-care for the professional, and peer support, are also key, she said. Dr Niamh O'Sullivan, Professor Emerita of Visual Culture at the National College of Art and Design, ended the day on a very different note with an extraordinary and often very moving lecture on the difficulty inherent in artistic representations of the Famine. Using eyewitness accounts, and analysis of a selection of artworks, Niamh presented both a stark reminder of the horrors of this period of Irish history, and a fascinating look at art history, and how conventions of the time

had to be subverted in order to provide a remotely accurate representation of events. It was a truly thought-provoking end to the day.

Cutting-edge research

Saturday's session started with a first for the Annual Conference, a breakfast lecture, sponsored by Colgate. Prof. Philip Marsh offered an overview of the oral microbiome in health and disease. He discussed the mouth as a microbial habitat, outlining research into prevention and control of oral disease by direct inhibition of the causative organisms and promoting natural balance (symbiosis) in the mouth. He is looking at a more holistic approach, which includes a range of measures, from good mechanical plaque control, to research into probiotics and functional foods, and oral health products that contain a broad spectrum of antimicrobial agents. This focus on innovative research was continued by Shane White, who outlined some groundbreaking research into tooth enamel. Shane's



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LEFT: Prof. Stassen visited the Colgate stand where he met with Stephanie Gribben, Kurtis L'Estrange and Emma Van Eyssen. The 2019 Colgate Caring Dental Awards, which operate in conjunction with the Journal, are now open for nominations. Packs for dentists, including a display stand, were distributed at the Annual Conference. Patients can nominate their dentists or dental team at www.colgatecaringawards.ie.



RIGHT: Honorary Editor of the Journal Dr Ciara Scott with Prof. Brian O'Connell, Dean of Dental Science at the Dublin Dental University Hospital.

research into enamel "of mice and men" has led to significant discoveries about its composition that have implications for future treatments. Shane acknowledged that their ultimate goal, the engineering of new enamel, will be a very difficult task, so the take home message for those present was that it is vital, as far as possible, to preserve it. He recommended thinner restorations that do not undermine the dento-enamel junction, and preserve the thickness of the

enamel. Periodontist Rachel Doody offered a very practical update on the new perio classifications and how they can assist dentists in diagnosis, treatment and referral. She used a range of case photos to illustrate the various periodontal diseases and where they fit in the new classification. While there is no fundamental change to the way dentists will care for their patients, the emphasis on classifying health rather than disease is the biggest change, as well as the inclusion of classifications for implants.

Caoimhin Mac Ghiolla Phadraig presented his top tips for stress-free dental care for adults with disabilities. He talked about the importance of creating a dental home for all patients, which starts before the patient comes to the surgery. He discussed modifying assessments as needed, and being realistic about what represents a good outcome for a particular patient, and emphasised the importance of making defensible and risk-based decisions, asking: "Is what I'm doing safe, effective and acceptable"? Flexible treatment that includes communication, behaviour support and minimal intervention is key. Finally, he discussed prevention, and outlined his 'Brush my Teeth' project, a series of videos on effective toothbrushing for people with a range of disabilities and oral health needs.

Kate Counihan moved the emphasis to orthodontics with her presentation on the ideal appliance for the individual patient. With massively increased demand, the advent of direct-to-consumer advertising, and the wide range of available appliances, pose challenges for clinicians. Kate presented cases to illustrate how different appliances can work for different needs. She emphasised that every case is individual and there is no one size fits all, but with an array of appliances available and technology advancing, it is possible to find the right appliance for your patients.

Avi Banerjee presented two lectures on Saturday afternoon on the minimally invasive approach to caries management. He argued that all dentistry should be minimally invasive, and outlined the key elements of patient-focused care. We should be waiting much longer before we drill, he said. Prevention and control includes talking about patient behaviour as well as minimally invasive restorations, where needed.

Patients with maxillary and mid-face malignancy present extremely complex challenges for the surgical team, and Chris Butterworth gave a fantastic lecture on implant-based rehabilitation of these patients using a classification-based approach. He used a number of recent case studies to illustrate the restorations carried out by the multidisciplinary team in University Hospital Aintree and Liverpool Dental Hospital, and the use of zygomatic implants to achieve extraordinary results.

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Fresh communication from Dentsply



New Vice President of Corporate Communications and Public Relations at Dentsply Sirona, Marion Par-Weixlberger.

Marion Par-Weixlberger has been appointed Vice President of Corporate Communications and Public Relations at Dentsply Sirona. Marion took over the position in February. In this role, she is responsible for corporate communications globally and for product PR for all business units, as well as interdepartmental projects within the company.

Dentsply states that Marion can draw on a wealth of experience as a communications expert in the dental industry and specifically with Dentsply Sirona. She has been working as PR Manager with the company since 2012. Maureen MacInnis, Senior Vice President, Chief Human Resources Officer and Communications at Dentsply Sirona said: "Marion Par-Weixlberger has been working for our company as a communications expert for several years and with great success in a leading position. Her extensive knowledge of the dental industry and her unceasing endeavours to constantly develop new approaches and inspire others make her the ideal occupant of this position".

Increase in illness benefit claims

Omega Financial Management has released its annual analysis into income protection claims by its policy holders. Just over one in five dentists claimed on their income protection policy in 2018 according to the company, compared to

one in seven the previous year, marking a significant increase. For the first time, the dental profession has taken the top spot regarding the rate of claims among the medical professions.

This finding comes from Omega's annual review of claims paid on their day one policy with DG Mutual, of which hundreds of Irish dentists are policy holders. The analysis is carried out to better understand the illnesses and injuries that have faced policy holders.

As usual, viral infections and gastrointestinal illnesses made up the largest category. As a policy with no waiting period, Omega states that this is

Table 1: Sample claims (Dental Surgeons) 2018.		
Illness/injury	Time claimed	Benefit received
Cancer	Ongoing	€19,073
Cancer	13 weeks	€10,533
Anxiety/depression	Six weeks	€4,800
Vertigo	Six weeks	€4,000
Soft tissue injury	Four weeks, four days	€4,667
Fractured finger	Two weeks, four days	€3,200
Back pain	Two weeks	€2,567
Viral infection	One week, two days	€2,000

Henry Schein's digital solutions

Henry Schein states that its ConnectDental brand is all about finding digital solutions for dental practices or dental laboratories. It also believes that its Business Solutions team can help you to operate a more efficient practice.

Henry Schein has been in Ireland since 1994, and the company states that it has a wealth of locally based, knowledgeable experts to assist dental professionals in their delivery of patient care.

The company has over 50 employees in the country, including 14 manufacturer-trained dental service technicians and 16 sales consultants. According to the company, it has over 50,000 products available to order online. It also offers a rewards scheme to dentists. Henry Schein Ireland states that it can help you if you are starting your career as a dental student right through to retirement.



Back row (from left): Equipment Sales Specialist Ben Brittain; Equipment Sales and Service Manager John Rice; and, Equipment Sales Specialist Jim Way. Middle row (from left): Field Sales Consultant Aidan Canning; Special Markets Account Manager Chris Redl; Field Sales Consultant Aoife O'Brien; and, Field Sales Consultant Vincent Clifford. Front row (from left): Field Sales Consultant Alayne Berkery; Equipment Sales and Service Support Specialist Aleksander Lesniak; Managing Director Pat Bolger; National Sales Manager Siobhán Cleary; and, Field Sales Consultant Andrew Troy.

expected. According to the company, what is notable within this category is that a number of these claims lasted for two to three weeks, as opposed to just a few days – sample claims are provided in **Table 1**. (This relates to claims made in accordance with the policy – pre-existing conditions and excluded issues that are not covered are discussed and confirmed at the time of sign-up.)

Unfortunately, there were a number of new cancer cases among the profession. There was an increase in the number of accidents and injuries, making up 12% of the total. Fractures and injuries to fingers and hands were the most common within this category. Omega revealed that the gender split of claims has grown to 75% female and 25% male. The average duration of a claim was 14 days.

All claims were paid to DG Income Protection members. As a mostly self-employed profession, the State sick leave payment of €198.50 per week represents a fraction of the average living/professional costs faced by dentists.

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Dentawealth at the Periodontal Suite

Richard Collins of Dentawealth recently gave a presentation entitled 'The Final Extraction' in the Periodontal Suite in Naas. The presentation aimed to give the group some insight into the most cost-effective and tax-efficient structures available to dental professionals.

This was followed by further presentations by Dr Jason Owens on the new classification of periodontal and peri-implant diseases, and Dr Edward Cotter on diagnosis and treatment planning.

Dr Owens of the Periodontal Suite, stated: "It was a very enlightening presentation by Richard and everybody seemed very interested in the topics covered".

Richard went on to thank Dr Owens for having Dentawealth in attendance:



"Peer group discussions such as this one are a crucial part in further educating dentists not only in areas that they will use in day-to-day practice, but also in other key elements of running a business efficiently, and we are always pleased to attend and present to professionals to highlight some of the things that the business owners might not be aware of in terms of reducing costs, reducing taxes, and improving business performance".

CEO of Dentawealth, Richard Collins.



At the opening of Dental Care Ireland Tuam were (from left): Dr John Burke; Dr Catherine Vaughan; and, Colm Davitt (CEO, Dental Care Ireland).

Dental Care Ireland opens 14th practice

Dental Care Ireland recently acquired its 14th practice. Formerly Abbeytrinity Dental Practice in Tuam, Co. Galway, Dental Care Ireland Tuam will continue to be led by previous owners and principal dentists Dr John Burke and Dr Catherine Vaughan. Building on the strong heritage of Abbeytrinity, Dental Care Ireland states that it will now invest in upgrading the five-surgery practice, while providing full administrative and management support.

According to founder and CEO, Colm Davitt: "This is an exciting time for Dental Care Ireland, as we enter a new phase of expansion. Working with trusted and established dental practices such as Abbeytrinity is hugely important to us".

Brushathon

To mark World Oral Health Day on Wednesday, March 20, Dental Care Ireland staff visited school children across the country to host a two-minute charity brushathon in aid of Diabetes Ireland.

At 2.00pm on World Oral Health Day, the children were invited to brush simultaneously for two minutes and donate €2 each to Diabetes Ireland. Dental Care Ireland staff provided oral health goody bags, as well as tips and advice on maintaining a good dental health routine.

Quintess Denta offering Omnia

Quintess Denta is a distributor for the Omnia range of products. For almost 30 years, Omnia has been supplying the dental industry. The company states that its mission is to allow dentists all over the world to work under the best possible conditions in terms of hygiene, security, efficacy, and efficiency.

According to Omnia, its product range includes custom procedure kits, sutures and irrigation line systems, with a special focus on the set-up of the operating room and the prevention of cross contamination.

