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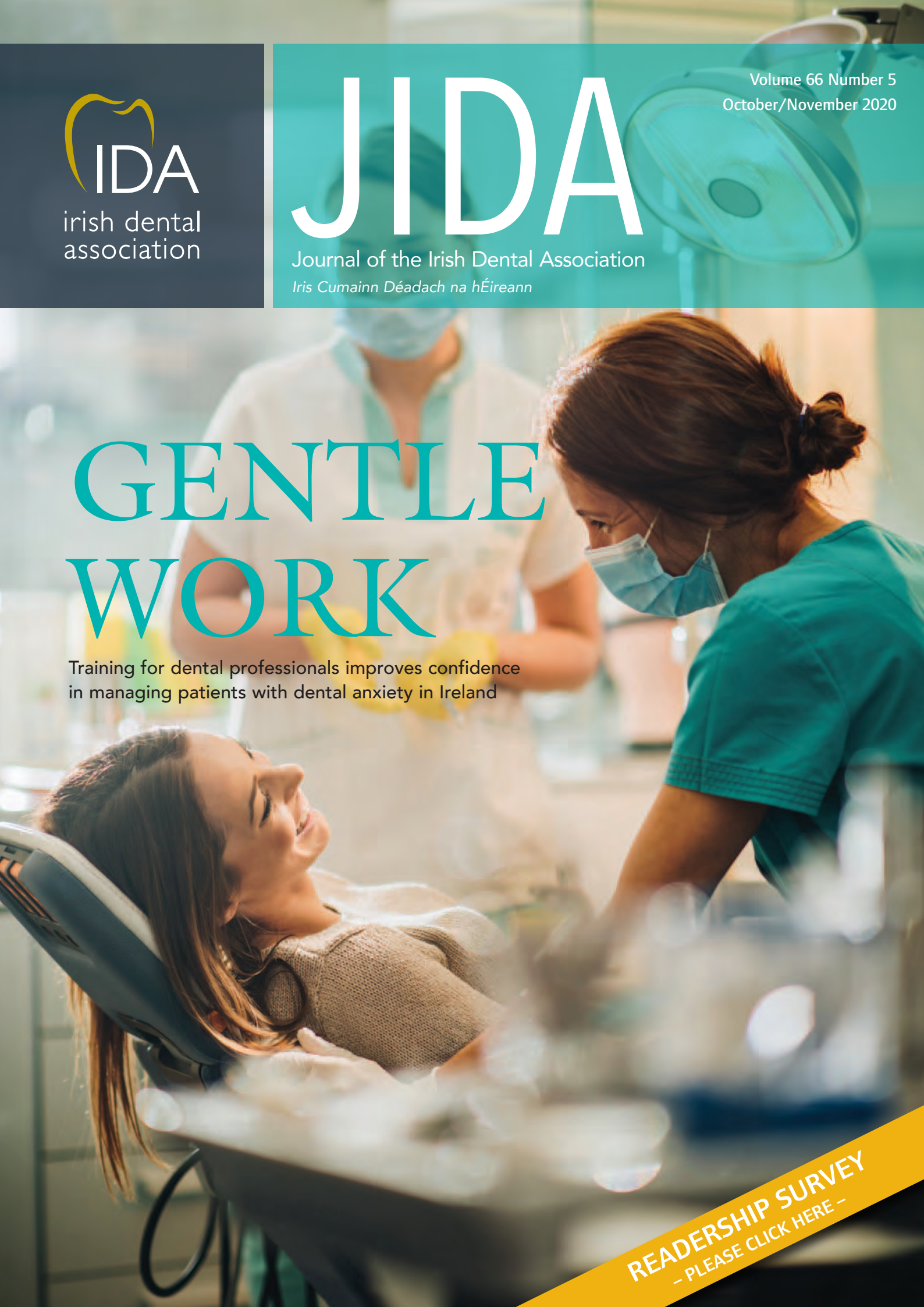

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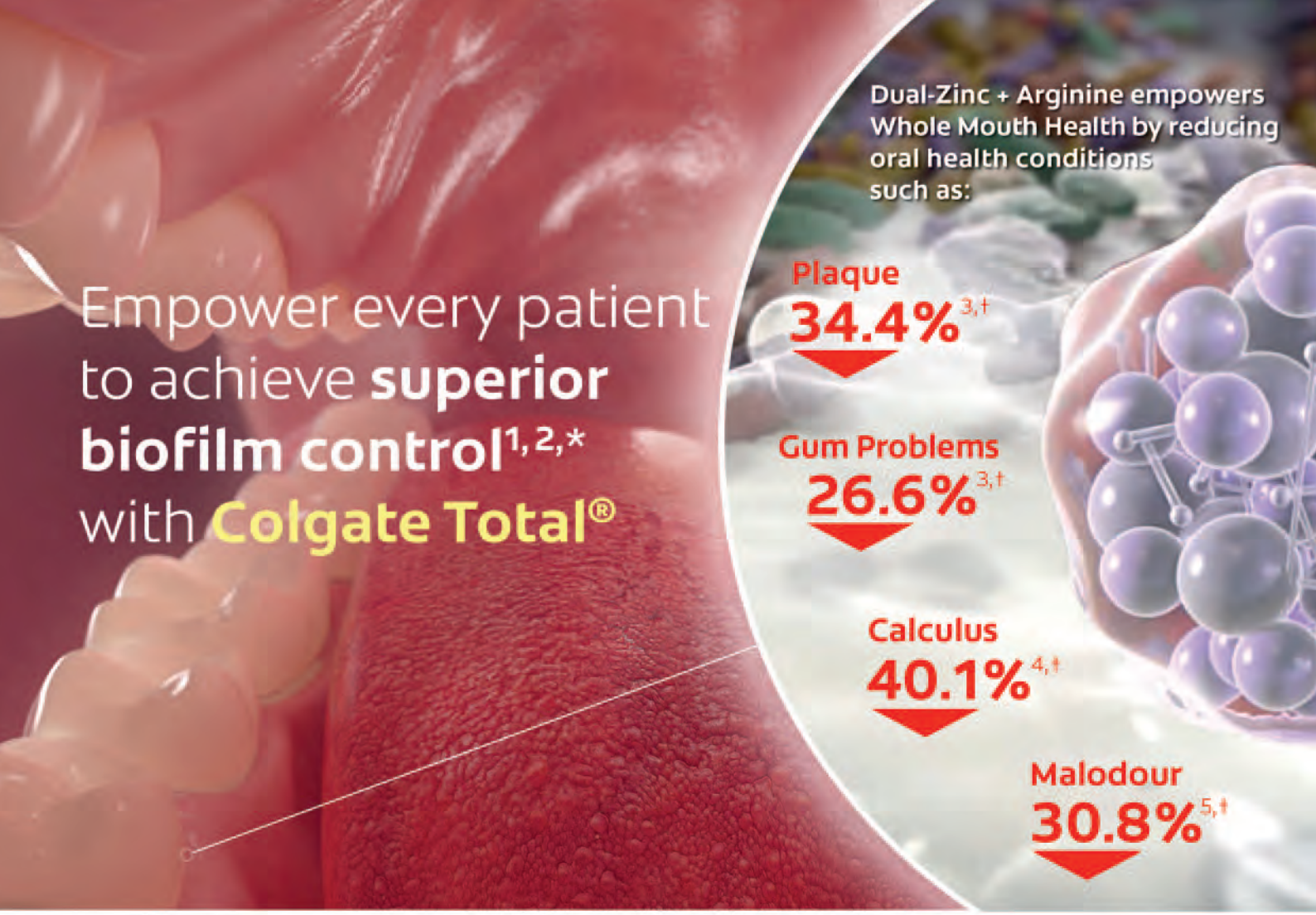

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#Statistically significant greater reduction of cultivable bacteria on teeth, tongue, cheeks, and gums with Colgate Total® vs non-antibacterial fluoride toothpaste at 4 weeks, 12 hours after brushing.

References: 1. Manus L, et al. *J Clin Dent* 2018;29(Spec Iss A)A10–19. **2.** Daep C, et al. August 2019, data on file. **3.** Li X, et al. *J Dent Res* 2019;98(Spec Iss A):3444. **4.** Seriwatanachai & Mateo, September 2016, data on file. **5.** Hu D, et al. *J Clin Dent* 2018;29(Spec Iss A)A41–45. **6.** Sanz et al, *J Clin Periodontol.* 2017;44(Suppl 18):S5–S11. **7.** Prasad K et al. *J Clin Dent* 2018;29(Spec Iss A)A25–32.

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EDITORIAL

Dr Ciara Scott
Honorary Editor

Our evolving profession

This edition includes a readership survey, and a call for stories of how dentistry has responded to the Covid-19 crisis.

"The rapid growth in knowledge of oral diseases, the change in disease prevalence and the continued improvement in world communication make this a challenging time in modern dentistry." These words grace the cover of a book I came across recently. While this could be true of today, *Evolution in Dental Care* was published 30 years ago and outlines the deliberations from the 1988 World Dental Conference, 'Decisions in Forward Looking Oral Health Care'.

So much has evolved in dentistry since, yet many of the issues are the same. The author, Richard Elderton, was forward looking and a promoter of minimally invasive approaches well before this was a popular viewpoint. It's fascinating to read the goals and predictions from that meeting of oral health professionals from around the world and the expectation that by 2025, education levels and access to healthcare would drastically reduce the need for operative dental surgeons in industrialised countries. Recommendations included one for dental curriculums to focus on "prevention and counselling" for a generation of oral health physicians who would do less operative work. It's hard not to see how all the current challenges with access to dental services, PPE, air quality, aerosol-generating procedures and rising overheads would be less of an issue in that parallel reality where better oral health had minimised the need for operative procedures.

Spectrum of skills

The last 30 years have brought many changes to dental curriculums and techniques as we have continued to develop our skills as oral physicians, counsellors and surgeons in patient care. Our first paper in this issue is focused on our role as counsellors and highlights the benefits perceived by dentists who received bespoke training to manage patients with dental anxiety. I am very grateful to Caoimhin Mac Giolla Phadraig and his co-authors for also contributing the clinical feature to share some techniques for understanding and communicating with this patient group.

We have recently marked Mouth Cancer Awareness Day. While some cancers respond well to chemotherapy and immunotherapy, excisional surgery remains the treatment of choice for oral squamous cell carcinoma. Radical surgery can have a devastating impact on both facial aesthetics and oral function, resulting in a significant impact on quality of life for cancer survivors. Radiotherapy can further compromise this. In this issue, Michael Freedman, Una Lally and Leo Stassen detail contemporary techniques in multidisciplinary digital treatment planning and the use of zygomatic implants to reconstruct form and function for a young cancer survivor. I am very grateful to them and their patient for sharing this extraordinary journey with us.

Readership survey

Our new President of the IDA, Anne O'Neill, has shared her perspective on the mountain we still have to climb in the implementation of the oral health policy in this issue. I congratulate Anne and all the newly elected officers of the IDA, and look forward to supporting them in their roles. We also welcome four new members to the *Journal's* Editorial Board and I thank our outgoing Board members for all their contributions to the *Journal* and Association. When we serve on committees and boards we represent the broader membership and we rely on engagement and feedback from the membership to help us to keep improving and stay relevant. With that in mind, we have included a reader's survey with this issue, which I hope you will take the time to complete to guide us as we move forward. We are back in print following two 'soft copy' online issues during lockdown. If you missed the notifications, all our past issues are archived and available on the IDA website.

We have seen lots of levels of leadership within the profession this year and on page 220 we invite you to share stories of dental colleagues who have shone and supported others professionally and in their communities during the Covid-19 crisis. We cannot hold a grand awards ceremony this December in the usual fashion, but we can still take the time to acknowledge and thank those who make us proud to be in the dental profession. We look forward to reading your stories and sharing them in our next issue.

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Dr Anne O'Neill
IDA President

Representing and advocating

An extract from the inaugural address by incoming President Dr Anne O'Neill, at the Irish Dental Association AGM on September 26.

As I take on the role of President, it seems appropriate to offer some reflection on where we should have been, where we are now and in what direction we next head.

Oral Health Policy

In April 2019, the Department of Health published the very long-awaited Oral Health Policy. There were some ambitions with which I agree – embedding preventive strategies into healthcare, and engineering data collection to enable us to track health and plan for the future, to name two. But to describe the provision of dental healthcare to patients as bundles, to reduce healthcare to a commodity, does not inspire me.

Diverting child patients to contracted care to reuse the vacated resources may be supported by papers on skill or case mix. But without considering the current Irish context – longstanding difficulties in existing contracted care systems, a lack of effective engagement between the substantial stakeholders, the number of patients with outstanding restorative treatment needs – I fear that the system is being replaced with one that cannot succeed.