Quintess Denta states that there are several set procedure packs to choose from, or the company will quote for your drape procedure sets. You can order gloves, masks, sutures, saline and more from Omnia through Quintess Denta. According to the Fermanagh-based company, the Omnia offering is one of quality and value.



The benefits of being connected

The IDA has had a long involvement with the Council of European Dentists and the *Fédération Dentaire Internationale*.

IDA members often ask me: “What exactly are the CED and the FDI?”, “What do you do there?” and “What advantage do they have for the IDA”? I would like to try and explain a little background about each organisation, how and why they operate, and why membership and representation is of such importance and value to the IDA, and therefore to Irish dentists.

Council of European Dentists

The Council of European Dentists (CED) is a not-for-profit association founded in 1961 and now composed of 32 member associations from 30 countries. Its objective is: to develop policy and strategies at EU level to preserve and promote high standards in the profession and the provision of quality dental care and health promotion; and, to monitor and influence political and legal developments that affect the profession and patients within the EU.

World Dental Federation

The *Fédération Dentaire Internationale* (FDI) is the world representative body for over one million dentists. There are 200 national dental associations represented, from 130 countries. It seeks to encourage participation from all countries and for those countries with financial constraints, support from wealthier member organisations is permitted and welcomed. It is a forum for knowledge exchange among the international dental community, with a common aim to advance the science and practice of dentistry. Its overall vision is to achieve global oral health for all, with access to quality care and prevention. It promotes this through educational initiatives, engagement with governments and many other international organisations and stakeholders (WHO, UN, etc.) to advocate, influence and lead on policies that recognise oral health as a crucial element of general health and well-being.

Work and collaboration

Both organisations are based in Europe – the CED in Brussels at the heart of the EU, and the FDI in Geneva, at the heart of world health organisations.

Both organisations are structured similarly to our own Association, with a small core office and management team, a board of directors, a council, and various working groups and task forces. The council, working groups/committees and task forces

are made up of dentists from the member dental associations, with expertise and enthusiasm relevant to the committee. These are voluntary positions.

The CED, being primarily focused on analysing and influencing legislation around dentistry in the EU, encourages active lobbying of political representatives when appropriate. The policy officers carry out frequent information gathering in order to stay fully updated on each national association’s position on various issues, and to gain insights into how legislation affecting dentistry is implemented across the member states. This information is shared with members, both in frequent written updates and at the biannual general meetings. It is a hugely valuable resource for national associations to be kept informed of exactly how issues are being dealt with across the EU, and an early warning system and flagging of challenges and legislative changes that may be coming down the line. There are currently five CED Working Groups (WGs): Education and Professional Qualifications; E-Health; Dental Materials and Medical Devices; Patient Safety, Infection Control and Waste Management; and, Oral Health. There are also task forces on antimicrobial resistance, communications and the EU internal market. Prior to the implementation of the Minamata Convention, amalgam had its own WG.

The FDI’s focus is broader and spans all the big issues in oral health: oral diseases; education; prevention; non-communicable diseases (NCDs); general health; the dental team; and, interprofessional collaboration. It must be appreciated that the resources, needs and priorities of dental associations from around the world vary dramatically, and there is a huge element of support from well-established associations and members for those countries where needs are great and resources limited. The working committees at the FDI are composed of: Dental Practice; Membership Liaison and Support; Public Health; Education; and, Science. The council and committee members are elected by popular vote at the General Assembly each year, with elected members serving a three-year term.

Active associations

Each year considerable work goes into preparing and publishing FDI policy statements on issues of current interest and debate. These are initially formulated by the relevant committee, and sent to each national association for review and comments, before being debated again at the General Assembly and finalised. This ensures that each statement is a genuinely collaborative global dental opinion. They are also excellent resources for national dental associations when it comes to preparing policy statements to share with decision makers, the dental profession, opinion formers, and the general public.

CED general meetings take place twice yearly, although working groups will have regular teleconferences and updates, and surveys are sent out frequently. The FDI holds an annual general meeting – the World Dental Parliament – which takes place over three days prior to the FDI World Dental Congress.

A fresh look

Both the CED and the FDI offer enormous potential for networking and the exchange of ideas with other international associations. Informal contacts outside of formal meetings can be invaluable. The discussions at social events and over coffee breaks are often when the most valuable personal contacts are made. These contacts contribute enduring value for the IDA; personal contacts are a huge resource of information and assistance on myriad topics, and are, in our experience, extremely generous with their time, expertise and information. They



Nuala Carney
BA, BDentSc, FFD(RCSI), LLM(Cardiff)



Drs Robin Foyle and Jane Renehan represent the Irish profession at the CED.

provide a fresh way of looking at things, often new ideas, new inspiration, practical and current insights into practice and policy in other countries and jurisdictions, and sometimes the voice of experience regarding challenges facing us.

It would be impossible for the small staff at the IDA to remain informed about EU legislation at the level required for our Association's members without our participation in the CED. (Britain may wish to leave the EU, but the British Dental Association (BDA) is very keen to remain involved in the CED as it is such a valuable professional resource.) The staff in Brussels are all multilingual, with legal backgrounds and significant experience in analysing and reporting on EU legislation, drafting position papers and proposals, and providing well-informed advice where necessary to national associations. It provides us with access to the key dental representatives in other EU countries and accurate insights into how current issues affect dentists around the EU.

Burning issues

Topics of importance (and often controversy) in the recent past have included the scope of practice of the dental team, recognition of qualifications and specialisations, standardisation of health services provision, legality of tooth whitening, accreditation of dental training, amalgam phase-down, corporate dentistry, antimicrobial resistance, and water treatment regulations, among many others. The topic of medical devices, now a national news item here, has been on our radar for some time and is of crucial importance for dentists. We are extremely privileged (and grateful) that Dr Jane Renehan is now chairing the CED WG on this topic, a huge service to Irish and EU members in terms of the level of expertise and commitment she has already brought to the Group.

FDI membership fosters relationships with associations further afield, specifically the New Zealand, Australian, Canadian, American and South African dental associations. This has resulted in a beneficial exchange of ideas and information. It has been particularly interesting to liaise with the NZDA, whose membership, population and delivery of practice are so similar to our own. We have established excellent links with the Canadian, American and Australian representatives. You wouldn't believe how many of their officers and CEOs have Irish heritage. Irish members now have access, at no cost, to both the *Journal of the American Dental Association (JADA)* and the *International Dental Journal* (published by the FDI). Please contact IDA House if you would like to access the complete *International Dental Journal* online.



The early birds – Dr Nuala Carney and Mr Fintan Hourihan ready for action.

The IDA team

The team that represents the IDA internationally is Drs Robin Foyle, Jane Renehan and Nuala Carney, and Mr Fintan Hourihan. The team reports directly to IDA Council, and submits regular written and oral reports. Each member of the team has become actively involved in sharing their expertise and contributing to the workload, all being members of WGs at CED. Jane is currently Chair of the WG on Dental Materials and Medical Devices and has been doing enormous work in this area for several years, recently liaising with the Health Products Regulatory Authority (formerly Irish Medicines Board) regarding medical devices and the impacts on dentists. Robin has worked actively on the Tooth Whitening WG since its inception, resulting in the recent adoption of a policy that we hope will allow tooth-whitening products (TWP) to be made available for specified suitable under-18-year-old patients. Fintan is an active member of the Oral Health WG and has been responsible for encouraging the support and awareness of Irish MEPs around issues related to oral health. He successfully persuaded them to host meetings on 'Ageing and Oral Health', 'Mouth Cancer Awareness', and 'Health Inequalities and Integrated Care and Oral Health', at which Dr Anne Twomey and Dr Conor McAlister from the IDA made powerful presentations.

I have recently joined the WG on Education and Professional Qualifications. In previous years at the FDI, I made a presentation on behalf of the IDA at the FDI General Assembly, served on its Budget Reference Committee, and I hope to stand for election to the Dental Practice Committee at the FDI in the near future.

The benefits of membership of both organisations are varied and ongoing. Your representatives spend many hours working away quietly at their briefs and liaising with their counterparts abroad. We are part of an increasingly interconnected global dental world, and the challenges we face in Ireland are similar to those faced by dentists in other countries, particularly our European counterparts. We cannot afford to be isolated, and now more than ever our commitment to engagement both at EU and world dental forums is essential in order to be involved in leadership and the progression of our profession.

Relevant websites

<https://cedentists.eu/>

<https://www.fdiworlddental.org/>

<https://onlinelibrary.wiley.com/journal/1875595x>

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Dr Derek Richards, former editor of *Evidence-Based Dentistry*, spoke to the *JIDA* about evidence-based dentistry, and the critical skills that dentists and non-dentists alike should have in the age of over-information.



Over his career, Dr Derek Richards has noticed the phrase “evidence-based” being used far more frequently than it used to be: “I think there’s a difference between using it and doing it, using the terminology and actually being evidence based”.

He has worked for most of his professional career to promote evidence-based practice, and founded and then edited the *Evidence-Based Dentistry* journal for 20 years. He says the concept is based on three different factors: the best available evidence; the patient’s wishes; and, the practitioner’s clinical abilities. Where those three interact, evidence-based practice is achieved.

He talks about how it is important that methods and technologies are evaluated properly before they are introduced into general use: “Most research is done in a hospital environment or a specialist high-end environment, and on highly selective groups of patients. If you have research from a lot of different countries, then the selection is going to be different so it’s much easier to say, ‘well if that’s worked in a whole range of places, it’ll probably work in other places”.

However, he cautions against pushing the boundaries of practice without sufficiently evaluating the evidence: “Trying things without evaluating them properly first is experimenting on patients, effectively without asking their

permission ... You have to be very careful with what you’re doing, and the patients need to be fully involved and engaged in the decision making. I don’t think patients can be fully engaged in decision making unless you’re providing them with the evidence. It’s as key to get the patients to ask for the evidence as it is to get the dentists to ask”.

Conversely, it is not always easy to get dentists to perform techniques even when there is good evidence they are effective: “I think that even when we have good evidence to do things, and I think some of our best evidence in dentistry is around prevention, certainly the highest-quality evidence, we can’t seem to persuade the dentists to do them. Things like putting plastic coatings or fissure sealants on back teeth for example: there’s good evidence that that’s very effective at reducing tooth decay in the biting surfaces of the teeth. And it’s not implemented as much as we would like”.

There seems to be a two-tier system to the adoption rates of different practices. New technology tends to go into general use quite quickly, perhaps too quickly, says Derek: “One of the latest trends is for cone beam radiography, which produces 3D images of the teeth. It produces very nice pictures but there is more of a radiation dose for the patient. There is a balance there between having that extra information and the potential risks for a patient. It’s an intervention that people are increasingly using and we’re still defining where its best use is”.

But often, interventions that improve outcomes for patients but perhaps lack the sense of appeal and excitement of the latest technology are not adopted for decades.

Telling good from bad

It can be a challenge to tell quality products and materials from those with good marketing but little substance; however, Derek believes: “Adopting a

Colm Quinn
Journalist with Think Media



good approach to the research and asking 'Where's the underlying evidence?' for these things to show that they work is key".

He says that when buying a car, we ask certain questions about the car's history, and the make and model's reputation: "You wouldn't just listen to the marketing hype, and healthcare professionals have to do the same kind of thing. They have to say what's the evidence for that and they have to acquire the skills to appraise that critically ... Being a critical reader of information is a key skill for healthcare professionals and I would probably argue it's a key skill for everybody. Because there is so much thrown at us these days and one of the challenges again for healthcare providers, as much as everybody else, is that you can access a huge amount of information on the internet about dentistry or any other topic, and a lot of it is marketing driven or there isn't the evidence for what they're claiming".

Benefits of the internet

Although the internet gives a platform to everyone with a bias or a bonus to earn, it also allows clinicians to get their message out. Derek writes the Dental Elf blog, which is highly regarded and part of the National Elf Service in the UK, a series of evidence-based healthcare blogs covering a wide spectrum of specialties: "What we do with that is draw to the attention of professionals (and it's aimed at professionals, not at the public) the new evidence on topics which we think is of a reasonable standard".

He says the Dental Elf (www.nationalelfservice.net) is about highlighting good evidence to practitioners that's free at the point of access so that they can have a quick summary of the latest information.

Resource allocation

Figuring out where to allocate resources and funds can be one of the biggest challenges for policymakers and those who advise them: "From a public health perspective, the arguments are always do we spend more money repairing and treating disease or do we do more to address the causes? And those tend to be social issues rather than health issues".

With the issue of tooth decay, Derek says the biggest problem in the UK is the amount of sugar that is consumed. He notes that during the Second World War when sugar was rationed, oral disease levels dropped significantly, particularly in children: "Once sugar came off ration, tooth decay shot up until the 1970s, when fluoridated toothpaste started to come in. Then we started to see reductions in disease. We've seen the introduction of sugar-sweetened beverage taxes and ... that will show some benefit in time. It's [about] where you spend your money to get those reductions. Do you put it into a healthcare system and treat disease, or do you put it further upstream and address the social causes in the first place?"

The National Dental Epidemiology Programme in Scotland has been running for over 30 years and Derek says it gives clinicians and policymakers a good indicator of disease levels in the country: "It's an excellent planning tool. It's also been used as a national indicator [of levels of disease], and it's been used as a target for reducing tooth decay".

Childsmile is a national programme to improve the oral health of children in Scotland and reduce inequalities in dental health. The two main interventions that are used in Childsmile are toothbrushing and fluoride varnish: "The two key interventions in the Childsmile programme and the effectiveness of those is monitored to a degree by the National Epidemiology Programme. That has provided us with a wealth of data to use, both to monitor our progress against

our targets and to argue for funding to redress disease levels. They're still quite high in children from the poorer backgrounds. Although we've had an overall reduction and everybody's benefitted across the socioeconomic spectrum, still the children from the poor end of the spectrum are suffering more disease. It just constantly reminds us that we still need to do more to reduce decay in other children".

Being a critical reader of information is a key skill for healthcare professionals and I would probably argue it's a key skill for everybody.

Finding the ideal oral health system is a continuous pursuit and Derek says all systems have their problems: "Some of the Scandinavian systems seem to work quite well but then when you talk to them, they always have problems with them. I suspect the best system probably hasn't been invented yet ... All systems have their various issues, so I don't think we've come up with the perfect system yet. From a personal view, the universal system seems to be, certainly the ideal type of system".

Highlights

Derek is retiring this year and looks back on some of the things he has been proud to be part of in his career: "I think the thing I'm probably most proud of is the *Evidence-Based Dentistry* journal, which we established just over 20 years ago. We've got a new editor who's been announced and will be taking over shortly, that's Prof. Elizabeth Kay".

The March edition was the last edition that Derek edited and in it was included a list of his 20 favourite articles from his time as editor.¹

Something he has had an involvement with over the years has been the Cochrane Oral Health Group, which he says has "produced some very high-quality systematic reviews on the evidence in dentistry. I think that's one of the biggest achievements over the past 20 years, certainly from developing the evidence base in dentistry, but it's not my achievement".

He particularly enjoyed participating in the York Review of Water Fluoridation and the development of the National Institute for Health and Care Excellence (NICE) dental recall guidelines.

He says the other thing he is proud to have been involved with is acting as an advisor to the Scottish Dental Clinical Effectiveness Programme (SDCEP), "which has produced a number of important dental guidelines over the past decade or so, really high-quality pieces of work that I've had input to but, again, most of the work was led by other people".

Profile

Derek lives with his wife just outside Perth in Scotland in what he calls "a very nice spot". He is a Consultant in Dental Public Health for the NHS and Director for the Centre for Evidence-based Dentistry. In his rare spare time he enjoys gardening and growing fruit and vegetables. He enjoys photography but hasn't had the time to do much of it during his career: "It's one of the things I hope I'm going to be able to spend more time doing once retirement comes at the end of May".

Reference

1. Richards, D. 20 years – 20 highlights. *Evid Based Dent* 2019; 20: 4-6.



FIGURE 1: Model of spine bending forwards.



FIGURE 2: Dentist slouching over a patient.



FIGURE 3: Having your head slouching forwards is similar to holding a 7kg dumb-bell in front of you all day!



FIGURE 4: Degenerative disc bulge.

Ergo-dontics

Ergonomics is vital for dentists as their working position leaves them prone to back and neck problems.

The human body is a complex machine, like a Ferrari. The human body is designed for movement, like a Ferrari. The human body does not like being

static or being stuck in a static position for prolonged periods. You buy a Ferrari to speed along the country roads, not to just park it in your garage. Like a Ferrari, your body needs regular servicing and exercise. If you had a Ferrari, you would get it serviced regularly. So why would you neglect your body, 'park it in the garage' and not service it regularly? Treat your body like a Ferrari because you can't go out and buy a new one if it crashes on you.

Spinal tips

Your spine is designed to move and absorb shock. The discs are basically shock absorbers that lie between the vertebrae. The younger you are, the more fluid you have in your discs and the more mobile you are. As you get older, you lose the fluid in your discs and you get shorter and stiffer. The reason why our discs degenerate (or dehydrate) as we get older is due to the compression forces acting through our spines all day long because we are upright, be it while standing or sitting. The weight of our body multiplied by the effect of gravity compresses our spines during the day; this is why you are slightly taller in the morning than you are in the evening (**Figure 1**).

When you are standing, the compression force acting through your lower back is 100% of your body weight. When you are sitting, that compression force rises to 190%! So the worst thing that you can do for the discs in your lower back is prolonged sitting, especially in a forwards slouched position, which



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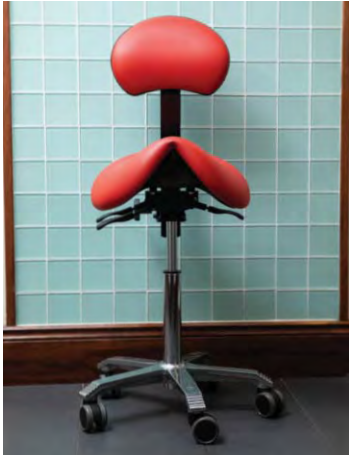


FIGURE 5a and 5b: KOS Ergonomics Saddle Stool.



FIGURE 6a and 6b: KOS Ergonomics Chest Support Chair.

unfortunately is the working position of most dentists (**Figure 2**).

In relation to neck problems, your head sits on top of your neck all day long. Your head weighs 8% of your body weight, which means that an average male of 95kg has a head that weighs 7.6kg. Now imagine holding a 7.6kg dumb-bell out in front of you all day long (**Figure 3**)! With your head flexed forwards for most of the day, the compression force exerts pressure out to the posterior part of your disc, which over time can cause a degenerative disc bulge (**Figure 4**).

Chairside

Therefore, your ergonomic position at work is vital in order to prevent back and neck problems, or to alleviate symptoms from a pre-existing condition. The KOS Ergonomics Saddle Stool helps to improve your sitting posture and encourages the forwards flexion to occur more so at your hips than slouching your lumbar spine forwards (**Figure 5a** and **5b**). It also helps you to engage your back extensor muscles rather than slouching forwards passively, where you aren't supporting your spine through engaging your core muscles.

The KOS Ergonomics Chest Support Chair will also help to reduce the compression force acting through your lower back because you lean the weight of your body forwards and gravity acts in a perpendicular line in front of you, rather than straight down through your spine (**Figure 6a** and **6b**). The chair can be locked into this forward leaning position so that your back can stay

supported in a good position, without constantly trying to remind yourself to 'straighten up'.

Get up, stand up!

However, the ideal position to work in to relieve pressure on your lower back is in the standing position, as the compression force in standing is roughly half what it is when you are sitting. Like the standing desks that have become all the rage since the *Operation Transformation* programme on RTÉ, an adjustable dental treatment chair that can rise up to the dentist's elbow height would be the optimal ergonomic position.

Obviously, when you aren't working you shouldn't be adopting a static position to compound the pressure that's building up on your spine all day in work. Swimming is the perfect antidote to the dental ergonomic dilemma, primarily because of the decompressing effect of the buoyancy of water. Walking/running/cycling/yoga/pilates/anti-gravity/yoga/gym workouts will all help to keep a balance in your lifestyle between the static compression periods of work and the dynamic decompression periods when you are exercising.

So take your Ferrari out of the garage and take it for a regular spin to keep it humming along! (I'm not going to comment on the ergonomic position adopted while driving a Ferrari.)

Record keeping: art or science?

A presentation at the IDA Annual Conference explained the importance of keeping good dental records.



Keeping good dental records is not only an essential part of good dental treatment, it reflects on the professionalism of the whole dental team and is also a Dental Council requirement. Good records may form the basis of any successful defence of a complaint or claim.

The Dental Council's Code of Practice states: "You must keep accurate and up-to-date records for all your patients. You must keep these records in a safe place and, in the case of adults, for eight years after the last treatment".¹

While a clinical record can be written by any member of the dental team, the treating clinician remains responsible for the accuracy and content of the records. Another important aspect to consider is what constitutes a contemporaneous record. This is a note made at the time of treatment and before the next patient comes into the room.