As someone who was a member of the IDA at the time of the development of the DTSS, I know the concerns that arise when the IDA represents two groups with competing interests. But by recognising that we work best when we work together, and keeping the patient in the centre of any system we build, the DTSS achieved access for patients in a system which was, at the time, acceptable to dentists (unfortunately it hasn't maintained its currency). As we face into a similar scenario of significant change on both the independent and salaried sides of the system, I hope that my experience might be of value, as well as being able to advocate for positive change.

Covid community

Rather than focusing on the depressing line of lockdown and isolation, I would ask you to remember some of the amazing positive community spirit in our dental community – the dentists who continued to provide emergency dental care despite not knowing all that this virus can do, the dentists who supported their local communities by keeping in touch with cocooners, the dentists who answered the calls for volunteers.

The IDA Management Committee met so often that the ink was rarely dry on the previous minutes. I'm not sure the members of the Quality and Patient Safety Committee slept for weeks! The important point to all of this is to recognise the dedication to patients, innovation, creativity, skills and perseverance shown by dentists during possibly the most challenging time for health services since the Spanish flu of 1918. I am proud to be a member of this community and I look forward to working with all of the committees to continue supporting members through our current crisis and beyond.

I also look forward to building positive engagement and negotiation with the Department of Health because there is no doubt that, just like so many aspects of healthcare, the new Oral Health Policy cannot withstand the impact of Covid-19.

Member engagement

One of the aspects of IDA membership we have not been able to reconfigure is the social interaction that is part and parcel of our meetings. One of our strategic ambitions to be one of the key sources of continuing professional development for dentists in Ireland can be enabled in part on digital platforms (and I thank the CPD Committee and IDA staff who have been tireless in pursuing that). But we also need to focus on how we might enable interpersonal contact in a time of social distancing. Maybe we can consider local couch to 5K meet-ups, or walking routes, or golf 4 balls or other activities that are available outdoors that can provide us with social contact with other IDA members at a distance, so that no member is left feeling that they struggle alone.

The Irish Dental Association has been here for 100 years. It will continue to do what it repeatedly does: collaborate to achieve our common goal of representing and advocating on behalf of the profession and patients. My personal thanks to the staff at the IDA, without whom we could not achieve any of our goals and for attending meetings out of their usual hours. Thanks to the outgoing Management Committee and Council for their time, hard work and dedication at a time when personal and professional lives were under such pressure.

My particular thanks to our outgoing Vice-President Kieran O'Connor, and our new Vice-President Leo Stassen, without whom this organisation would be the poorer.

Thank you for being members – the broader our range of members, the wider our conversations and the better we can reflect the profession. Please participate in all the activities that the Association offers and enrich our dental network.

Welcome to all our new committees, to our new non-executive directors. We enter a new challenging phase of the Irish Dental Association, but if we use even a fraction of the knowledge, skills and perseverance that was demonstrated during lockdown, we will continue to grow and achieve our goals.

IDA webinars

The IDA has produced a range of webinars, which are available to view by **IDA members** at any time via the members' section of the IDA website.

Oral radiation: am I compliant?	Dr Jane Renehan
Comparing the conventional and digital techniques in restorative dentistry	Dr David McReynolds
Finance issues during Covid-19 for dentists	David McCaffrey
HR and employment issues during the Covid-19 pandemic	Roisín Farrelly
Discussion of the Return to Work Safely Protocol	Drs Jane Renehan and Ahmed Kahatab
Costs associated with Covid-19 in dental practice	Stephen Lynch
Live Q&A re: costs associated with Covid-19 in dentistry	
Mental health	Dr Harry Barry
Medical emergencies in the dental practice	Safe Hands Training
Rubber dam made simple	Drs Alastair Woods and Maurice Fitzgerald
What to have in your dental drug kit	Safe Hands Training
Live Q&A for associates	
Let's talk about mental health	Jennifer Barry
Return to work safely: a refresher	Drs Jane Renehan and Ahmed Kahatab
10 top tips for compliance in dental radiography	Dr Andrew Bolas
Mouth cancer: lumps and bumps	Dr Sheila Galvin
Nutrition and lifestyle	Evan Regan
Physical health and well-being	Jenny Branigan
HR: working with Covid-19	Roisín Farrelly
Mobile phone usage in dentistry	Bernadette John

BLS/medical emergencies

Unfortunately, due to the Government restrictions in Dublin announced in September, the IDA has had to cancel the basic life support (BLS) course proposed for October 3. Further courses are planned (pending no further restrictions being announced), in other counties:

November 7 – Cork | November 14 – Tralee | November 21 – Dublin

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Mouth Cancer Awareness Day 2020

Mouth Cancer Awareness Day took place on Wednesday, September 16. This year we didn't ask dentists to provide free mouth cancer exams for their patients on the day; instead, it was mainly a social media campaign focusing on those over 55. The Mouth, Head and Neck Cancer Group has also launched a new website www.mouthcancer.ie.

HSE Dental Surgeons' AGM

The AGM of the HSE Dental Surgeons Group of the IDA will take place on October 15, at 7.00pm, via Zoom. All those wishing to participate in the AGM will get an invite to register in advance. Dr Grainne Dumbleton, President of the Group, will pass on the role of President to Dr Philip Mulholland.

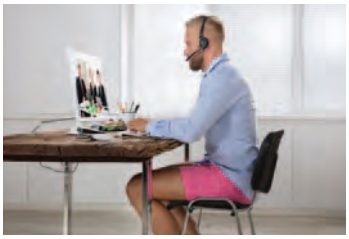
Calling all dental Covid heroes!

Did you or a colleague operate an emergency dental service during lockdown? Are you a HSE dentist who has been redeployed to Covid-related work?

The *Journal of the Irish Dental Association* would like to pay tribute to the dentists and dental team members who have risen to the challenge of Covid-19 in a feature in our next issue.

If you or a colleague have been working in testing centres, volunteering in your community, continuing to care for patients in enormously challenging circumstances, or any other Covid-related work, we would love to hear from you. A selection of stories will be featured in the December 2020/January 2021 edition of the *Journal*.

Contact ann-marie@thinkmedia.ie to tell your story or to nominate a colleague.



2021 Annual Conference

The IDA Annual Conference 2021 will take place from April 15-17, 2021. Further details will be announced soon. Maybe online!!!

Quiz questions

Submitted by Dr Brian Martin.

A 35-year-old man presents to your practice with a right-sided infraorbital facial swelling. He reports that he is fit and well. Clinical and radiological examination confirms the upper right first molar as the source.

1. What questions would you ask to help determine the severity of the infection?
2. What clinical features would indicate a severe infection potentially requiring hospital care?
3. The eye is open at rest with no associated ocular symptoms, and the patient denies any systemic symptoms. The swelling is oedematous and an obvious alveolar collection is evident buccal to the UR6. What is the most appropriate first-line treatment?
4. Does the patient require antibiotic therapy?
5. What potential sight-threatening complication can arise with infections involving the infraorbital and canine spaces?

Answers on page 254

Promoting oral health during lockdown

Fourth-year dental students at UCC used their time during lockdown to create a series of infographics to help encourage children to look after their oral health. With help from Charlie Ruxton of UCC Audio Visual Media Services, a suite of five colourful infographics was developed.

Dr Siobhán Lucey, Lecturer and Specialist in Paediatric Dentistry in the Cork University Dental School and Hospital, explains how the project came about: "Due to the restrictions that came into force in March 2020, our teaching had moved entirely online. This group assignment was designed to inspire and enhance student engagement on several levels: encouraging connections between the learners as peers and colleagues, but also connecting the students more deeply with the curriculum. The concept was inspired by the increasing use of visual strategies for communicating health and well-being messages to the public. I was also cognisant that children's access to oral healthcare services was severely limited during the lockdown. I felt it was an opportune moment for us to simultaneously reinforce preventive messages in the area of children's oral healthcare, while also encouraging our students to embrace their future role as oral health professionals. The Cork University Dental School and Hospital is privileged to serve the community and we hope that this work will contribute to improving the oral health of children both locally and nationally".

The infographics are available at: www.ucc.ie/en/dentalschool/patients/#brushing-up-on-your-baby-s-oral-health.

Readership survey

Enclosed with this edition of the *Journal*, you will find a readership survey. Your input is valuable in helping us to plan for the future of the *Journal of the Irish Dental Association*, so we would be grateful if you could take a few moments to complete the survey and return it to us. You can also complete the survey online at: https://www.surveymonkey.com/r/HTC6N6V.

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Always advocating

While it will be hard to be heard above all the news of Covid-19, new President of the IDA Dr Anne O'Neill says the Association will always advocate for the profession.

When Anne O'Neill was nominated for the presidency of the IDA back in September 2019, there appeared to be clear goals and problems that she would have to deal with: "I thought OK, we're going to be implementing this oral health policy, I can contribute a lot to the debate of how that system might be built, and what the IDA might advocate for independent practitioners and salaried services. Since March, so much has changed and the timeframes we consider for advocacy are so different. We now have changes happening every four weeks. My aims for the rest of the year as President are firstly, to maintain as many of the members being with us on the journey. It's a very difficult environment for dentists as a profession, and we need to support each other through these changing times. The second aim is to continue to reflect the aims of our strategy document. I believe that the IDA is one of the leading providers of continued professional development in dentistry in Ireland and we want to continue building on that. Unfortunately, we're going to have to rely heavily on digital platforms to do it. But I think we're certainly off to a good start with the team we have in IDA House, who are working hard to roll out new content to the membership".

While education programmes lend themselves to continuing online, Anne is eager to find a way to replace the social element of IDA events, which she says many are missing: "We want to see how we can replace the branch meetings, which were part scientific, part social. We're missing the face-to-face interactions that are part of the social fabric of our professional network. If we could find a way of reconnecting the social interactions into local networks, that would be a great achievement in the current environment".

Anne qualified from UCC in 1989, where she was awarded the IDA Costello Medal. Shortly after graduating, she was unsure where she wanted to practise, and decided to join the HSE dental service for a year but forgot to leave. She now exclusively provides clinical care to special care patients.

After working in the health service for two years in Dún Laoghaire, her principal at the time, Dr Gerry Fitzgerald, told her she should join the Irish Dental Association: "I started, like most people do, just going to the various education pieces, in particular the Health Board Dental Surgeons Conference, as it was at the time. It was a great way to network with people from around the country. Then I joined the Health Board Dental Surgeons' committee, spent time representing it at Council and was president of the group twice. I've also worked on different IDA committees, depending on topics of interest at the time. I have also had the great honour of being one of the judges of the Colgate Caring Dentist Awards".

Colm Quinn
Journalist with Think Media

Covid-19 and other issues

Like everywhere else in society, Covid-19 has muscled its way to the top of the agenda for the IDA. Anne says one of the biggest challenges is staying sane against a backdrop of constant change: "As a profession we are fixers of problems, creative, patient focused, and very organised. If you look at how dentists organise their day, something that's common among all of us, we organise things against what was up until recently a fairly fixed background. With Covid, all of that has changed, and that's been one of the biggest challenges".

It is going to be hard for dental care to get the attention it needs while Covid is around, says Anne, but the issues that were there before its emergence remain: "We waited a long time for the publication of the National Oral Health Policy document. The policy proposes substantial changes in a system that has seen little or no development within the past 10 years. It comes at a time when the profession has very little confidence in the Department to implement change. The gap between where we are and the proposed finished system is vast".

She warns against too much commodification of dentistry, as is reflected in parts of Smile agus Sláinte: "When health is treated as a commodity, it mitigates against continuity and you don't get patients buying into their own health.

They'll chop and change depending on the price, depending on what they want. They'll take the easy pieces they want, ignore the others and expect to be able to purchase a solution when things go badly. Good dental health doesn't work like that. Good dental services don't work like that. And that is one of the biggest challenges. While you do have to interact with your patients as consumers, too much consumerism reduces the quality of engagement with people and their health, so trying to get that rebalanced is a much bigger issue".

Although she doesn't agree with everything in the policy, Anne says there are some good aspects to it: "If I were given the pen and paper to write it, would you have gotten the same document from me? The answer's no. I think if you review the policy as a series of ambitions, then it is easier to agree with some of the content. The ambition to add prevention to the programme is key to oral health improvement. The ambition to have more frequent services available: the policy talks about attendance every two years, where ideally it should recommend attendance every year. Even to get funding for attendance every two years on a structured basis for everybody would be a fantastic improvement on our current system. More structured digital information so that we can develop our dental public health, part of my day job I know, is essential to support continued development of our dental system".