While everyone has different ways of recording notes from their patient interactions due to the availability of various recording systems, a good documentation typically includes contemporaneous recording of relevant history, examination findings and test results, as well as treatment options as discussed. It should also include advice given by the dentist, decisions jointly made, actions expected from the patient, important patient concerns that were

answered, and follow-up plans. In addition, keeping a record of advice about fees is commendable too.

While it may be challenging to document every detail due to time constraints, dentists need to be aware that these records are vital to good patient care, and to any defence against a claim or complaint of substandard care.

It is equally important to record things that did not happen, such as failed appointments, or any actions that are expected from the patient, such as planned future treatment or refusal to undergo treatment.

Another common query from Dental Protection members is whether records can be altered after the consultation. The simple answer is yes, but any alteration should be clearly identified, signed and dated on the day it is made. If an item is deleted, it should still be visible so that another party can see the deleted entry.

Access to dental records and how long to keep records

Civil claims can be made up to two years either after an incident, or after the patient can reasonably prove that they were first made aware of the problem. However, complaints and Dental Council cases are frequently given leeway to be investigated, even if the incidents took place over two years before.

According to the Dental Council's Code of Practice, it would be optimal to keep the records of adult patients for eight years; for children, it is advisable to keep their records until their 25th birthday. If the patient was 17 years old when they

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Dento-legal Consultant
at Dental Protection



Key features of a good dental record:

- ▶ clear;
- ▶ accurate;
- ▶ honest; and,
- ▶ legible;
- ▶ contemporaneous;
- ▶ understandable.

Essential requirements for any dental record:

- ▶ patient identification data;
- ▶ medical history;
- ▶ dental history;
- ▶ clinical examination;
- ▶ radiographic examination;
- ▶ diagnosis;
- ▶ treatment plan;
- ▶ reference to consent;
- ▶ progress notes (including name or initials of treating clinician); and,
- ▶ exit notes.

Apart from the narrative contained within the record, it should also contain, if applicable:

- ▶ handwritten contemporaneous notes or contemporaneous computerised records;
- ▶ pocket depth charting and indices;
- ▶ radiographs;
- ▶ treatment plans and estimates of cost (DTSS and private);
- ▶ referral letters;
- ▶ photographs/audiovisual material;
- ▶ laboratory forms;
- ▶ payment forms/receipts;
- ▶ confirmation of consent and consent forms (where applicable);
- ▶ clinical models; and,
- ▶ aides memoire/diagrams/illustrations.

finished treatment, their record should be kept until their 26th birthday. Otherwise, dental records must be securely destroyed when it is appropriate to do so.

Under the General Data Protection Regulation (GDPR), dental records must be provided to a patient or their representative free of charge within 30 days of their written request.

In conclusion, good records will facilitate good defence, while poor records can

lead to poor defence, and an absence of records will provide no defence. For further advice, dentists should get in touch with their dental defence organisation.

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Regulatory changes affecting the profession

The Government recently set out important reforms to how dentists are regulated.

The Regulated Professions (Health and Social Care) (Amendment) Bill 2019,¹ which has been approved by Cabinet, amends the five health professional regulatory acts, in particular in relation to fitness to practise (FTP) and registration. In order to be effective, a regulator needs to be able to request and publish information about the people they regulate. They also need their decisions to be subject to judicial oversight. Dental Protection's experience in supporting members around the world has shown that it is vital that the right balance is struck in each of these areas.

Major reforms to professional regulation do not come around often. While this legislation is at a very early stage, and has a considerable distance left to travel before it becomes law, it is important for Dental Protection to ensure that any regulatory changes are implemented correctly and at the right speed.

Some of the key reforms within the Bill are as follows:

Greater judicial oversight

Both the dental professional and the Dental Council will be able to seek the involvement of the courts on the conclusion of an FTP case. For the Dental Council, it will be able to seek binding confirmation on the lawfulness of its determinations about a dentist's practice in future. To be effective, this mechanism must be used proportionately to ensure that legal costs – costs borne by dental professionals – are kept as low as possible. For the dental professional, they will be able to take the regulator to court to fight an inappropriate sanction – something that we often support members to do in other countries where this is already possible.

More information about dental professionals published in the public interest

The Dental Council will be compelled to publish all sanctions that it imposes on registrants, as well as greater detail about all of its FTP proceedings. It is important that this is introduced in a proportionate way. We believe it is not always in the public interest to publish such information – especially if the dentist is unwell or if it is a low-level sanction. The detail of how this will be introduced is yet to be confirmed and we will be looking to influence this.

Raj Rattan
Dental Director at
Dental Protection



Power to request information about dental professionals

The Dental Council will be given a range of powers to request data about a dentist from any other healthcare regulator, as well as regulators outside of Ireland.

Declarations by registered dental professionals

Dental professionals will be required to provide details – on an annual basis – of any proceedings they are involved in anywhere in the world. This could either restrict them from practising or impact on their job applications. Dental Protection is concerned because the standard of proof is different in regulatory proceedings and jurisdictions. This could mean that the Dental Council relies on a regulatory finding, for example, from the UK – where the legal standard is on the balance of probabilities – whereas in Ireland the standard is beyond reasonable doubt. This is a serious constitutional point.

Next steps

Dental Protection wants to work closely with the Irish Dental Association, Dental Council and Department of Health to explore how this legislation will be implemented. We need assurances that the Dental Council will be equipped to discharge this range of new powers and duties it is set to be given.

We are determined to ensure that the regulation of dental professionals remains proportionate, fair and consistent – key markers of viability. Where necessary, Dental Protection will not be reticent in calling for the Bill to be amended if it appears that those three key markers are not being met. As a defence organisation with dental members around the world, our experience in various jurisdictions puts us in a strong position to positively influence reforms that affect the profession.

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1. **Department of Health.** Regulated Professions (Health and Social Care) (Amendment) Bill 2019. Available from: <https://health.gov.ie/blog/publications/regulated-professions-health-and-social-care-amendment-bill-2019/>.

An uncommon cause of isolated hypoglossal nerve palsy: a case report

Précis

A rare case of isolated hypoglossal nerve palsy observed clinically as tongue deviation, and diagnosed by MRI identification of a meningioma in the hypoglossal canal.

Abstract

Introduction: Isolated hypoglossal nerve (CNXII) palsy is rare due to the course of the nerve and its close proximity to other cranial nerves and vessels. Aetiology includes space-occupying lesions, head and neck trauma, and infections. Characteristically, hypoglossal nerve palsy presents with unilateral atrophy of tongue musculature and deviation of the tongue to the affected side.

Case report: A 50-year-old woman attended Belfast Dental Hospital complaining of tenderness and swelling of the left side of her tongue for the previous eight weeks. Her medical history was unremarkable and she was a non-smoker. On examination, there was no evidence of lymphadenopathy, asymmetry or swelling. Cranial nerves (CN) I-XI were intact; however, testing of CNXII revealed fasciculation and deviation of the tongue to the left on protrusion. A magnetic resonance imagery (MRI) scan revealed a lesion in the left hypoglossal canal, in keeping with a meningioma. The patient has now been referred to neurology, awaiting the possibility of neurosurgery.

Discussion: Hypoglossal nerve palsy is uncommon and rarely presents in isolation. It raises suspicion of a sinister underlying pathology and therefore a prompt referral for an MRI scan was made. Meningiomas arising in the hypoglossal canal are extremely rare and this is the fourth case to be reported in the literature.

Conclusion: Isolated hypoglossal nerve palsy can present in any clinical situation, either as a complaint or incidental finding. It highlights the importance of detecting subtle intraoral clinical changes, the use of appropriate imaging, and the importance of multidisciplinary teamwork in diagnosis and management of complex cases.

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Introduction

The hypoglossal nerve (twelfth cranial nerve; CNXII) is a motor nerve that is responsible for the innervation of all the extrinsic and intrinsic muscles of the tongue with the exception of the palatoglossus muscle. It originates from the hypoglossus nucleus in the medulla oblongata, passes laterally across the posterior cranial fossa, within the subarachnoid space, and exits the cranium via the hypoglossal canal. The nerve passes downwards and forwards in the neck

between the internal carotid artery and the internal jugular vein until it reaches the lower border of the posterior belly of digastric muscle. Here it turns forward and crosses the internal and external carotid arteries and the loop of the lingual artery. In the floor of the mouth, it is intimately associated with the hyoglossus, the lingual nerve and duct of the submandibular gland, before continuing to move in an anterior direction to enter the tongue.¹



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FIGURE 1a and 1b: Patient's tongue showing deviation to the left side on protrusion.

Table 1: Differential diagnoses for hypoglossal nerve palsy

Nasopharyngeal carcinoma
Metastatic disease to base of skull
Periostitis of hypoglossal canal
Head and neck trauma
Epstein-Barr virus infection
Dural arteriovenous fistula of the transverse sinus
Post-vaccination cranial neuritis
Carotid artery dissection/aneurysm
Post-retropharyngeal infection
Schwannoma
Meningioma
Idiopathic

Hypoglossal nerve palsy is uncommon due to its complex course and close proximity to other cranial nerves and vessels. Numerous causes of hypoglossal nerve palsies have been documented in the literature (Table 1). These include: nasopharyngeal carcinomas;² metastasis to the base of the skull;³ trauma;^{4,5} vertebral artery and extracranial internal artery dissection;⁶⁻⁸ hypoglossal schwannoma;⁹ Epstein-Barr virus infection;¹⁰ and, post-vaccination cranial neuritis.¹¹ Idiopathic causes have also been reported.^{12,13}

Damage to the hypoglossal nerve produces characteristic clinical manifestations, mainly fasciculation, atrophy and deviation of the tongue on the affected side on protrusion, with dysarthria frequently reported. Hypoglossal nerve palsy is usually reported in combination with other cranial nerve symptoms such as facial palsy and ophthalmic manifestations. However, it is rare to see isolated hypoglossal nerve palsy and, when present, it is considered a diagnostic conundrum.

We report an unusual case of unilateral isolated hypoglossal nerve palsy. This case highlights the importance of interpreting subtle clinical signs and symptoms in the context of underlying pathology, and the role of the multidisciplinary team in the management of this case.

Case report

A 50-year-old Caucasian woman presented with an eight-week history of

SPECIAL INVESTIGATION

Basic haematological:

Full blood count
Erythrocyte sedimentation rate
C-reactive protein

Normal range

Immunology:

Antinuclear antibodies
Complement

Normal range

Serology:

Epstein-Barr virus
Herpes simplex
Cytomegalovirus

Negative

Imaging:

MRI head

Meningioma

DIAGNOSIS

FIGURE 2: Special investigations to determine the cause of hypoglossal nerve palsy.

perceived 'thickening' of the left side of her tongue. At first she assumed it was related to a mouth ulcer, as she was prone to development of these. She reported that the left side of her tongue was tender to touch but otherwise she had no other symptoms. There was no impact on day-to-day activities such as swallowing or speech, nor did she recollect any significant events that might have corresponded to the onset of her symptoms.

Initially, she attended her general medical practice and was seen by numerous GPs in the practice, all of whom found the presentation quite peculiar. A second opinion was requested privately from an oral and maxillofacial surgeon, who referred her urgently to the Oral Medicine Department for further investigation.

Her medical history was unremarkable and she was not taking any medication other than occasional analgesics. She was a regular dental attender who had had no recent dental complaints or treatment. She was a non-smoker who drank one to two units of alcohol per week.

During extra-oral examination at the oral medicine clinic, there was no evidence of cervical lymphadenopathy, facial asymmetry or salivary gland swelling. Examination showed that cranial nerves I-XI were intact. On intra-oral examination she was partially dentate with a well-maintained dentition, good lubrication of all mucosal tissues and adequate oral hygiene. Examination of her tongue revealed mild wasting on the left side, which had a heaped appearance and quite marked tongue scalloping. There was visible fasciculation on the left lateral border and, on protrusion, the tongue deviated to the left side (**Figure 1**) with some limitation of tongue movements. There was no evidence of speckling, erythema or ulceration of soft tissues, nor any mass lesion palpated within the substance of the tongue.

The clinical impression was that of an isolated left hypoglossal nerve injury. A number of investigations were carried out in order to determine the cause of the suspected hypoglossal nerve injury (**Figure 2**). Haematological and biochemical investigations were undertaken, which revealed neutropenia, and this subsequently normalised on repeat testing. Immunological studies including complement, antinuclear antibody and double-stranded DNA were undertaken to identify an autoimmune aetiology. The results of these were negative. There were no signs of inflammation or infection, and no antibodies were identified for any infectious diseases.

In order to explore the possibility of a space-occupying lesion, an urgent magnetic resonance imagery (MRI) scan of the head was requested rather than a CT. This revealed a soft tissue lesion approximately 12x6mm in the left cerebellomedullary cistern, extending into the left hypoglossal canal (**Figure 3**). The case was discussed with a consultant neurosurgeon within the hospital trust who advised an urgent referral to their department and discussed the case at the next neuro-oncology multidisciplinary meeting. The general consensus based on imaging was that the lesion was likely to represent a meningioma. A conservative approach has been adopted due to the position of the lesion. The patient has regular review in neurology with repeat MRI imaging. One year on, there has been no significant change on imaging or in clinical presentation.

Discussion

The hypoglossal nerve is a motor nerve that innervates tongue musculature controlling its voluntary movements, and is also involved in speech and swallowing. Disorders affecting the function of this nerve lead to imbalanced action of the genioglossus muscles, causing the tongue to deviate towards the weakened side.

Hypoglossal nerve palsy is uncommon and rarely presents in isolation. Keane *et al.*,⁴ in their case series of hypoglossal nerve palsy, found neoplastic aetiology in 85% of their cases, thus emphasising that isolated hypoglossal nerve palsy often suggests an ominous prognostic sign. However, a further case series of isolated hypoglossal nerve palsy¹⁴ reported idiopathic hypoglossal nerve palsy in four out of nine cases and metastasis in three cases, with Arnold Chiari malformation and dural AV fistula as causes in the remaining cases.

The presentation of hypoglossal nerve palsy should raise suspicion of a sinister underlying pathology and should prompt referral for further investigations. In this case the hypoglossal nerve palsy presented as an isolated finding in the absence of any history or regional symptoms, which was in part reassuring. Regardless of the suspected aetiology, haematological and autoantibody investigations in addition to imaging studies, including CT scan and MRI, are mandatory in the diagnostic approach to identify the causative pathology.¹³ In our case blood investigations were normal, and the diagnosis of meningioma

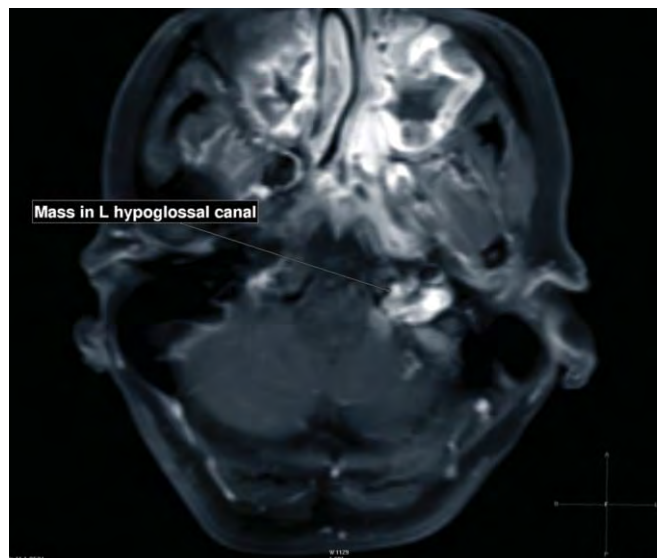


FIGURE 3: MRI T1 weight axial slice of posterior cranial fossa showing mass in left hypoglossal canal.

was made on the basis of MRI imaging and discussion at the neuro-oncology multidisciplinary team meeting.

Meningiomas are common neoplasms of the nervous system, arising from the meninges of the brain, and represent 19% of all primary intracranial tumours, of which approximately 90% are benign, and 2% are malignant.¹⁵ However, meningiomas arising in the hypoglossal canal, are extremely rare and this is the fourth case to be reported in the literature so far.¹⁵⁻¹⁷ The choice of treatment approach depends on several factors including: tumour type; size; compression of neural structures; patient age; symptoms; and, comorbid conditions. Should surgery be considered, there is currently no consensus regarding the ideal surgical approach for treating these lesions.¹⁸

Conclusion

We describe an unusual case of isolated hypoglossal nerve palsy, which has rarely been reported in the literature. This case emphasises the importance of detecting subtle changes in the oral cavity, the importance of special investigations in the diagnosis, and the role of the multidisciplinary team in managing the case.

Acknowledgement

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CPD questions

To claim CPD points, go to the MEMBERS' SECTION of www.dentist.ie and answer the following questions:

- | | | |
|--|---|---|
| <p>1. The hypoglossal nerve innervates all muscles of the tongue except:</p> <p><input type="radio"/> A: Hypoglossus muscle</p> <p><input type="radio"/> B: Palatoglossus muscle</p> <p><input type="radio"/> C: Styloglossus muscle</p> <p><input type="radio"/> D: Genioglossus muscle</p> <p><input type="radio"/> E: Superior longitudinal muscle</p> | <p>2. Which of the following statements about hypoglossal nerve palsy is false?</p> <p><input type="radio"/> A: In unilateral palsy, the tongue should deviate away from the weakened side</p> <p><input type="radio"/> B: Damage to the hypoglossal nerve may not always be noticeable to patients</p> <p><input type="radio"/> C: In unilateral palsy, the tongue should deviate towards the weakened side</p> <p><input type="radio"/> D: It can present with atrophy and fasciculations of the tongue</p> <p><input type="radio"/> E: It can present with facial palsy and ophthalmic manifestations</p> | <p>3. The percentage of intracranial meningiomas that are benign is approximately:</p> <p><input type="radio"/> A: 10%</p> <p><input type="radio"/> B: 30%</p> <p><input type="radio"/> C: 50%</p> <p><input type="radio"/> D: 70%</p> <p><input type="radio"/> E: 90%</p> |
|--|---|---|



Case report: Management of an impacted second premolar

Précis

This paper describes the prevalence, aetiology, and management of impacted second premolars in relation to the current evidence.

Abstract

Impaction of mandibular second premolar teeth may result from local factors such as abnormal positioning of the tooth bud and insufficient space in the dental arch. It can also be caused by ankylosis, early exfoliation, or prolonged retention of the primary second molars. Pathological factors such as alveolar cysts or odontomes have also been implicated. The recommended treatment for these cases varies according to case-specific clinical characteristics. This may include periodic observation, space maintenance, or surgical exposure with/without orthodontic traction or extraction. In this paper, the aetiology, diagnosis and treatment planning for mandibular second premolar impaction are reviewed. Furthermore, the treatment of one case will be presented.

Journal of the Irish Dental Association April/May 2019; 65 (2): 95-98.

Introduction

Impacted teeth can have a negative impact on the dentition by producing aesthetic compromise, impaired oral hygiene, development of pathology (e.g., cysts), and possible damage to neighbouring teeth. Impaction of the mandibular second premolar is a relatively rare occurrence. Radiographically investigated samples of adult populations show prevalence ranges between 0.2 and 0.3%.¹⁻⁹ Impacted second mandibular premolars are second in frequency only to impacted mandibular third molars.¹⁰ Impaction is attributed to lack of space or an aberrant path of eruption brought about by idiopathic or local pathological factors.

Literature review

Normal development

The development of the mandibular second premolar begins with coronal calcification starting between 24 and 30 months of age, and ends with complete root formation expected between 12 and 14 years.¹¹ Eruption of the mandibular second premolar typically occurs at 11-12 years of age. Mandibular premolars are susceptible to several anomalies including:

- impaction (prevention of eruption due to a physical barrier);
- aplasia (congenital absence); and,
- supplementals (extra premolars in addition to the normal sequence of teeth).

Aetiology of mandibular premolar impaction

Lack of space for the eruption of mandibular premolars may result from:

- tooth size-arch length discrepancies arising from over-sized, abnormally formed or multi-cusped second premolar teeth;
- severe decay/early loss of the primary second molar teeth permitting mesial drift/tilting of the adjacent first permanent molar teeth; and,
- mesial ectopic eruption of the first permanent molar causing early loss of the primary second molar.

The mandibular second premolar bud usually develops between the roots of the primary second molar. The bud may be distally inclined. This can result in an aberrant, distoangular path of eruption, culminating in impaction against the mesial root of the first permanent molar, especially if this permanent molar mesially tilts.

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Table 1: Aetiology of mandibular premolar impaction.