However, she believes it will come down to the money available for implementation, which will be difficult to secure: "We can't ignore the competition in the system for existing health resources – dental has to complete with cardiac, orthopaedics and others. I think that the system that they're proposing is far more complex than the one we operate now; it will be far more expensive relative to current investment in dental public health and I think that will be the greatest obstacle for implementation".

Financial decisions have decimated dentistry in the past, and against this backdrop it is understandable that there is little trust among dentists for any Government-backed scheme. The approach of the Government towards dentistry needs to change: "If the Department promises something, the Department needs to deliver. It is that simple. The most recent example has been PPE, where the Minister promised but there's no delivery. This undermines the trust between the profession and the Department. It will take considerable effort to rebuild that relationship".

Modernisation

There is a temptation to look elsewhere when developing models of care but Anne says we've devised good systems before in Ireland, such as the school screening service, which has been in operation since the 1970s: "I chaired a group that was researching evidence on which to base guidelines for what was known at the time as school screening. We quickly came to realise that the service wasn't screening according to accepted definitions. It was assessing

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children in schools and bringing them in to surgeries for treatment. Part of the work the group undertook was looking at models in other countries. We identified that where the salaried service targets children at specific age ranges and provides them with care, where examination is linked to the provision of care, is a very positive model. Actively targeting the children ensured that the service was able to identify those who hadn't responded and we were able to follow up to make sure that they participated in attending for care. As not everyone prioritises the dental health of their child in the same way, the current model has an inbuilt dental public health safety net, which is not obvious in the proposed new model".

Smile agus Sláinte mentions the dental home, but Anne explains: "The dental home comes from the American dental system, which is a predominantly insurance-based system. People who can afford dental insurance can access the relationship and care that the American Association of Pediatric Dentists defined as the dental home. There are very poor public dental services for people who don't have that level of insurance. The dental home is not part of their public health model, which has significant care provided by charitable organisations. I think it's important we look at other countries' models of care to see what works and what doesn't, but that we can't necessarily import another country's model of care or dental culture. Ireland is unique in that we still have the examination and the assessment being done by the salaried service, which has prevention inbuilt, albeit under-resourced for many years. We shouldn't throw out the current model until we are sure we're replacing it with something better".

Mental health

With new Covid practice advisory notices coming from different organisations and countries every day, Anne says we are on the verge of advisory overload: "There's an awful lot of Covid dental advice out there. You turn around and there's another advisory from another jurisdiction that suggests something slightly different for the implementation of safe dental care in the current environment. It leads to great stress and difficulty for dentists as we strive to provide safe care to our patients.

"The one social event I attended on behalf of the IDA before events were cancelled was the inauguration of the president of the Northern Ireland Branch of the BDA [British Dental Association]. That was before Christmas last year when I had the great pleasure to sit beside Roz McMullan, President of the BDA at the time, when we discussed her great interest in the mental health of the members. Considering that was before Christmas, before Covid made its little presence felt, you can imagine how much more concerned we are now.

"I suggest two positive things for dentists: the first is to check in with themselves on a regular basis as to how they're actually feeling about life, the universe and everything. We get so busy minding patients, providing care for patients, and

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A proud Megan examines her Mum's chain of office.

providing care for staff. We are trained to mind everybody else, but we don't necessarily include ourselves in the list. The second relates to how we look after the staff we work with: check in with them, see how they're getting on. Much of our stress can come from family. When we stop and ask how someone is, it can make a huge difference to them as an individual. It doesn't improve the quality or carving of a restoration nor change the cost of the electricity bill, but it makes a huge difference to their mental health and well-being".

If needed, the Practitioner Health Matters Programme is available, as well as the Dental Benevolent Society to support dentists navigating the many stresses that Covid has imposed. Anne reminds members to engage more with the IDA, be that through the website, branches, committees, and the Council in particular. Each member has a voice and if they communicate with the IDA, the Association can then build their individual concerns into action: "We've been using surveys recently because with Covid it's very hard to do face-to-face contact. We're getting some response to those, but we could do with more. It takes five minutes to answer a set of questions, and that's an easy way for members to give us direction that we will then incorporate into our advocacy on their behalf. We're advocating hard on behalf of the patient and the profession the whole time. It's very hard to advocate against a system that has selective deafness, but we will keep advocating".

Driving back into the IDA

Anne got back to being very active in the IDA only in the last few years: "When you've a small person in the house who needs to be both dropped and collected from school, and they expect mammy to do everything for them, you don't have much time, so I was less active during the mammy phase. But as they get older and their only need is a taxi driver, you get some of your own time back". Outside of dentistry Anne lives with her husband Richard and daughter Megan. She is an avid choral singer and knitter: "Besides doing some choral singing, some knitting, being the taxi driver for those who are not old enough to drive themselves, and working full time, that's probably about as much time as there is time in the day. Singing is something I've kept up from college and brought with me. It's a great way of meeting people if you go to a new place but unfortunately, it's not an avenue that's open to us at the moment, so I'll have to rely on the needles!"

Postgraduate certificate in orofacial pain

Dr Dermot Canavan, Joint Director, Certificate in Orofacial Pain.

The Dublin Dental University Hospital (DDUH) is offering a new online Postgraduate Certificate in Orofacial Pain. It is the first postgraduate certificate in a dental discipline that the DDUH has offered online and the first such qualification to be taught jointly by two universities – Trinity College Dublin (TCD) and the University of Southern California (USC). Students will be able to log in from anywhere to tutors who will be based in Dublin and California. Prof. Glenn Clarke of USC, world-renowned researcher in orofacial pain, is a joint course director, along with Drs Dermot Canavan and Philip Hardy of TCD. Speaking to the *Journal*, Dr Canavan said: "The course will focus on problems that general dental practitioners in both private and public practice come across regularly, but which are not routinely covered in undergraduate programmes. Dentists who complete this course will have a much better knowledge of how to deal with these problems. Additionally, they will, if they wish, be able to go on to complete an MSc in orofacial pain through USC". The first course starts in January 2021 and interested parties should contact the DDUH immediately.

HIQA's radiation webinars

Dr Jane Renehan, left, of Dental Compliance Ltd reminds dentists of the key take-home messages from the Health Information and Quality Authority's (HIQA) recent radiation webinars (September 2020) on upcoming self-assessment and inspection processes in the dental sector. HIQA informed dentists that it is currently rolling out a programme to regulate radiation in the dental sector starting with CBCT installations in quarter four, 2020, and in the following months inspectors will be assessing radiation in general dental practice. The first steps in this process will be a self-assessment questionnaire (SAQ) to dentists assessing their regulatory compliance. HIQA is setting up a portal system to facilitate communications via a reliable electronic-based process. During the webinar, HIQA acknowledged that dental exposures are generally seen as low risk but new technology, e.g., CBCT, may pose an increased risk for patients.

As the programme rolls out, most inspections will be announced with a 10-day notification being emailed to the designated manager and copied to the practice (legally known as the 'Undertaking', which carries legal responsibilities). Following the inspection visit, a draft report will be sent to the practice for feedback response within a tight timeframe. The final report will be published with public access on the HIQA website. It is a regulatory requirement to provide information to HIQA, which has enforcement powers of compliance notices and prohibition orders (cessation of practice).

All dentists should be familiar with HIQA's 50-page 'Guide to the inspection of dental services providing medical exposure to ionising radiation', which is available on the HIQA website. Dental Compliance Ltd offers an advisory programme and training for dentists who require support with their regulation and compliance concerns.

Full virucidal activity demonstrated with DAC Universal

Dentsply Sirona states that the full virucidal activity of the DAC Universal range of products, which reprocess dental instruments, was demonstrated in a lab study by the independent accredited test lab HygCen Germany. The test was performed in accordance with EN 17111 with temperature-resistant parvoviruses.

According to the company, after completing the reprocessing, including cleaning, lubrication, thermal disinfection and cooling, no murine parvovirus could be detected in the eluate of the test pieces. Dentsply Sirona states that this confirmation of full virucidal activity is an official demonstration that DAC Universal devices have the highest possible efficacy level and thus the maximum safety for the reprocessing of straight and contra-angle handpieces and turbines.

The company states that the results showed that DAC Universal exceeded the required safety for the determination of the full virucidal activity, by reducing temperature-resistant parvoviruses. Furthermore, according to Dentsply, after carrying out complete reprocessing, no parvovirus in sufficient numbers could be detected.

Property and pension service

Omega Financial and property advisors Knight Frank have teamed up to provide a bespoke property and pensions service for medical professionals. Omega states that the collaboration with Knight Frank will provide a holistic service to clients wishing to purchase an investment property in their pension. According to Omega, their dentist clients have little time to prepare themselves properly for retirement financially. Omega states that this is the first time that all of the needs of the investor can be taken care of, from advice on the eligibility of the pension itself, to the selection of the property and the subsequent management of the property if required. According to the company, it means that clients can make the decision to invest in property and be given options to choose from without having to research property sites and attend multiple viewings. Removing the search process will make property/pension investing a much more realistic possibility for extremely busy dentists, according to Omega.

The company goes on to explain that the new service simplifies the process into three stages. Omega will review your pension arrangements with its dental profession-specific knowledge in mind, including private arrangements and/or HSE entitlements. As part of this stage, the company can discuss investment options and whether appropriate property investment is for you. The next stage includes structuring your pension to ensure that it works for this form of investment.

Omega states that it then works closely with Knight Frank to develop suitable property options for your circumstances. According to Omega, Knight Frank's comprehensive market knowledge and property search expertise ensures that you will be presented with the best selection for your requirements. The service continues through the selection and purchase process. Knight Frank also offers management of the property throughout its rental lifetime, offering clients a complete outsourcing option.

Quintess Denta launches PPE website

The Quintess Denta team (from left): Ian Creighton; Elaine Bailey; Noelle Doherty; and, Kieran Keown.

Quintess Denta has launched a new business in the supply of personal protection equipment (PPE): . According to the company, all products are CE certified and test approved. The PPE product range includes:

- medical disposable masks, including IIR, FFP2 and FFP3;
- face fit test kits;
- protective clothing, including gowns and hats (disposable and reusable), nitrile gloves EN455 medical grade, shoe covers and aprons;
- face visors, loupes-friendly face shields and goggles;
- branded floor-standing and countertop sanitiser stations;
- automatic sanitiser dispensers and all bottle sizes of liquid and gel sanitiser;
- disinfectant wipes;
- sneeze screens and welfare products;
- infrared thermometers; and,
- Jade medical grade air purifier units.

Biofilm control from Colgate

Colgate states that its new Colgate Total toothpaste with zinc and arginine can help to achieve superior biofilm control. According to the company, the toothpaste does this in three steps. Firstly, it penetrates into the biofilm to deposit a high concentration of zinc. According to the company, the toothpaste then breaks down the biofilm and reduces biomass. Finally, Colgate states that the product offers biofilm inhibition for 12 hours and calls it the next generation of biofilm control.

New dental recruitment website

James Parish, above, a graduate of Queen's University Belfast, has created a new company he states will improve dental recruitment in Ireland. A former winner of the Leo Heslin Memorial Medal, James currently works as an implant dentist here in Ireland. He previously worked in Cheltenham and Bristol, where he studied for his MSc in dental implants. When he returned from England, he found it difficult to find a suitable job. Despite being well qualified and experienced, James states he found it hard to connect with recruiting practices and decided to work in a hospital for a year before settling into his current practice. It was his initial experience of recruitment in Ireland that prompted him to set up Dental Jobs Online.

James remarks: "I felt that recruitment in Ireland was difficult for both recruiting practices and for dental jobseekers, and that it didn't need to be this way. Dental Jobs Online has been created to make recruiting in Ireland effective, simple and affordable".

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Avoiding dental anxiety traps

Dental phobia affects about 4% of the population, while dental anxiety affects one in five.[1,2] Our dental professions can profoundly help these people. However, our professions also have the power to profoundly wound them, with indifference and inconsideration. We have all heard of the 'the butcher' dentist in our patients' stories. Of course, in the stories that each of us hear, this character is always played by another dentist. But if you really think about it, many of us must have featured in stories told in other clinics. This is, of course, not to say that we are deserving of this inglorious position. Perhaps we are remembered unfairly? After all, the stories of dentists having a knee on a patient's chest are ergonomically questionable. However, we need to recognise that dental anxiety promotes the construction of such memories, among many other negative outcomes. Regardless of historical fact, the distress that such memories bring is real and crippling. Dental anxiety also breeds catastrophisation and causes exaggerated, but actual, increases in pain. These real-life implications are deserving of both our consideration and our respect.

In this clinical feature, we share advice on how to avoid four common traps that lie before dental professionals when treating people with severe dental anxiety so we can avoid becoming the protagonist in future stories.

Table 1: Delivering the right message to patients.