- Irregular resorption of the roots of the primary second molar
- Prolonged retention of the primary second molar
- Local pathology (e.g., cysts, supernumeraries and odontomes)
- Syndromes (e.g., cleidocranial dysostosis)
- Other genetic factors (e.g., PTHR1 mutations)
- Ectopic development of the tooth bud
- Idiopathic rotation of the tooth bud
- Early extraction of the mandibular first permanent molar

In instances where there is sufficient space for the eruption of the mandibular second premolar, impaction may be caused by (Table 1):

- uneven resorption of the roots of the primary second molar;
- ankyrotic prolonged retention of the primary second molar;
- local pathological conditions, including the presence of inflammatory or dentigerous cysts, supernumerary teeth or odontomes;
- syndromic genetic factors such as cleidocranial dysostosis;
- non-syndromic genetic factors such as parathyroid hormone 1 receptor (PTH1R) mutations in primary failure of eruption (PFE);¹²
- ectopic development of the tooth bud;
- idiopathic rotation of the developing tooth bud;¹⁰ and,
- early extraction of the mandibular first permanent molar might also contribute to the intraosseous distal migration of the second premolar until it becomes impacted when it contacts the mesial roots of the adjacent second permanent molar.^{13,14}

In extreme instances, the premolar has been shown to impact in the coronoid process.¹⁵

Management

When there is sufficient space for eruption, treatment options include:

- periodic observation of premolar development, possibly combined with extraction of primary teeth;
- surgical exposure of the impacted tooth, possibly combined with orthodontic traction;
- surgical extraction of the impacted premolar; and,
- surgical repositioning (autotransplantation).^{7,16-18}

In instances where the primary second molar is retained, its extraction is often warranted to encourage spontaneous eruption of the unerupted second premolar. If orthodontic treatment is to be delayed, the application of a mandibular space maintainer will help maintain the necessary space in the mandibular arch. Spontaneous eruption of the impacted premolar is observed mostly in patients where the second premolar is not profoundly ectopic and its root development is favourable. If the impacted tooth has an associated cystic lesion, both tooth and cyst are commonly removed to prevent recurrence of the cyst. However, it is also possible to marsupialise the cyst in order to retain the impacted tooth and facilitate its eruption.^{1,8} Extraction is commonly indicated for impacted premolars having caused root resorption to standing teeth.¹⁹

Where the space in the mandibular arch is insufficient to accommodate the second premolar, the implementation of a carefully planned orthodontic treatment can provide this space. Possible complications in the management of these teeth include:

- damage to roots of adjacent teeth;
- loss of vitality of the impacted premolar or adjacent teeth;
- paraesthesia of the inferior alveolar nerve; and,
- mandibular fracture.^{8,19}



FIGURE 1: Clinical absence of both mandibular second premolars with retained left primary second molar.

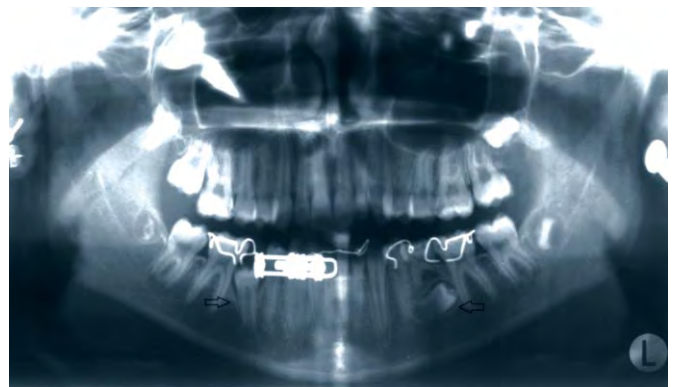


FIGURE 2: Orthopantomograph at presentation demonstrating the presence of both mandibular second premolars with distoangular impaction of the 35 (removable orthodontic appliance in situ).

Case report

A 14-year-old female patient was referred for orthodontic consultation. At the time of presentation, she was wearing a mandibular removable appliance incorporating expansion screws within the lingual acrylic baseplate. This device was fabricated by her family dentist to address the lack of space in the lower arch, with the aim of gaining the necessary arch length to allow for normal eruption of the mandibular second premolars. Intraoral examination evidenced that neither second premolar had erupted nor could be palpated (Figure 1).

Close clinical examination revealed a lack of space for eruption of the right mandibular second premolar (<7mm), while there was sufficient mesiodistal space to accommodate the left mandibular second premolar. The right primary second molar had been extracted two years previously due to caries. The panoramic radiograph revealed the presence of both mandibular second premolars (Figure 2). The right premolar was vertically inclined whereas the left premolar was impacted at an acute, almost horizontal inclination facing the



FIGURE 3: Baseline periapical radiograph of impacted left mandibular second premolar pre-surgery.



FIGURE 5: Radiographic view six months post op.

mesial root of the first permanent molar (**Figure 3**). The impacted premolar had not developed more than one-third of its prospective root length. In addition to the above, mild imbrication of the lower anterior teeth was noted accompanying a class II molar and canine relationship. No clinically significant dental pathology was detected except for plaque-induced gingivitis. Oral hygiene instructions were administered in an attempt to improve this. Extraoral examination of the patient showed a class I skeletal profile, symmetrical facial attributes, competent lips and an aesthetically pleasing smile.

The existing removable appliance was discarded, a mandibular fixed orthodontic appliance was applied, and extraction of the left second primary molar was carried out. After the initial levelling and alignment stage of the orthodontic treatment, active coil springs were inserted bilaterally on a rectangular 17x22 stainless steel archwire with the aim of gaining adequate space for spontaneous eruption of the second premolars. Six months later, the cusp tip of the right second premolar was evident, while there was no sign of



FIGURE 4: Clinical view of appliance to orthodontically erupt the impacted premolar with the bonded bracket.



Baseline → Six months post op

FIGURE 6: Radiographic progress of treatment from initial presentation to six months.

the left tooth.

Surgical exposure of the impacted tooth was planned and performed. Since the impacted tooth was positioned centrally within the alveolus, it was decided to access the tooth occlusally so as to maintain the integrity of the buccal and lingual alveolar plates. At the time of surgery, a bracket with a stainless steel chain was bonded to the impacted tooth allowing for subsequent orthodontic traction (**Figure 4**).

The eruptive orthodontic force on the impacted tooth was renewed every three weeks via the application of elastic thread. Six months later the tooth was clinically erupted and a periapical radiograph demonstrated continued root formation (**Figures 5 and 6**). Arch alignment and closure of residual spaces constituted the orthodontic finishing procedures. The fixed appliance was then removed and a fixed canine-to-canine lingual retainer was applied. Post-treatment clinical and radiographic examination revealed no adverse effects pursuant to the combined orthodontic-surgical approach.

Conclusions

Mandibular second premolars may develop with varying degrees of rotation and inclination. Rehabilitation of deeply impacted mandibular second premolars presents a significant challenge for the orthodontist and oral surgeon. Surgical exposure of a moderately mesiodistally or buccolingually impacted second premolar may result in spontaneous eruption, where there is sufficient space. In cases of deep or horizontally impacted mandibular second premolars, surgical exposure combined with orthodontic traction is typically the treatment of choice.

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Relationship between selective serotonin reuptake inhibitors and risk of dental implant failure

Carr, A.B., Gonzalez, R.L.V., Jia, L., Lohse, C.M.

Purpose: To identify associations between implant failure and selective serotonin reuptake inhibitor (SSRI) medication use in a cohort of consecutive patients receiving dental implants during a 20-year period.

Materials and methods: A retrospective review was conducted of all patients who received at least one dental implant from January 1, 1995, through December 31, 2014, assessing their history of SSRI use, active SSRI use, and SSRI use during follow-up with implant failure. Cox proportional hazards regression models assessed associations between demographic characteristics and SSRI use with implant failure, and outcomes were summarised with hazard ratios (HRs) and 95% confidence intervals (CIs). Follow-up SSRI use was analysed with time-dependent covariates.

Results: During the study period, 5,456 patients received their first implant (median age 53 years). The median duration of follow-up was 5.3 years (interquartile range 2.3–10.2 years) for the 4,927 patients who did not have implant failure. For the 529 patients who had implant failure, it occurred at a median of 0.5 years. After adjusting for age, sex, and era of implant, history of use of the SSRI sertraline was associated with an increased risk of implant failure among all patients (hazard ratio [HR], 1.60; 95% CI, 1.15–2.23; $p=0.006$), and among the subset of patients with a history of SSRI use (HR, 1.64; 95% CI, 1.07–2.52; $p=0.02$).

Conclusions: In the population reviewed, a history of sertraline use was associated with a 60% greater risk of implant failure; however, active SSRI use at the time of implant placement or during follow-up was not significantly associated with an increased risk of implant failure.

Journal of Prosthodontics 2019; 28: 252–257.

The role of bacterial biofilms in dental caries and periodontal and peri-implant diseases: a historical perspective

Colombo, A.P.V., Tanner, A.C.R.

Over the last hundred years, ground-breaking research in oral microbiology has provided a broad and deep understanding about the oral microbiome, its interactions with our body, and how the community can affect our health, be protective, or lead to the development of dental diseases. During this exciting journey, hypotheses were proposed, and concepts were established, discarded, and later revisited from updated perspectives. Dental plaque, previously considered a polymicrobial community of unspecific pathogenicity, is recognised as microbial biofilms with healthy, cariogenic, or periodontopathogenic profiles, resulting from specific ecologic determinants and host factors. The “one pathogen, one disease” paradigm of oral infections has been replaced by a holistic concept of a microbial community as the entity of pathogenicity. Cutting-edge technology can now explore large microbial communities related to different clinical conditions, which has led to finding several novel disease-associated species and potential pathobionts and pathobiomes. This vast amount of data generated over time has widened our view of the aetiology of caries and periodontal and peri-implant diseases, and

has promoted updated strategies to treat and prevent the oral diseases.

Journal of Dental Research 2019; 98 (4): 373–385.

A retrospective cohort study of the survival rate of 88 zygomatic implants placed over an 18-year period

Chana, H., Smith, G., Bansal, H., Zahra, D.

Purpose: The management of patients with a severely atrophic or resected maxilla with zygomatic implants can be surgically challenging, but postoperative complications are relatively uncommon. This retrospective cohort study evaluated the percentage survival rates of zygomatic implants placed over an 18-year period.

Materials and methods: This study evaluated patients receiving zygomatic implants in primary care (specialist referral dental practice) and secondary care (hospital) settings over an 18-year period.

Results: In total, 88 zygomatic implants were placed in 45 patients aged between 42 and 88 years. Of the 88 implants, 54 were immediately loaded. The implant survival rate was 94.32%, with five implants failing during the study period (implant level cumulative survival rate: 5.68%; mean follow-up: 7.5 years; maximum: 18 years). The failures were not significantly associated with sex, surface finish, implant length, zygomatic anatomy-guided approach (ZAGA) classification, or implant position (all P -values > 0.05). All failed implants were fitted with fixed prostheses. Failures occurred between six months and 15 years after placement.

Conclusion: This study of zygomatic implants placed in patients with a severely atrophic and resected maxilla confirms that this approach is a predictable method for supporting fixed or removable prostheses for up to 18 years, demonstrating high survival rates. Given the low number of failures, no potential risk factors for failure could be identified.

International Journal of Oral and Maxillofacial Implants 2019; 34: 461–470.

Patient expectation and satisfaction with different prosthetic treatment modalities

Colvin, J., Dawson, D.V., Gu, H., Marchini, L.

Purpose: To investigate the relationships between gender, age, patients' perceptions about the dentists' conduct, number of adjustments, treatment type, and expectation prior to prosthetic treatment, and patient satisfaction with their treatments.

Materials and methods: Data were integrated from four studies that measured patient expectations before treatment and satisfaction after treatment using a visual analogue scale (VAS) from 0 to 10. These scores were given for each of our aspects of the therapeutic outcomes: chewing; aesthetics; phonetics; and, comfort. Patients' perceptions about the dentists' conduct were also assessed using a Likert-scale questionnaire. The total sample size, after combining the data from all four studies, was 223 subjects. Bivariate and multivariable analyses were performed. The covariates entertained were gender, age, treatment type, patients' perceptions about the dentists' conduct, number of adjustments, and expectation prior to denture fabrication.

Results: In the entire sample, 115 (51.57%) patients were female and 108 (48.43%) were male. They ranged in age from 28 to 81 years old; the mean age was 53.2 years (SD=11.5). Combining four treatments, there was no significant difference between patients' expectation and satisfaction scores for all four items. There were no significant differences between expectation and satisfaction for different genders. Multivariable analysis showed that patient expectation, satisfaction and the difference (satisfaction score–expectation score) for all four aspects were associated with treatment type (implant treatments were favoured), and expectation prior to prosthetic treatment (the higher the expectation, the higher the satisfaction) was associated with satisfaction and difference scores. Satisfaction and difference scores for chewing were associated with number of adjustments and satisfaction, and satisfaction and difference scores for phonetics and comfort were associated with how well the dentist explained the intended treatment before performing it.

Conclusions: Patient satisfaction was associated with treatment type (implant treatments were favoured), expectations prior to prosthetic treatment (the higher the expectation, the higher the satisfaction), and how well the dentist explained the intended treatment before performing it.

Journal of Prosthodontics 2019; 28: 264-270.

Quiz answers

Questions on page 66.



1. Florid cemento-osseous dysplasia. This condition occurs in the jawbone, in particular close to where the teeth are formed. Lesions are noted where areas of normal bone are replaced with a mix of abnormal bone and connective tissue, and this presents as multiple radiopaque or radiolucent lesions on an OPG radiograph.
2. Florid cemento-osseous dysplasia is often asymptomatic and it is often discovered as an incidental finding while taking radiographs at a dental examination. Sometimes the lesions may get infected and cause pain or discomfort.
3. Florid cemento-osseous dysplasia commonly does not require treatment unless the lesions become infected. It is recommended that radiographic review is implemented, with dental radiographs taken every two to three years.



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Experienced associate required three to five days/week in Limerick. Busy, modern private practice. Fully computerised, digital x-rays, OPG. Excellent supportive staff. Email limerickassociate@gmail.com.

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Part-time associate required for Clonakilty, Co. Cork. Three to four sessions per week, more with time, computerised and digital x-ray. GMS, PRSI, private. Email westcorkdental@gmail.com.

Progressive exciting opportunity! Associate needed for busy, modern, digital, paperless practice one hour from Dublin. Full list available. Full-/part-time considered. CDT onsite. Predominantly private treatments, 50% remuneration, experience necessary. Email kingscourtdentalpractice@gmail.com.

Leinster – Dublin and Longford. Experienced, flexible, full-time associate required with postgraduate qualifications to work in both centres, three days in Dublin, two days in Longford. Both practices busy, computerised, digitalised with separate decontamination. Excellent support staff. Reply to niall@innovatedental.com.

Associate dentist required for Carndonagh, Co. Donegal. Two or three days a week with possible full-time at a later date for suitable candidate. Email donegaldental@yahoo.ie.

Dentists

General dentist with good experience required for Saturdays, 8.00am to 4.00pm. Busy list, modern practice in Dublin 6, CVs to peter@beechwooddental.ie.

Experienced dentist required for two days a week in modern, busy practice 30 minutes from the M50. General dentistry with support of well-trained staff and hygienist. All applications to applytokildarepractice@gmail.com.

Carlow – dentist required to work in a beautiful, bright, modern surgery. Are you passionate about your job yet able to have a laugh and enjoy yourself? Then this is the place for you. Full-/part-time negotiable. Email caroline@kiwidental.ie.

Southgate Dental is looking for a passionate, enthusiastic, experienced GDP to join our private, modern, well-equipped, established practice in Drogheda. Full-time position with one late night per week and one Saturday per month. Email emma@southgatedental.ie.

General dentist required to replace departing colleague for full-/part-time position in busy modern practice 30 minutes from Dublin. Full book, computerised and digital x-rays. Good terms available. Private and PRSI only. Email CV to piersedentaltrim@gmail.com.

We are looking for a dentist candidate with a minimum of two years' experience in pursuit of advancing skills, commercial knowledge and opportunity to join us in offering the highest quality modern dentistry. South Dublin practice. Digital, Cerec, OPG, hygienist, TCO. Email manager@d18dentalrooms.ie.

Busy, established, mixed family practice in Raheny needs a dentist to cover leave of principal; potential flexible regular hours for correct candidate. Email recruitdentistraheny@gmail.com.

Experienced, driven and friendly GDP required to join our modern practice in Cork, taking over an existing list. The role will be three to four days per week, including one evening and alternate Saturday mornings. Email mountovaldentalpractice@eircom.net.

Dentists required for our new clinic in Claremorris, Co. Mayo. Must be motivated, hardworking and experienced. Part-time and full-time work available. Please forward your CV and contact details to jobs@alexandridental.ie.

Experienced, personable dentist required for March and April in Wicklow to cover principal dentist's busy book. Four days, Monday to Thursday, 9.00am-5.00pm. General dentistry. Full support staff, well-equipped digital practice 30 minutes from south Dublin. Please forward CV to info@rathdrumdental.ie.

Experienced dentists required in Letterkenny. Part-time and full-time work available. Please forward your CV to hundental.dentalsurgery@gmail.com.

Exciting opportunities for enthusiastic, self-motivated and experienced dentists in Dublin 1 and 12 areas. Full-time, part-time positions available. Also looking for experienced orthodontist. Modern, well-equipped practices with fully computerised and OPG x-ray. Email diamondsmilejobs@gmail.com.

Looking for a dentist to cover one week in each of March, April and May in Co. Galway. Possibility for future part-time work if happy. Email seaportdental@hotmail.com.

Dentist required for Dublin south-west practice. Part-time to begin to expand to full-time as dentist leaves to go abroad. Email adasethsmith@gmail.com.

Dentist required for busy, expanding practice in Bray, to replace departing colleague. Modern practice with supportive staff. Three days per week, some flexibility on days and times. Ideally a dentist with interest in continuing education and expanding skill set. Email dentist2required@gmail.com.

Dentist required full-time in west Dublin. Busy mixed practice. Experience beneficial but clinical support available. Would suit a dentist interested in continuing education. Email dentalassociatedublin@gmail.com.

Enthusiastic dentist required for Fridays for a very busy private practice in south Co. Dublin. Fully computerised, CBCT, intra oral scanner, Cerec, etc. Excellent support team. This is a fantastic opportunity for the right candidate to join our team. Email careers@deansgrangedental.ie.

The Seapoint Clinic is looking for an experienced general dentist. The working environment is modern, fully equipped, and supported by a well-trained professional team. We offer a competitive associate package with shared lab fees and bonuses. Email: victoria@seapointclinic.ie.

Great opportunity for an experienced general dentist working two days/week, one of which is Saturday, with a view to becoming three days. The right candidate should have experience in endodontics, extractions, and crowns. Great support staff, friendly working environment. Email dr.erika.barta@crowndental.ie.

Killaloe Dental is looking for an experienced general dentist, working two days/week (Thursday and Friday). Computerised and digital x-ray. GMS, PRSI, private and supported by a well-trained professional team. We offer a competitive associate package. Email killaloe dental@gmail.com.

Locum dentists

Locum required for private/PRSI dental practice in Milltown, Dublin 6. Immediate start. Please email wmunroe@eircom.net.

Locum dentist required from month of April 2019 in busy west Cork practice less than one hour from Cork city. Contact dentaldemesne@gmail.com for details.

Specialists/limited practice

Endodontist – Smiles Dental is looking for an experienced, motivated endodontist with an MSC in endodontics to join our well-established, modern, state-of-the-art practices in Dublin and Wexford. Flexibility with days. Email joanne.bonfield@smiles.co.uk.

Prosthodontist required for sessions in a busy Cork city practice. Flexible working hours possible. Email corkcityassociate@gmail.com.

Specialist orthodontist required to provide ortho services on a part-time basis in Co. Meath. Modern, computerised practices with excellent support staff and great patient loyalty. Specialist registration essential. Email careers@dentalcareireland.ie.

Specialist orthodontist required to provide ortho services part-time in the west of Ireland, Galway based. Modern, computerised practices with excellent support staff and great patient loyalty. Specialist registration essential. Email careers@dentalcareireland.ie.

The Seapoint Clinic is looking for an experienced cosmetic dentist. The working environment is modern, fully equipped, and supported by a well-trained professional team. We offer a competitive associate package with shared lab fees and bonuses. Email victoria@seapointclinic.ie.

Dental nurses/managers/receptionists

Part-time dental nurse needed for specialist practice in Sandyford. Main duties to assist prosthodontist and oral surgeon, some reception work required. Computerised practice, some experience preferred. Hours: 9.00am-5.00pm, Monday, Tuesday, Friday. Please email CV info@specialistdentistry.ie.

Full-time dental nurse/receptionist required to work in a computerised (Aerona) practice in Swords. The position requires a friendly and outgoing individual with excellent organisational and communication skills. The role would entail some cash handling and day-book management to ensure smooth day-to-day running of the practice. Please forward CVs to Louise at vacancy.odc@gmail.com.

Experienced, qualified dental nurse required full-time in south Dublin dental practice. Available in April 2019. Must be flexible, with great communication/organisation skills. Experience in orthodontics/implant is an advantage. Please forward CV and cover letter to smartdental14@gmail.com.

Experienced dental nurse required for newly opened specialist practice in Limerick. Position involves both dental nursing and reception duties. Part-time initially (three days per week) with a view to full-time. Email application to castletroyortho@gmail.com.

Dental nurses and practice manager required for our new clinic in Claremorris, Co. Mayo. Must be motivated, hardworking and experienced. Part-time and full-time work available. Please forward your CV and contact details to jobs@alexandradental.ie.