Patient feedback	Suggestion
"I felt like I was in control"	Let the patient feel that they are in control. Let the patient select certain aspects of care: the seat they sit on, the dentist they see, the use of probes, the use of 3 in 1, etc.
"When you are so afraid, being listened to and heard is critical"	Give assurance that you will listen and be responsive. Then listen and be responsive. This means that if the patient puts a hand up to stop, you stop immediately. This builds trust. This tells the patient that they are the boss here and we will listen.
"I would have worried about being judged about my teeth and then with the overall treatment process, my pain threshold would be zero"	Lectures don't work. They reinforce all the negative cognitions, emotions and behaviours that we are trying to address. Send the message that: "You will not be judged here". It's much better to get patients on side by offering understanding, support and hope. Something like: "I'm sure it's a big deal for you coming in today after that length of time. Well done for starting the process" is much more constructive than "Oh no! You should have come sooner".
"I found his empathy to be immediately obvious. You can tell that he takes genuine care of his patients, and I found the approach to be respectful of both my dental and mental well-being. I didn't feel like the fool I usually felt and I felt my fears were actively listened to"	This patient's response would have been impossible if we had started with a typical 30-minute assessment. Show that you genuinely care by giving a longer appointment so you do not become anxious yourself. This will avoid escalation of your patient's emotional response and give you that crucial extra 15 minutes to address the anxiety. This cannot be rushed.

TRAP 1: Not setting the team's expectations

It can be difficult to keep our cool when under extreme pressure. While our responses are mostly rational and help keep us safe, sometimes they are out of kilter. Just like our reactions to threat, patients with dental anxiety may naturally react to dental encounters with 'fight or flight'. So when an anxious patient seems irrationally 'needy' or argumentative (fight), or cancels last minute (flight), we need to understand that this is simply the physiology of fear and not a purposeful or intentional trespass! The team's natural responses to such interactions tend to be negative by meeting emotion with emotion (fight) or begrudging the lost clinical capacity (flight).

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Table 2: What to ask anxious patients and why.

Question	Rationale
If you could magically decide on the best way for this visit/treatment to go, what would that look like?	The patient is the best person to decide how they want their care. Listening to their wishes empowers them hugely. It also lets the practitioner understand expectations, and supports planning of what adjuncts are needed. Take this time to get to know their concerns, triggers, priorities, goals. Realise that they are telling you how they would (and would not) like to be treated.
How urgent do you think your treatment need is?	Urgency of treatment need lets the clinician understand the patient's experience of their current status. It also helps plan timelines. If a patient is in pain now, a course of psychological treatment is not a realistic option for that problem and sedation/general anaesthesia may be considered.
Measurement of dental anxiety	Anxiety measurement is a must for appropriate dental anxiety screening, diagnosis and baseline measurement. It also helps to identify specific aspects of dental care that are problematic. The Modified Dental Anxiety Scale (MDAS) is commonly used for this purpose. It is simple, quick, reliable and valid. The MDAS score provides valuable insight to decide whether we can manage the patient in the practice or if additional specialist services are required. It is best for both dentist and patient if the right call is made early in the process. You can download MDAS forms in English and as Gaeilge at: https://www.st-andrews.ac.uk/dentalanxiety/faq/.
Out of ten, how anxious are you now?	This introduces the idea of self-monitoring the level of anxiety. It is useful as a baseline if the question is repeated later in the appointment and over the course of treatment. It's also a useful concept if you are planning to demonstrate the patient's ability to lower their level of anxiety through relaxation or distraction.
Can I ask why you are nervous of the dentist?	The answer to this question lets us further our therapeutic rapport. Some patients may not want to share and that is fine. Remember that we are not there to explore childhoods or interpret dreams unless you are thus qualified and inclined. Ask why the patient is phobic, listen and acknowledge. It is not a time to fact check or investigate, just understand, empathise and reassure.
Are you interested in finding out more about dental anxiety/phobia?	People with dental anxiety are generally very rational people who are keen to explore their emotions and beliefs with a good grasp of evidence. In our experience, we find talking abstractly about concepts and evidence of fear and phobia helpful. This involves giving the patient a description of the fear response, usually with analogies to fear in other mammals and the development of avoidance behaviour. We then introduce research around generalisation and extinction of fear before some reflection on cognitions. If this is outside your skillset, research the Little Albert experiments. We talk about him a lot with our patients to introduce a proof of concept that fears can be overcome. Why not ask your patients if they are interested in learning about this? It may also reassure them that you understand the phenomena that they experience and their veracity.
When you were at previous dentists: 1. What did not work well? 2. What worked well?	This gives further opportunity to the patient to have control in their treatment. Often they will say that they were not listened to or were made to feel ashamed. The second question encourages the patient to construct and verbalise what has worked for them and therefore ask what will work well for them again?

One crucial feature of fear response that is often overlooked is its crippling effect on communication. Patients may come across as inattentive, rude or short. If our whole team understands that this is a fear response rather than an intention, it takes away a lot of the negative emotion that these interactions elicit.

Our advice is to have a team discussion about intention and reaction so everyone, especially the person answering the phones, understands that anxious patients do not choose their responses, rather they suffer them. Merely phoning to make a dental appointment can be the equivalent of a rollercoaster ride for people with dental phobia. They are facing physiological and psychological challenges that demand understanding and patience from the whole team. Simply having this discussion can make dental anxiety encounters so much better for the team and patients. It lets the team understand how they can be proactive in supporting patients with dental anxiety. When will you have yours?

TRAP 2: Not sending the right message

The team must be conscious of the message that patients may take from their interactions. Patients can be reassured with the right message. These messages can be generic like: 'You are in control' or 'You are in the right place'. When done well, we can meet the patient's specific needs so they can see and feel that their issue has been addressed. If you are unsure of the patient's specific needs, ask. This information is gold dust. **Table 1** summarises actual feedback from patients who felt their specific needs were met, with suggestions for how to elicit this experience.

TRAP 3: Avoiding the issue

In general, anxious patients will benefit greatly from knowing that we recognise their fear and take it seriously. Opening a conversation is key. This lets patients know we take their concerns seriously. It lets them share their needs and preferences, shaping our response. However, it can be difficult to know how to elicit this information and build rapport. We share the questions we ask our dentally anxious patients in **Table 2** to help. You can copy and paste these six questions into your dental anxiety interview.

TRAP 4: Not reacting proportionately

Dental anxiety is not uniform in aetiology, presentation or severity. Rather, it represents a spectrum, particularly regarding severity. It is crucial to get a

sense of how anxious a patient is. This can easily be quantified using the MDAS score. Newton's article can help you to find out how.[3] Patients should be treated proportionally to their level of anxiety: mild, moderate or severe. Patients with mild anxiety can be supported using relaxation and distraction-based techniques, among others. These are easily provided by general dentists. People with higher levels of anxiety will more likely need pharmacological or psychological intervention.

Cognitive behavioural therapy (CBT) is a talking therapy provided by psychologists or trained dental professionals. Studies have shown substantial rates of reduction in dental anxiety resulting in long-term benefits.[4] There is no doubt that this multidisciplinary approach should be utilised a lot more than it currently is. If you search for CBT therapists in your area you will find them. Why not drop them a line? Wouldn't it be wonderful to offer a successful outlet to that group of phobic patients whose oral care is otherwise so unpredictable?

Sedation and general anaesthesia are alternative options that are suitable for urgent care and high treatment needs in patients with high levels of dental anxiety. Their down side is that they fail to actually 'fix' the problem and are probably best considered a work around rather than a solution. Having said that, access to such services is crucial so ensure that you are appropriately endowed with access to these vital options.

Conclusion

Treating people with dental anxiety presents many challenges. However, if managed effectively there are many positives – this group has high treatment need, is incredibly loyal, acts as a practice builder and provides powerful testimonials. Above all, there is no greater professional satisfaction than observing the gradual transformation of a person's whole life simply by overcoming severe dental anxiety. Try it!

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MEMBERS' NEWS

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Dentists were asked to estimate the increase in their day-to-day operating costs as a result of Covid-19, and 50% put that increase at between 30% and 50%.

Pre-Budget submission

In its pre-Budget submission, the Association has called for urgent Government action in Budget 2021 to address the ongoing crises that exist around capacity and resourcing in dentistry so that all patients can be supported.

Fiona Houlihan, Chief Executive of the IDA, said that the Government could no longer afford to delay its response to the dentistry crisis, given the

Private out-of-pocket payments account for 83% of all monies spent on dental care, with State-provided or funded dental services accounting for just 14%. The Central Statistics Office (CSO) Survey on Income and Living Conditions (2017) shows that 32.5% of households with children, where at least one person in the household had a dental examination and/or treatment in the last 12 months, reported that the associated costs were a "financial burden".

The way forward for the IDA and dentistry

The 2020 IDA AGM was a historic occasion for a number of reasons.

New President Dr Anne O'Neill with outgoing President Prof. Leo Stassen.

The IDA's 2020 AGM was hosted with a hybrid model featuring live presentations from IDA House and with over 80 members joining online, raising questions and voting on motions using the Zoom social media platform.

Dr Anne O'Neill was appointed as President of the Association. Dr O'Neill addressed the AGM, as did outgoing President Prof. Leo Stassen, and Association CEO Fintan Hourihan.

Positive engagement

In her address, Dr Anne O'Neill spoke about the development of the DTSS, and reflected on her Covid-19 experience as a member of the Association's Management Committee.

I am also looking forward to building positive engagement and negotiation with the Department of Health because there is no doubt that just like so many aspects of healthcare, the new Oral Health Policy cannot withstand the impact of Covid-19.

"Patients deserve care pathways that support oral health; dentists deserve to spend their time providing care, not telling patients why they can't.

Dr Anne O'Neill

The AGM in full swing via Zoom with, from left, Dr Anne O'Neill, President; President Elect, Dr Clodagh McAllister; Vice President, Prof. Leo Stassen; Honorary Treasurer, Mr Andrew Norris and; Chief Executive Fintan Hourihan.

"One of the aspects of IDA membership we have not been able to reconfigure is the social interaction that is part and parcel of our meetings. One of our strategic ambitions to be one of the key sources of continuing professional development for dentists in Ireland can be enabled in part on digital platforms, (and I thank the CPD committee and IDA staff who have been tireless in pursuing that). But we also need to focus on how we might enable interpersonal contact in a time of social distancing so that no member is left feeling that they are quite alone."

"We have felt let down, angry and disappointed by many, and rightly so, but as professionals we must remain above that 'damaging rhetoric', and advocate for what we believe to be the right way forward for dentistry.

"2020 is not the time for the demanding and argumentative negotiator: it is the time for the negotiator with the accurate facts, the research, the reasoned argument, and the willingness to listen, but to demand what is right and correct for the standard of dentistry/oral health that we would expect for ourselves and our families."

Ambitious plans

In his address, IDA CEO Fintan Hourihan discussed the Association's five-year plan, and said that the State must recognise that it has failed in its responsibility to promote better oral health.

"The advances we have seen are entirely due to the efforts of our members in all branches of dentistry: in general practice, specialist practice, public service and academic dentistry.

"The State has to recognise that only by recognising and working with the Association can it hope to achieve the ambitious goals it has set out in its oral health policy. As an Association we will face many challenges too in engaging with the State, but with your support I have no doubt but we will succeed.

"Just prior to the pandemic, the Association published an ambitious five-year strategic plan and that, of course, will need to be revisited. Action plans for each of the five years will need to be prepared and, only to take account of the original plan, but also of the new circumstances and, sadly, a heavily

Indemnity beyond September 2020

As the Dental Council is consulting on the arrangements dentists should have in place to protect themselves against claims and cases, Dental Protection discusses the differences between discretionary indemnity and insurance.

The relative merits of discretionary indemnity and insurance might not be an issue that dentists spend a lot of time deliberating, particularly at a time when they are working hard to resume patient care as much as possible while sustaining their practice. However, with the Dental Council currently consulting on what arrangements dentists should have in place, some dental professionals have been interested to learn more about indemnity, insurance, and the factors to consider to ensure that they have the right protection for them.

Types of organisation that provide indemnity

Traditionally, the majority of dentists in Ireland have been indemnified by a mutual indemnity organisation. Dental Protection, as part of MPS, has remained a steady and trusted partner for dentists in Ireland for many years, with the assistance and protection provided for members based on mutual discretionary indemnity.

Members of Dental Protection are part of a mutual organisation that they collectively own. Members pay subscriptions that go into a central pool. If they face a complaint, claim, regulatory investigation or any other matter, members have a right to request assistance from this central pool.

As the organisation is owned by members, the default position is to see how the member seeking assistance can be helped. Once a request for assistance is approved, an experienced team of dento-legal consultants and lawyers can then offer the right level of assistance without being restricted by small print, financial caps or exclusion clauses.

This is different to insurance companies, where the dentist has a contract of insurance, which specifies what protection the insurance company will and will not provide, along with details of any exclusions and caps.

Dr Helen Kaney
BDS LLB Dip LP MBA FFGDP (UK) FFFLM

Helen is the Team Lead for Medico and Dento Legal Services, MPS

Personal experience

I am in the slightly unique position of having worked for both an insurance company and now a discretionary indemnity provider.

I worked for The St Paul International Insurance Company Limited ('The St Paul')[1] as a dento-legal adviser in the UK from 1999 to 2001. The St Paul saw the clinical indemnity market in the UK as an attractive business, which is how insurance companies as commercial organisations must think, and they provided cover to UK doctors and dentists on a claims-made basis.

For the avoidance of doubt, I have absolutely nothing against insurance companies and, like everyone else, have several insurance policies to cover many of the usual risks in life. However, The St Paul pulled out of the UK indemnity market in 2001 after only two years. This left their insured UK dentists scrambling for indemnity cover and many decided to become members of Dental Protection.

Reliability, responsiveness and quality

The first consideration for many is whether protection will be available when you need it. Members of Dental Protection are part of an organisation, the default position of which is to always consider how they can help to protect you. Dental Protection has been operating in Ireland for over 100 years, and in the past 12 months has said yes to 100% of requests for assistance from dental professionals in Ireland that met the basic qualifying criteria. The organisation has been there for members on each occasion – provided the individual was a member at the time of the incident, indemnified for the type of work or procedures that were the subject of the complaint or claim, and the request was within the scope of the benefits of membership.

By way of contrast, an insurance contract clearly specifies when the insurance company will step in to support and when it will not. It is important to check the fine print of some insurance policies and consider whether there are financial limits, or caps, imposed. For example, a Dental Council fitness to practise investigation can easily cost in excess of €50,000 in legal fees,

depending on the nature of the case. Some insurers have financial limits on such legal costs as well as imposing significant excesses, which could mean that an individual has to fund some of their own legal costs or risk being unrepresented before the regulator, which is obviously far from ideal. The experience of Dental Protection is that those who have representation before professional regulators obtain better outcomes than those who do not.[2] It is in your best interests to check the extent to which your provider will help with matters such as complaints or disciplinary procedures.

A further consideration is whether your protection will be responsive to your needs. Discretionary indemnity has always been considered more flexible and responsive, since the scope of assistance offered to the member can be wider than the precise policy wording of contractual insurance. Discretionary indemnity allows Dental Protection to respond to changes in the dentolegal environment and assist members with emerging risks that may not have been foreseen at the time membership was taken out. This is especially important when new challenges arise, as has been the case during this pandemic.

Dentists also need to be assured of the quality of the support they will receive. Dental Protection has a long history of providing an excellent quality of service to members, with experienced dento-legal consultants and lawyers available to advise, guide and support members when they are facing the most stressful situations in their professional lives. Not all indemnity providers provide the same level of service and assistance, and no other organisation has our experience in managing dental claims. Dental Protection has the largest team of experienced dento-legal consultants of any indemnity provider in Ireland, and indeed internationally, and a member can speak with a dento-legal consultant whenever they need to. Our legal and professional expertise can ensure that your issues are resolved as quickly as possible, with the least upheaval and impact on your career and professional reputation.

Financial strength and longevity

It is, of course, vital that an indemnifier is in a strong financial position and has a long-term commitment to protecting members. The good news for Dental Protection members is that MPS is in a strong position to provide financial security.[3] Data published by Dental Protection[4] revealed that almost 40% of its estimated annual claims costs in the UK in 2018 related to cases where treatment started ten or more years before the claim was made. Claims are increasingly being made in the UK for larger amounts, often in excess of £100K. In general terms, in Ireland, the amount of damages awarded to patients is much higher than comparable awards in the UK. Therefore, for an indemnifier, both financial security and longevity are vital, so it is important to consider how likely it is that your indemnity provider will be here for you for the long term.

Who takes the risk – you or the indemnity provider?

Dentists need to understand whether their protection is 'occurrence based' or 'claims made', and what extra steps you might need to take if you opt for the latter. Both the subscription charged by mutual organisations and the premiums charged by insurance companies are analysed and decided upon by actuaries, based on the risk to the mutual fund or reserves of the organisation concerned.

With occurrence-based indemnity, the responsibility for any future risk lies with the indemnity provider, who ensures that the subscriptions collected today are sufficient to ensure that the organisation will be there when needed, to help members in perhaps 10, 15 or 25 years' time.

With claims-made insurance, the extent to which risk is carried into the future depends on whether the dental professional can secure run-off or 'tail' cover when they end their policy or membership, retire or leave the profession. Therefore, claims-made policies do not need this element of future risk priced into their premiums, which is why they may appear more affordable in the short term.

If not offered or able to purchase the necessary run-off cover, an individual with a claims-made policy has no protection in place if a claim later arises, and the incident that gave rise to the claim was not reported in accordance with the terms of the policy. The individual would only be covered if they have separately purchased another insurance policy with a retroactive date spanning that time frame.

With occurrence-based indemnity, any incident that arises from the time they are with their indemnity provider – even if the claim is raised years later – is indemnified in perpetuity. Claims against dentists are arising in the UK 15 or even 20 years after the clinical care was provided and the same could happen in Ireland in future. A run-off period of any less than these time frames will not protect a dentist in the event of a clinical negligence claim being made many years in the future. It should also be noted that there is often a need with claims-made insurance for 'incidents' to be reported within specific time frames, but what constitutes an 'incident' can be open to interpretation in dental claims.

For all of these reasons, many dentists prefer the occurrence-based indemnity that Dental Protection currently provides.

Final considerations

With dentists facing significant financial pressures due to Covid-19, Dental Protection has recently been able to pay the equivalent of two months' subscription fees back to members, as well as enabling members to adapt their membership to reflect the changing level of work they are doing. It is unclear whether insurance companies, due to the contractual and capital restrictions in place that form their relationship with dentists, could be as supportive or flexible. Where others may only provide help with claims, we offer far more – including assistance with dento-legal and ethical advice, patient complaints, disciplinary procedures, inquests, regulatory matters and media advice.

Ultimately, the decision on whether to choose discretionary indemnity or insurance, occurrence-based or claims-made protection, rests on your individual circumstances. The indemnity provider or insurer that you opt for should be able to explain how they will protect you. Dental Protection would be more than happy to answer any questions you might have that are not addressed in this article.

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Training for dental professionals improves confidence in managing patients with dental anxiety in Ireland

Précis

Reducing barriers to oral care for patients with dental anxiety in Ireland.

Abstract

Statement of the problem: Dental anxiety is common and its impact can be profound. Dental professionals may lack training and confidence to support patients with dental anxiety. In 2017, an educational intervention was provided to dental care professionals designed to improve participants' management of adults and children with dental anxiety. The aim of this study was to measure the impact of the intervention on participants' confidence in managing patients with varying levels of dental anxiety.

Methods: Dentists and dental care professionals were invited to participate in a bespoke training day on dental anxiety management. Self-administered questionnaires were completed immediately before and immediately after the educational intervention. Respondents scored their level of confidence in managing patients who are anxious about dental treatment before and after training using a visual analogue scale. Differences were tested using Student's t-test.

Results: Fifty-seven participants responded (RR=73.1%). Participants were predominantly female (n=52, 91.8%) and reported seeing a median of 12, 10 and two patients with mild, moderate and severe dental anxiety, respectively, per week. Paired data were available for 40 participants regarding mildly and moderately anxious patients, and for 39 respondents for severely anxious patients. Mean confidence scores increased from pre to post training, increasing by 9.1%, 11.9% and 25.1% for management of patients with mild, moderate and severe dental anxiety, respectively ($p<0.01$).

Conclusions: Training was effective in improving confidence among dental professionals regarding the treatment of patients with mild, moderate and severe dental anxiety. Participants highlighted barriers to oral healthcare for patients with dental anxiety.

Key words: Dental anxiety, confidence, training, evaluation

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Introduction

For some people, dentistry can be the stuff of nightmares. For those people, dental anxiety is a general term often used to describe their fear, anxiety and phobia.[1-3] High levels of dental anxiety affect between 10 and 30% of the population worldwide.[1,4] In Ireland about 20% of the population report dental anxiety.[5,6] Dental anxiety promotes a vicious cycle of avoidance of dental visits and associated deterioration in oral health. This ultimately leads to symptom-driven attendance, negative experiences and further avoidance. These experiences affirm negative cognitions and reinforce anxiety.[7,8] Therefore, people with dental anxiety are less likely to attend for routine care and are more likely to have oral disease.[9] Psychologically, people who experience significant dental anxiety report negative experiences at the dentist[10] and increased experience of pain.[11] The impact of this fear can be profound, affecting people in ways that reach far beyond dental visits and oral health.[12,13]

Dental anxiety holds a unique position of significance for the dental profession because of its prevalence and potential negative impact on the public. Dental professionals could make a holistic impact at a population and individual level through the prevention, diagnosis and management of dental anxiety. However, dental anxiety is seldom given adequate coverage in dental education and practising dentists often feel inadequately prepared.[14,15] Deficiencies of this kind have a role in initiating and perpetuating dental anxiety. If dental professionals were better trained about this phenomenon, they could avoid precipitating such anxieties,[16] identify those at risk of and suffering from dental anxiety, and support these patients appropriately.[17] They could also provide appropriate care to people with dental anxiety and recognise appropriate referral processes.[18] This has the potential to decrease reliance on restrictive supports such as sedation and increase patients' opportunity to learn coping skills. This would ensure a better experience of and outcomes from dental care for those with dental anxiety.

In recognition of a training need, the Irish Society for Disability and Oral Health facilitated a continuing professional education day in managing patients with dental anxiety for Irish dental professionals. This was the first such training day in Ireland, where there is no care pathway for management of dental anxiety. The aim of this study was to measure the effect of this training. The specific research question was: is there a change in trainees' confidence scores from before to immediately after an educational intervention designed to improve trainees' confidence in managing patients with dental anxiety?

Materials and methods

Design

This study adopted a simple pre-/post-training survey design. Surveys were completed anonymously immediately before and after a one-day training programme. Ethical approval was received from Trinity College Dublin.

Sample

An exhaustive convenience sample of attendees at the annual Summer Conference of the Irish Society for Disability and Oral Health in Dublin in 2017 was obtained for this study. This sample included dentists and dental care professionals.

Intervention

Training was developed by a team of experts in King's College London to meet the specific needs of dental teams who wish to support adults and children with dental anxiety in an Irish context. The aim of the day-long training programme was to enable dental teams to plan, implement and evaluate methods to assess and treat patients with dental anxiety. Participants were first introduced to basic concepts of dental anxiety and psychological supports for both adults and children. Applied techniques to assess dental anxiety were then taught with emphasis on measurement of anxiety using scales. Management techniques were taught including distraction, relaxation, control giving, muscle tension techniques and systematic desensitisation. Following this, groups practiced these skills via case-based learning before reviewing learning. Finally, attendees developed individual plans describing how they would implement and evaluate the learning in their practice. Learning outcomes for the day are summarised in **Table 1**. This study summarises elements of the evaluation of this training.

Table 1: Learning outcomes for the training day.

By the end of the session participants will be able to:

- apply methods for assessing dental anxiety among phobic and non-phobic patients;
- apply techniques for alleviating dental anxiety;
- outline the appropriateness and effectiveness of different techniques for alleviating dental anxiety;
- write a plan for implementing behavioural and cognitive techniques for alleviating dental anxiety in their practice; and,
- write a plan for monitoring the implementation of behavioural and cognitive techniques for alleviating dental anxiety in their practice.

Data collection

Self-administered questionnaires were completed immediately before and after the educational intervention. Recruitment was undertaken at online registration (www.isdh.ie). All registrants were advised of the intention to evaluate the impact of the intervention. Immediately prior to the commencement of training, the purpose of the study, details of anonymity, data storage, and the right not to take part were discussed. Participant information leaflets were also supplied. Attendees were given time to complete the pre-training survey at the start of the day. At the end of the session, attendees were given time to complete the post-training survey. All documents were anonymised.

Data analysis

Population demographics were presented using counts and proportions. Respondents were asked to score their level of confidence in managing patients who are anxious about dental treatment before and after training using a visual analogue scale. Difference in confidence scores were tested adopting related samples Student's t-test.