Newbridge. Full-time dental nurse required to cover maternity leave. Start ASAP, work till November 19 minimum. Friendly two-surgery practice. No Saturdays or late evenings. Computerised Aeron system. Some flexibility with time off/holidays. CVs to 999eaw@gmail.com please.

Dental nurse and receptionist required in busy Dublin 24 practice. Part-time and full-time positions available. Experience not required. Must be hardworking, motivated with excellent organisational skills. Email your CV to squaredentalsurgery@gmail.com.

Newbridge – full-time dental nurse required. Start ASAP. No late evenings or Saturdays. CV please to 999eaw@gmail.com.

Dental nurse required one day a week (Wednesdays) for southside specialist practice, Blackrock area. Please apply enclosing CV to dublinorthodental@yahoo.com.

Exciting opportunity for qualified dental nurse in our Newbridge practice. Modern practice with full support team. Friendly approach, excellent communication and organisational skills required. Immediate start. Reply with CV to heidi.lane@centrichealth.ie.

Full-time dental nurse required for a modern, computerised practice in Ennis. Excellent support available. Email application to gbrowne.ennis@gmail.com.

Qualified dental surgery assistant required for multidisciplinary specialist dental practice in Galway city. Position suitable for newly qualified DSA. Contact Michelle on 091-569 110 or email obrienandmolloy@gmail.com.

Dental nurse required full-/part-time for busy south Dublin and Cork city practices. Email alex@whitesmiledental.ie for further information.

Rathfarnham dental practice has a dental nurse position available. We are looking for a friendly, helpful and organised nurse to join our team. Experience not essential. Apply with CV to info@rathfarnhamdental.com.

Full-time nurse required. Full-time dental nurse required, immediate start, southwest Dublin. Email sbarnes@ballyfermotdental.ie.

Blessington Dental. Part-time dental nurse, Tuesdays and Fridays initially. Hours may increase. Experience preferable. Email CV to niall@blessingtondental.ie.

Dental nurses, Dublin. An enthusiastic, empathetic, efficient individual to join our friendly team. Fully private dental surgery in north Dublin. Reception experience an advantage. Computer-proficient/team player a must. Good remuneration for suitable candidate. Forward CV to niall@innovativedental.com.

Hygienists

Hygienist required for busy Dublin 7 practice. Full-time, fully computerised. Please email CV to hygieneplacement@gmail.com.

Dental hygienist required for part-time work in a busy practice in Co. Clare. Fully computerised with friendly staff and great patients. Email CV to mcgrath.eimear@yahoo.ie.

Dental hygienists required for both our Limerick and Shannon clinics. Part-time and full-time positions available, excellent remuneration, state-of-the-art clinics with good support team. Please forward your CV and contact details to jobs@alexandradental.ie.

Hygienist required one day/week (Thursday) to replace well-established hygienist position in modern family practice based in Killaloe, Co. Clare. Brand new dental chair, new Cavitron, excellent support staff. Please email or call 087-233 3053 for more information. Email killaloe dental@gmail.com.

Dental hygienist required for a half day every second Saturday. Dental practice is in New Ross, Co. Wexford. Email dillondental@gmail.com.

Locum hygienist needed for 10-12 weeks. We can be flexible with days and hours. Please call Paula on 091-562 932, or email paula@eyresquaredental.ie.

Part-time hygienist required for a busy dental practice in Tralee, Co. Kerry. Email info@flynnsdentalcare.ie.

Enthusiastic, caring hygienist required for a part-time position in our modern, growing dental clinic in Dublin 8. Email info@cleardentalcare.ie.

Part-time hygienist required for a busy dental practice in Bray, Co. Wicklow. Flexible days and times. Email dentist2required@gmail.com.

Part-time hygienist required for a busy practice in Enniscorthy, Co. Wexford. Flexibility available. Email courtstreetdental@hotmail.com.

We require a qualified dental hygienist to work Saturdays and possibly one morning weekly. We are a fast-growing new dental practice in Dublin, the practice is modern and forward thinking. You will be working alongside a fantastic team. Email shauna@3dental.ie.

Experienced, flexible and enthusiastic dental hygienist required to replace well-established hygienist position. Great patients and excellent support staff in a modern, computerised family practice in Westmeath. Send cover letter and CV to info@kinnegaddental.ie.

Locum dental hygienist required for 12 weeks. Days are flexible, full book, excellent rates. Please call Ruth on 01-825 9787, or email dentalpracticemeath@gmail.com.

Dental hygienist required part-time from May 2019 to cover maternity leave in Wexford Town. Optional days available. Full book from start. Email bhom@eircom.net.

Enthusiastic hygienist required for large surgery in busy, modern practice situated in north Co. Dublin. Starting at two days a week, one a Thursday, with flexibility over second day and great potential to increase hours. Email colinpatricklynam@hotmail.com.

Dental technicians

Dunboyne. Part-time/full-time dental technician position available. Work includes acrylic and orthodontic experience necessary. Excellent support staff. Please email CV to Email: dunboyndentallab@gmail.com.

Facial aesthetics

Part-time position required for very busy facial aesthetics injector to work in Killarney. Send CVs to info@eden-medical.ie.

PRACTICES FOR SALE/TO LET

Cork City. Two-surgery, modern, recently renovated, digital x-ray, computerised, HSE standards passed. Freehold offers preferred. Well-established with good name, low medical card. Email practicesalecork@gmail.com.

Leinster midlands. Single-handed surgery within easy commute to Dublin – one hour. Ample room for expansion. Very well equipped, including OPG, etc. Flexible options, rent/freehold. Good profits. Favourably priced. Very large potential for growth. Email niall@innovativedental.com.

Limerick. Long-established, full planning permission single surgery, room to expand, leasehold. Huge catchment area. Fully private practice. Great potential for growth – very low overheads. Principal retiring. Immediate profits. Suit progressive associate. Contact niall@innovativedental.com.

Killybegs, Co. Donegal: private practice for sale – established 2011. Two fully equipped surgeries – great location – high patient volume. Email vajda.istvan@yahoo.com.

Galway city. Long-established two-surgery practice for sale. Good steady turnover, low DTSS. Long-standing associate can remain. Owner retiring. Contact galwaypractice1@gmail.com.

South-east freehold practice – private, PRSI, GMS. Current principal of 30 years retiring. Three surgeries, computerised, OPG, great staff. HSE certified. Great location, parking, near general hospital. Excellent opportunity to expand and introduce specialties. Email seiredent@gmail.com.

Dublin 12 – private, PRSI, GMS. Currently fully booked two-three surgeries, computerised, OPG, great staff. HSE certified. Great location, parking on site. Excellent opportunity to expand and introduce specialties. Email diamondsmiledental@gmail.com.

Dublin City Centre. For sale – long-established, busy, general practice – superb location. Experienced, loyal staff. High new patient numbers. Growth potential as premises is 1,750 sq ft. Principal retiring shortly, immediate sale, knock down price. Open for offers. Email niall@innovativedental.com.

EQUIPMENT FOR SALE

Planscan intra-oral scanner for sale. Little used with original laptop and Romexis Licence. No ongoing licence fees. Realistic reserve. Contact 087-207 1077, or email northbrookxraydepartment@gmail.com.



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The business of connection

Originally from Rathdowney in Co. Laois, Dr John O’Keefe graduated in 1980 and worked in Ireland and the UK before deciding to make the move to Canada in 1991.

What prompted your move?

I wasn’t interested in a career in private practice, and while I was the youngest Principal Dental Surgeon in the country at the time (based in Co. Clare), the pre-Celtic Tiger public service was a resource-constrained environment. I wanted some adventure and opportunity, and in fact considered leaving dentistry when we moved. Also, my wife, Lucie, is from Montréal.

Were you prepared by your Irish education for life in Canada?

Professionally, in one way, no (I had to pass Board exams). In another way, the education I received in Dublin gave me a great grounding for clinical practice, and especially for interacting with patients. Personally, I had family there, I was well on my way to speaking both official languages, and socially and culturally it is very familiar and comfortable.

What was your career path when you moved?

When we moved to Canada I made the decision to do an MBA. When I completed that I took an academic post at the University of Toronto, which enabled me to take my Board exams. Then in 1997 I was lucky enough to be offered a role with the Canadian Dental Association (CDA) in Ottawa as Editor of the *Journal of the Canadian Dental Association*.

What does your role consist of?

I am responsible for communication within the profession (journal, magazine, websites, social media channels), and I also have an ambassadorial role (industry, academia, other professions). The CDA has been amazingly good to me; they’ve always allowed me a broad canvas, and this has helped me to develop a large network of contacts in dentistry and beyond.

My role has changed enormously over the last 20 years. My title now is Director of Knowledge Networks. My job is to communicate with the ‘diaspora’, and create a sense of belonging. A lot of what I do now was inspired by a talk I attended in 2009 by Clay Shirky, who talked about how the old monopolies that associations have had in the past are either gone or going. The best chance for any organisation to keep some connection with its people is to host the platform with the conversations that are most important to them. That is what I aspire to do, and I reckon I have the best job in dentistry in the world.

What are the main differences you see between the Irish and Canadian systems?

There are many similarities in that private practice fee-for-service is the dominant model, with employment-related dental benefits being enjoyed by over 50% of the population here. There has also been a move away from single-dentist operations in recent years. Canada is a federal country, with professions regulated at provincial level and labour mobility of professionals.

What involvement have you had over the years with the IDA?

Do you keep in touch with Irish classmates and colleagues?

I got involved in Irish organised dentistry as a student. I was on the Executive of the Irish Dental Students’ Association and during my time, we were granted student member status of the IDA. I can still remember how proud I felt to be welcomed into the IDA. During the mid-1980s I was a member of the Council and the Executive Committee of the IDA, representing salaried dentists. I learned so much from that experience that has stood me in good stead in my subsequent roles. Our class was very tight knit, probably because of our experience occupying the Dublin Dental Hospital for ten days and nights! Our most recent reunion was held in Galway, in conjunction with the IDA Conference.

What do you think are the benefits of working abroad? What are the challenges?

I think Canada is the most wonderful country for any Irish person to emigrate to; it’s a stable, rich country, with English as one of the official languages, there is plenty of opportunity, and it has great transportation links with Ireland.

For me, it has always been a country where I felt welcome and respected. I have had personal and work-related opportunities here that have exceeded my wildest dreams. From my perspective, the challenges have been minor. You have to be willing to start at the bottom and accept that experience outside the country might not count for much. The winter temperatures might get some people down, but I think that the cold weather is nicely balanced by all the days with blue sky.

Dr John O’Keefe with his wife Lucie in Galway at the recent IDA Annual Conference.





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