Results

Sample demographics

Fifty-seven out of 78 participants responded to the survey, giving a response rate of 73.1%. Most attendees were female (n=52, 91.8%). Fifty-four (94.8%)

participants practised in Ireland and three practised further afield. Attendees had qualified on average 16 years earlier (median=16; SD=9.5), with a range from 37 years to one year qualified. Respondents reported a mean of 32.2 hours at clinical practice per week (SD=8.9) and on average worked alongside four dentists in their practice (median=4, range 1-40 dentists). As **Table 2** demonstrates, a range of dental professionals attended, with most being dentists in public dental services. Attendees saw a range of adults and children with dental anxiety and disabilities.

Respondents reported seeing a median of 12 patients with mild dental anxiety (range 100-0), 10 with moderate dental anxiety (range 40-0) and two with severe dental anxiety (range 20-0) per week. Thirty-five (71.2%) assessed anxiety, but only 17.9% reported adopting a specific measurement of dental anxiety. Most attendees reported that they usually treat patients with dental anxiety rather than refer (**Table 2**).

Change in confidence

Figure 1 demonstrates mean levels of confidence (and 95% confidence intervals) as scored by respondents when asked how they would rank their level of confidence in managing patients who are mildly, moderately and severely anxious about dental treatment before (pre) and immediately after (post) training. Paired data were available for 40 participants regarding mildly and moderately anxious patients, and for 39 respondents for severely anxious patients. Mean confidence scores increased regarding all groups of patients from pre to post training. Mean confidence score increased by 9.1%, 11.9% and 25.1% for management of patients with mild, moderate, severe dental anxiety, respectively, from before to after training. These differences, when tested in separate paired t-tests, were statistically significant ($p<0.01$).

Perceived barriers

Cost, either to patients or to health services, was the most commonly perceived (n=15) barrier to dental treatment for people with dental phobia. This was followed by: time (n=13); lack of integrated services including referral processes and the availability of cognitive behavioural therapy (CBT) and sedation services (n=10); and, lack of training to manage dental anxiety (n=8).

Discussion

Summary of findings

This study demonstrates that bespoke training in the assessment and management of dental anxiety was effective in improving the confidence of dental professionals who treat anxious patients in supporting those with mild, moderate and severe dental anxiety. The effect of training seemed to increase with increasing anxiety, meaning that the greatest increase in confidence was reported for managing patients with higher levels of anxiety. Participants suggested that dental services for people with dental anxiety could be improved through improved funding, time allocation, training and care pathways that include dedicated sedation and psychological services.

Weaknesses of this study

There are a number of weaknesses relating to this study that readers should consider when interpreting these results. Firstly, the purpose of this intervention was to upskill dental teams, thereby leading to improved access and support for patients who experience dental anxiety. However, the assessment only measured confidence and not behaviour intention, behaviour,

Table 2: Professional details and behaviour.

	N	% (valid)
Professional status[a]		
Dental nurse	8	14.3%
Dental hygienist	5	8.9%
General dentist in private practice	7	12.5%
General dentist in HSE	26	46.4%
Specialist dentist or trainee	8	14.3%
Practice type[b]		
Public	43	76.8%
Private	12	21.4%
Patient group[c]		
Adults with dental anxiety	16	28.1%
Adults with disability	16	28.1%
Children with dental anxiety	22	38.6%
Children with disability	21	36.8%
Other	12	22.2%
Treat/refer[d]		
Treat	51	89.5%
Refer	6	10.5%
Assessment of anxiety[e]		
Yes, for all patients	22	38.6%
Yes, only for those we suspect are phobic	19	33.3%
No	16	28.1%
Specific anxiety measurement used[f]		
Yes	10	17.9%
No	46	82.1%

a Two participants (3.6%) reported other;
b One participant (1.8%) reported other;
c Which of the following groups do you mainly work with? Multiple response options allowed;
d Does your team usually treat patients who are anxious about dental treatment yourselves or do you refer them?;
e Does your team assess the level of your patients' anxiety?;
f n=56.

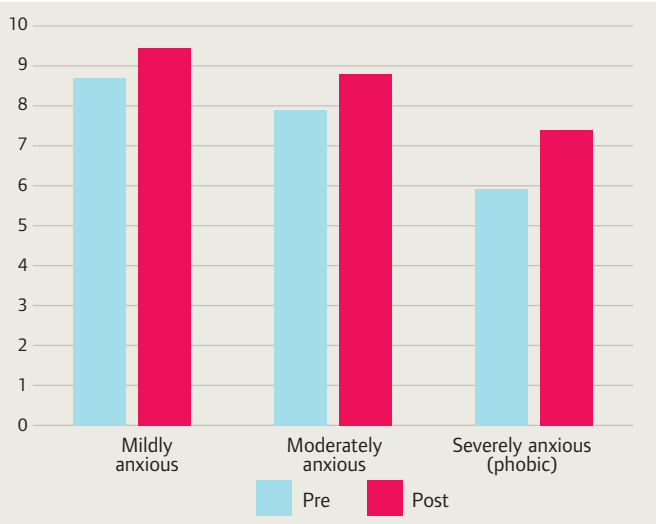

FIGURE 1: Confidence managing patients with differing levels of anxiety.

Mean difference mildly anxious 0.79 (95% CI 1.15-0.42); mean difference moderately anxious 0.94 (95%CI 1.39-0.49); mean difference severely anxious (phobic) 1.49 (95%CI 2.10-0.92).

access or patient experience. Nevertheless, confidence itself is important, because a lack of confidence is a barrier that prevents dentists from treating people with dental anxiety.[15] In our study, confidence was only measured immediately after training and it is unclear how this relates to confidence into the future. One Swedish study suggests that dentists who had training in dental fear as postgraduate students were more likely to be confident managing such patients afterwards, so we can be hopeful that such changes may persist.[19] It is fair to say that this study may best be considered as a proof of concept study for this type of training rather than a proof of effect. In essence, this study demonstrates that training could have, rather than does have, an impact for anxious patients.

Implications

This study demonstrates that continuing education may be effective in improving confidence of practitioners in managing patients with dental anxiety, but much more is needed. As a start, evidence-based models for undergraduate training should be delivered.[20] Ireland lacks the infrastructure to support a tiered purpose-designed dental service for people who experience dental anxiety. Access to sedation and general anaesthesia is extremely limited[21,22] and there are no purposely designed services to actively engage people with dental anxiety outside of a handful of interested private practitioners. Participants recognised this as a barrier for their patients with dental anxiety. Similar to comparable international research, they recognised the need for improved training and care pathways that offer a framework for dentists and patients that includes dedicated sedation and psychological services. Participants reported that Irish dental services could be improved through better funding of both public and private practice. Dentists in Sweden previously perceived financial barriers for patients with dental anxiety.[23] Ultimately, these funds must come from either the patient or, realistically, the State. Financial issues obviously relate closely to the issue of time, as dealing with patients with dental anxiety takes longer and funding structures may not recognise this. Previous research in Scotland reported that this is an issue for the majority of dentists there too.[24] In summary, this study suggests that it is time to address the lack of dedicated services for people with dental anxiety in Ireland. Schemas and service models are reported in the literature, which demonstrate the necessary complexity of such services.[16,25,26]

Conclusion

This study demonstrates the potential benefit from one-day bespoke training in dental anxiety for a workforce who treat these patients in the absence of appropriate funding, time, care pathways and training. The results of this study suggest that effective training can be delivered that fits the needs of practising dental teams. Further research regarding long-term stability of confidence, behavioural effects and patient outcomes is needed but this study demonstrates that capturing such data may be challenging.

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CPD questions

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

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CPD

1. What percent of the population report high levels of dental anxiety?

- ○ A: In Ireland about 10% of the population report dental anxiety
- ○ B: In Ireland about 20% of the population report dental anxiety
- ○ C: In Ireland about 30% of the population report dental anxiety
- ○ D: In Ireland about 40% of the population report dental anxiety

2. Which of the following are features of dental anxiety?

- ○ A: Symptom-driven attendance
- ○ B: Negative experiences of dental care affirming negative cognitions, reinforcing anxiety
- ○ C: Increased experience of pain
- ○ D: All of the above

3. Which of the following was not reported as a barrier to dental care for people with dental anxiety?

- ○ A: Cost to patients and dental practitioners
- ○ B: Time taken to treat patients with dental anxiety
- ○ C: Lack of access to sedation services
- ○ D: Lack of access to hypnotherapy services

Case report: post-maxillary (mouth) cancer: oro-facial and dental rehabilitation using zygomatic implants to support a bar-retained obturator

This case report details the orofacial dental rehabilitation of a 46-year-old man, who had lost significant maxillary bone following a T4N2 oral squamous cell carcinoma. The cancer was treated with surgery and adjuvant chemoradiotherapy. Rehabilitation was based on the placement of four oncology zygomatic implants, which were splinted by a ring-shaped milled titanium bar. This formed the support for a removable obturator, which was retained by precision attachments. The treatment resulted in a large reported improvement in the patient's quality of life, chewing capacity, speech and appearance. The treatment also allows for long-term mouth cancer surveillance in a young man of this age, as the resection site can be easily visualised on removal of the obturator.

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Introduction

It is estimated that 700 new cases of oral and pharyngeal cancers occur in Ireland each year.[1] The incidence of oral cancer is also increasing, particularly among women.[2] In contrast, the treatment options and survival rates for oral cancer have not changed significantly over time (9.5-78.5% five-year survival).[3] Surgery following multidisciplinary team discussion remains the main treatment modality for mouth cancer, including maxillary cancer, supplemented by radiotherapy when needed and, less frequently, chemotherapy. The sequelae of treatment include loss of teeth, loss of alveolar and facial bone, reduced mobility or loss of support of the soft tissues, and loss of sensation to parts of the mouth, head and neck.[4]

Dental rehabilitation has traditionally been provided following the initial recovery period from the cancer surgery and radiotherapy. Where large surgical maxillary defects exist, this has conventionally taken the form of a removable prosthesis that functions as an obturator to cover the defect and a denture to replace the missing teeth.[5] Retention and stability of this type of prosthesis becomes more challenging as the defect size increases and dental implants can be used to provide improved support.[6]

We report on a post-cancer case where zygomatic implants were used to support a bar-retained obturator. Following cancer surgery, a large maxillary defect limited the functionality achievable with a conventional obturator. Further, the lack of remaining alveolar bone in prosthodontically useful sites prevented the use of conventional dental implants.

Case report

Background

A 46-year-old man attended following successful treatment for a 35mm well-differentiated squamous cell carcinoma arising from the anterior right maxillary gingivae three years previously. The cancer had been surgically removed and a neck dissection carried out. The tumour was graded as T4N2 using the TNM cancer staging system.[7] As a result of close margins, adjuvant chemoradiotherapy was provided. This comprised 66 Gray as fractionated steriotactic radiotherapy with cisplatin chemotherapy. The patient had worn a surgical splint for one year following his cancer surgery and then had a conventional obturator fabricated. He found that it was very mobile in his mouth and was difficult to eat with. Liquids could escape beneath the obturator and would frequently come out his nose. As a result, his diet was quite restricted and eating socially could be embarrassing for him. His speech was indistinct and hypernasal. The lip and cheek support provided by the obturator were inadequate. There was no relevant medical history and he was a life-long non-smoker. He was married with a supportive family.

Extra-oral examination showed reduced facial hair growth that was consistent

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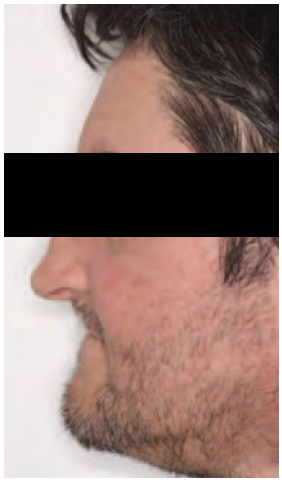


FIGURE 1: Due to loss of alveolar bone, the patient's nose was undersupported and his facial profile flattened.

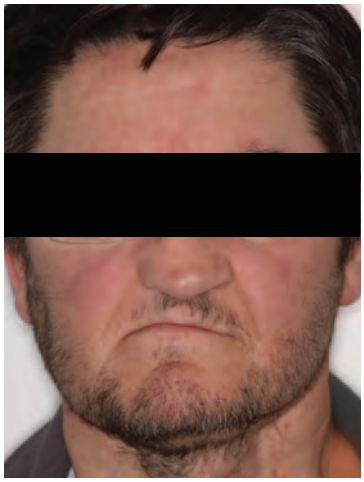


FIGURE 2: Normal drape of the upper lip was disrupted due to loss of support and tightening of tissues, with asymmetric scarring leading to asymmetric elevation.

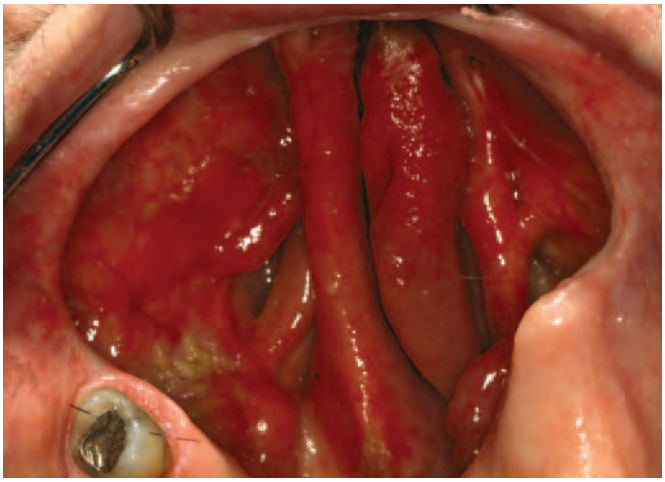


FIGURE 3: Complete absence of anterior maxilla and hard palate.

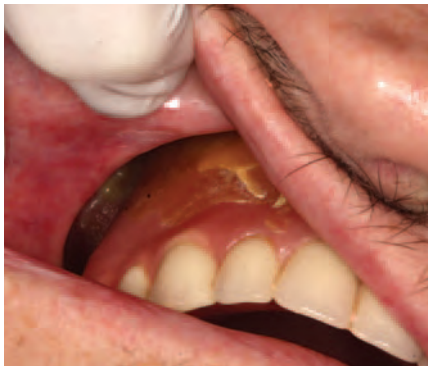


FIGURE 4: The obturator moved up and down, falling into the defect in function.

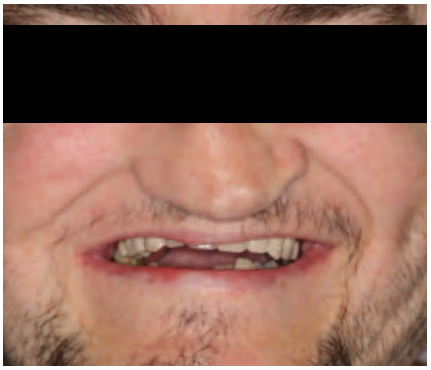


FIGURE 5: The patient's appearance was poor with limited tooth display.

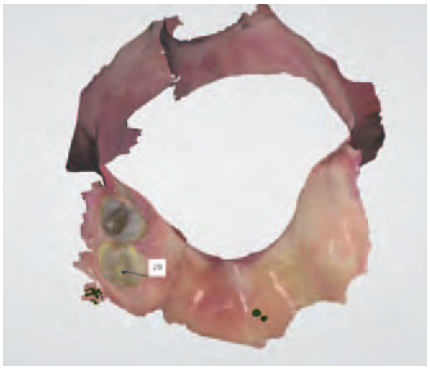


FIGURE 6: An intraoral optical scan was taken to generate a primary model.

with the previous radiotherapy. Due to the loss of alveolar bone, the nose was undersupported and the facial profile flattened (**Figure 1**). The normal drape of the upper lip was disrupted due to loss of support and tightening of the tissues, with asymmetric scarring leading to asymmetric elevation (**Figure 2**). There was bilateral paraesthesia of the upper lip. Intraorally, there was a complete absence of the anterior maxilla and hard palate (**Figure 3**). The left tuberosity, and right second and third molars were retained, with a strap of hard palate connecting the two. The oral cavity was continuous with the nasal and pharyngeal cavities. There was an intact lower dentition with moderate oral hygiene and some carious lesions, as is typical following radiation treatment. With the absence of a typical denture-bearing area, the obturator lacked stability and retention. It moved up and down, falling into the defect in function (**Figure 4**). The resulting appearance was poor with limited tooth display (**Figure 5**).

Treatment planning

The treatment options for dental rehabilitation included a new conventional obturator, an implant-supported obturator or a late microvascular reconstruction. As it was felt that a new conventional prosthesis would suffer the same problems as the existing prosthesis, implant options were investigated. A CT scan of the remaining maxilla, nasal bones and zygomatic bones was taken. This was examined to look for potential sites for implant placement. The remaining alveolar bone in the tuberosity region lacked sufficient bone volume for conventional implants and was poorly positioned for prosthodontic utility. Ideally, implants would need to offer support in the mid-anterior palatal region where the bulk of the obturator would be positioned. In this case, the zygomatic bones did have sufficient bone volume to support two implants on each side.

Prosthetic planning was developed to establish the prosthetic envelope, where an implant bar could be housed to offer support and retention for an obturator of the required size, while satisfying appearance, soft tissue support and occlusal requirements. The position of the bar would be determined by the palatal vault inferiorly, the nasal and pharyngeal tissues superiorly, and the flanges of the obturator laterally. An important step in restoring zygomatic implants is to rigidly splint the implants within 24 hours following placement. For this reason, a ring-shaped bar design would be used rather than the horseshoe shape design typically used in overdentures supported by conventional dental implants. The severe loss of hard and soft tissues provided an abundance of restorative space; however, the implant head positions were restricted to an arc defined by their emergence from the remaining zygomatic

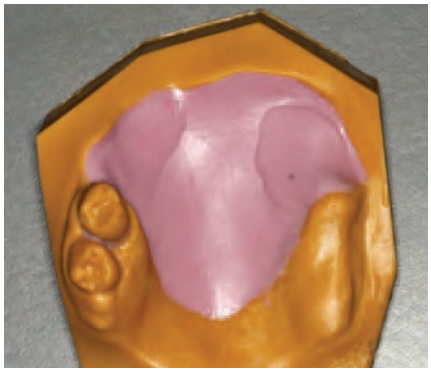


FIGURE 7: Space for the retentive bar was defined and wax added to the milled model to form an arbitrary floor of the defect.

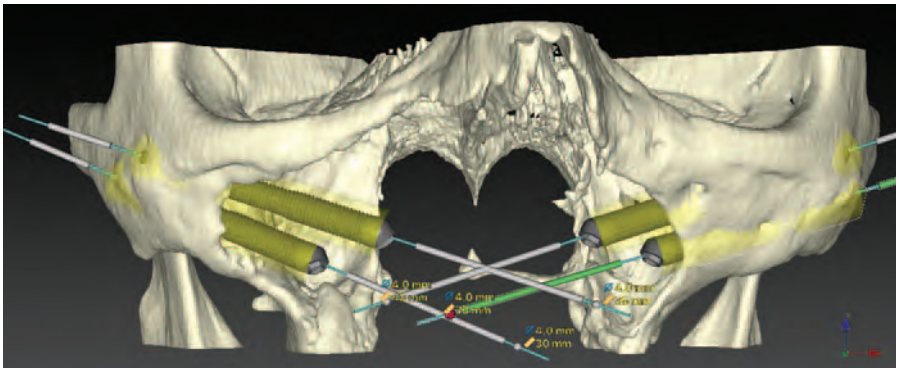


FIGURE 8: Virtual implant planning was carried out using the CT scan data to estimate the implant positions and lengths.

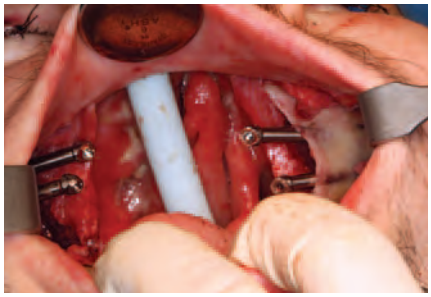


FIGURE 9: Surgical treatment was carried out under general anaesthetic.

bones. A surgical guide was required, which would optimise the positioning of the head of the zygomatic implants and remain stable during surgery.

The surgical guide was fabricated as follows:

- an intraoral optical scan was taken to generate a primary model (**Figure 6**) – the anterior border and base of the defect could not be imaged accurately;
- wax rims were formed on a temporary base with hard reline material added to the anterior border;
- teeth were set in wax for try in;
- space for the retentive bar was defined and wax added to the milled model to form an arbitrary floor of the defect (**Figure 7**); and,
- this cast was used to fabricate a vacuum-formed guide, with retention from the molars and tuberosities.

Surgical planning occurred in tandem with the restorative planning. This included the fabrication of a steriolithographic model of the remaining facial bones. In combination with the surgical guide, this could be used to visualise the relationship between the zygomatic bones and the planned prosthesis and tooth positions prior to surgery. Virtual implant planning was carried out using the CT scan data to estimate the implant positions and lengths (**Figure 8**).

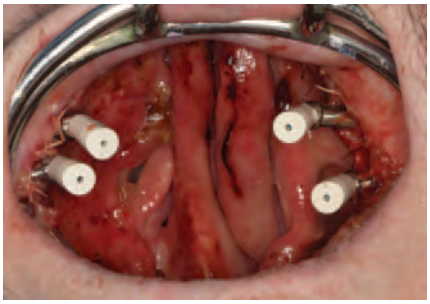
Surgical treatment

The surgical treatment was carried out under general anaesthetic (**Figure 9**). Due to prior radiotherapy, conservative mucoperiosteal flaps were raised via an intraoral approach to expose the zygomatic bones bilaterally. The infra-orbital nerves were identified and protected. The prosthetic guide was used to visualise the planned tooth positions and prosthetic envelope. Four oncology zygomatic implants (Southern Implants; Irene, South Africa) were placed. Leukocyte-rich, platelet-rich fibrin (Intra-Lock; Florida, USA) was placed over the sites to encourage vascularisation and with the aim of improving wound healing. Primary closure of the wound was achieved with resorbable sutures. Postoperative healing was uneventful initially. There was anaesthesia of the upper lip, where previously the patient had partial sensation. Some wound breakdown then occurred, with exposed bone between the two left implants. This slowly healed with time and local, gentle irrigation using 0.2% chlorhexidine mouthwash.

Prosthetic treatment

An immediate obturator and immediate temporary bar was constructed after the surgery as follows:

- an acrylic obturator with the previously established tooth positions was fitted while a definitive milled bar was being constructed;
- an optical impression was made recording the positions of freshly placed



FIGURES 10 and 11: An optical impression was made recording the positions of freshly placed zygomatic implants – soft tissues are recorded with reduced accuracy and gaps are not well accepted by the technology.

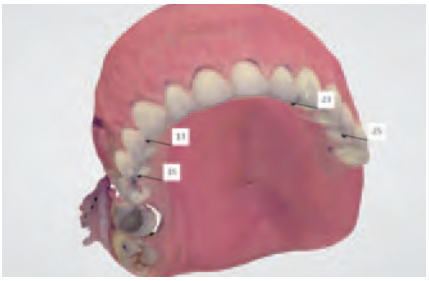


FIGURE 12: Optical scan of the obturator in situ, which was referenced to the scan of the implant positions – scans contained retained natural molar teeth, providing reference points for comparison.

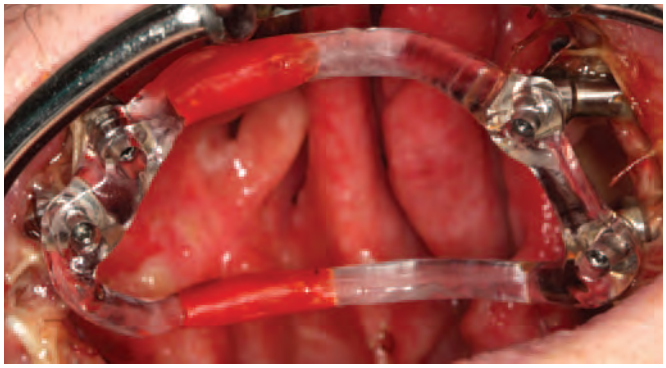


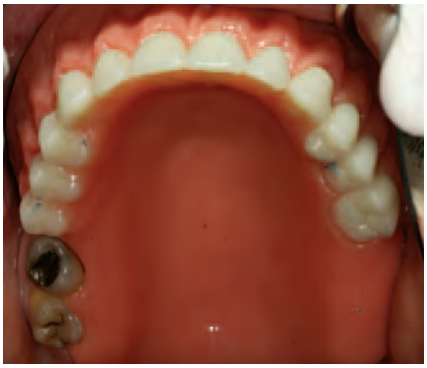
FIGURE 13: A milled primary bar was designed using CAD – a cross arch error in the optical scan was readily corrected by sectioning the bar and relinking it with Duralay resin under rubber dam isolation intra-orally.

zygomatic implants (**Figures 10** and **11**) – soft tissues are recorded with reduced accuracy and gaps are not well accepted by the technology;

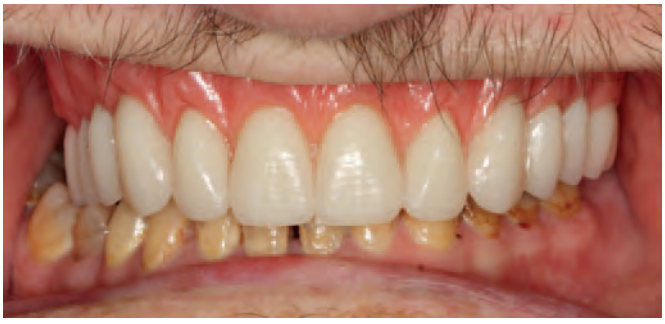
- an optical scan of the obturator in situ was referenced to the scan of the implant positions – both scans contained the retained natural molar teeth and this provided reference points to compare both scans (**Figure 12**).
- a milled primary bar was designed using CAD, milled in acrylic and offered to the implants – a cross arch error in the optical scan was readily corrected by sectioning the bar and relinking them with Duralay resin under rubber dam isolation intra-orally (**Figure 13**);
- this bar served to rigidly splint the implants and offer support to the obturator while the definitive milled titanium bar was being fabricated;
- this resin bar also served as a verification jig and was used to correct the cross arch discrepancy on the master model; and,
- the immediate obturator was modified on the undersurface to allow full seating with respect to the occlusion established (**Figures 14** and **15**).

The definitive obturator, retained on a milled titanium bar with Novaloc (Valoc AC, Switzerland) attachments was constructed as follows:

- a milled titanium bar was fabricated with four Novaloc attachments along with a corresponding milled framework to be embedded within the obturator (**Figure 16**);
- this bar and framework offered an extremely stable foundation to verify tooth positions and detail the occlusion for finalising the definitive obturator – the retained natural molars maintained the patient's preoperative occlusovertical dimension;



FIGURES 14 (left) and 15 (below): The immediate obturator was modified on the undersurface to allow full seating with respect to the occlusion.



- the framework of the bar was positioned within the defect to avoid interfering with the palatal denture form and to support the maximum bulk of the obturator – at least 3mm of space above the bar was allowed for hygiene access; and,
- a border seal was generated using a functional impression of the periphery – this accounted for the changes in shape following healing (**Figures 17** and **18**).

The patient was delighted with his appearance, speech and ability to chew (**Figure 19**). Function exceeds that of a conventionally restored edentulous patient and liquids no longer escape above the obturator. Maintaining the natural molar teeth in the upper arch mitigates against excessive force generation as proprioceptive feedback is maintained. The retention and stability achieved with this type of prosthesis is so great that it closely replicates the function that can be generated from a fixed prosthesis, but still allows removal to facilitate monitoring of the soft tissues as well as cleaning of the prosthesis, bar and implants. Oncology zygomatic implants have a machined cervical collar with no threads to minimise plaque accumulation.

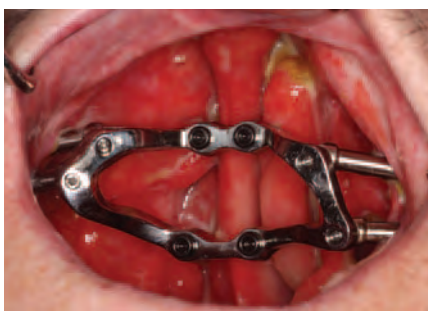
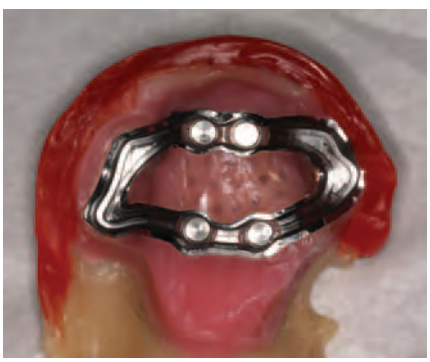
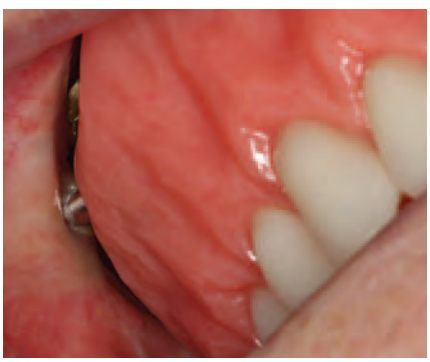


FIGURE 16: A milled titanium bar was fabricated with four Novaloc attachments along with a corresponding milled framework to be embedded within the obturator.





FIGURES 17 and 18: A border seal was generated using a functional impression of the periphery – this accounted for the changes in shape following healing.

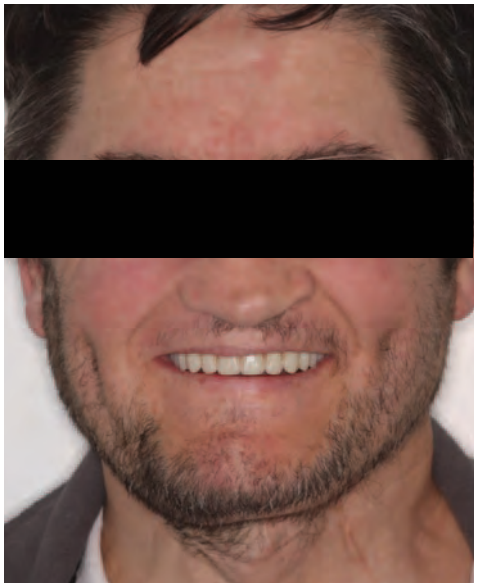


FIGURE 19: Final patient appearance.

At follow up 18 months following implant placement, the patient reported a continued high level of satisfaction with his result. He has no restriction of his diet, is happy with his appearance and can speak well. He removes the obturator for hygiene and mucosal monitoring, and is well motivated with his home cleaning. The anaesthesia of the upper lip has resolved, returning to the baseline of partial sensation that the patient had following his cancer surgery.

Discussion

Tooth loss can occur following oral cancer treatment where teeth are included as part of the cancer resection and when teeth of poor prognosis are removed prior to radiotherapy. The loss of teeth and bone leads to significant lack of soft tissue support, affecting the patient's ability to eat and speak. A reduction in the oral aperture and scarring can make routine oral hygiene challenging following cancer treatment. Radiotherapy contributes to this, causing reduced mouth opening and a reduction in salivary function.[8] Loss of teeth contributes to reduced chewing function and speech difficulties, as well as reduced overall and oral health-related quality of life.[9,10]

When there is reduced mouth opening, salivary hypofunction and poor oral hygiene, conventional fixed prostheses can be technically challenging to fabricate and difficult for the patient to maintain and even tolerate. Removable prostheses have the advantage of maintaining access for hygiene as well as for mucosal monitoring; however, retention and stability can be difficult to achieve following large resections. Ali *et al.* (2018) investigated the impact of a conventional obturator on quality of life following maxillectomies.[5] Their study, while limited by a small sample size, showed improved quality of life when obturators were provided. One of the significant factors that related to reduced quality of life, however, was poor retention of the obturator. Radiotherapy was also associated with a further reduced quality of life.

In this case report, a conventional obturator had been attempted; however, the size of the defect meant that there was little to no retention or stability. Establishing tooth positions was complicated by the lack of a stable foundation for record bases to allow the three-dimensional positioning of replacement teeth. Conventional obturators rely on support gained from the remaining hard palate along with any remaining natural teeth. Where a well-defined scar band remains around the defect, some retention can be gained by gently engaging the undercut of the defect and subsequently any implant positions can be extremely challenging using conventional impression techniques. An optical scanner was employed to overcome some of these challenges and avoid the risk of impression material escaping into the airways. An initial scan allowed a reasonably accurate primary cast to be generated; however, this cast was still a poor representation of the anterior extent of the defect since the boundaries were positioned on mobile tissues. A combination of digital and analogue technologies was necessary to capture all of the information.

Dental implants have the advantage of providing a fixed point of anchorage where teeth have been lost following cancer surgery. The use of dental implants to retain removable prostheses has been associated with high patient-related outcomes and quality of life.[11]

Despite the large defect present in this case report, the prosthetic envelope was limited by the palatal vault and planned tooth positions. The need for thorough prosthetic planning in order to generate accurate tooth positions and estimate the shape of the final prosthesis pre-operatively cannot be overstated. Transfer of this information at the time of the surgery is challenging. In this case, the use of preoperative models, CT scans and close multidisciplinary planning allowed the implant positions to be estimated prior to the implant surgery. This was then successfully transferred to the time of implant placement and resulted in optimal implant positioning.

Zygomatic implants have been used to support both fixed and removable prostheses in the upper jaw, with high success rates when there is limited available alveolar bone such as can arise following tooth loss, severe trauma or following cancer surgery.[12,13] In large defects, where the site of implant fixation is distant from the teeth, they offer the capacity to move the restorative platform from the position of the available bone towards the teeth. The design of the implants incorporates a 45º or 55º angulated head, which allows the screw access to be inclined occlusally. The zygomatic bone has the advantage of being distant from the site of an oral cancer and is, therefore, rarely involved in the resection. The available bone volume in the zygomatic bone also remains suitable for implant placement over time, in contrast to alveolar bone, which tends to resorb significantly over time and following tooth loss.[14]

Boyce-Varley *et al* (2007) set out a protocol for the management of maxillary defects following oncology resections.[12] They found that the use of zygomatic implants allowed the provision of fixed as well as removable restorations, and reduced the need for vascularised free flaps. More recently, in 2017, Butterworth and Rogers described the use of a soft tissue vascularised flap that is supported by zygomatic implants.[15] This, as well as the approach advocated by Boyce-Varley *et al.*, suggests a protocol of placing implants at the time of cancer resection.[12] Immediate placement and restoration of implants has been advocated as a way of minimising distress, speeding up recovery, and providing an opportunity to place the implant prior to radiotherapy.[16] While this is likely to be the ideal timing for implant placement, it is reliant on the availability of the appropriate expertise and resources.

In our case, the option of placing implants was not available at the time of the cancer resection. This led to a delayed reconstruction and placement of implants following radiotherapy. Placement of implants following radiotherapy carries a risk of osteoradionecrosis. While an increased failure rate would also be expected, a recent study by Butterworth does not support this.[17]

Preliminary one-year post-loading data from a randomised controlled trial suggests that immediately loaded zygomatic implants were associated with significantly fewer prosthetic and implant failures, as well as reduced time

needed to functional loading when compared to augmentation procedures with conventionally loaded dental implants. The early findings from this study support zygomatic implant rehabilitation as a superior treatment modality for severely atrophic maxillae despite more complications being reported for zygomatic implants. Long-term data is required to evaluate if these positive results can be demonstrated after long-term follow-up.[18]

Conclusion

This case report demonstrates the provision of four zygomatic implants to support a large bar-retained obturator. The treatment has improved this patient's quality of life and self-esteem by restoring his appearance, speech and chewing function.

Acknowledgements

With thanks due to Sami Azizi and Glenn McEvoy of Eurocast dental laboratory, who provided laboratory support, and Mark Barry, who facilitated the optical scans and technical support. All photos were reproduced with consent of the patient.

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CPD questions

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

IDA irish dental association

CPD

1. Which of the following statements is true of a removable prosthesis for patients with oral cancer?

- ○ A: There is a reduced rate of cancer recurrence
- ○ B: There is improved access for cancer monitoring compared to a fixed prosthesis
- ○ C: There is reduced stability when an implant-supported prosthesis is used

2. How many new cases of oral and pharyngeal cancer occur per year in Ireland according to the Irish Cancer Society?

- ○ A: 200
- ○ B: 700
- ○ C: 1,000

3. Which of the following statements is not true of zygomatic implants?

- ○ A: They are indicated where insufficient maxillary alveolar bone is present to support conventional dental implants
- ○ B: They can be used to support removable prostheses only
- ○ C: An angulation correction can be incorporated in the implant head

Covid-19 re-infection by a phylogenetically distinct SARS-coronavirus-2 strain confirmed by whole genome sequencing

Kelvin Kai-Wang To, Ivan Fan-Ngai Hung, Jonathan Daniel Ip, Allen Wing-Ho Chu, Wan-Mui Chan, Anthony Raymond Tam, et al.

Background

Waning immunity occurs in patients who have recovered from Covid-19. However, it remains unclear whether true re-infection occurs.

Methods

Whole genome sequencing was performed directly on respiratory specimens collected during two episodes of Covid-19 in a patient. Comparative genome analysis was conducted to differentiate re-infection from persistent viral shedding. Laboratory results, including RT-PCR Ct values and serum SARS-CoV-2 IgG, were analysed.

Results

The second episode of asymptomatic infection occurred 142 days after the first symptomatic episode in an apparently immunocompetent patient. During the second episode, there was serological evidence of elevated C-reactive protein and SARS-CoV-2 IgG seroconversion. Viral genomes from first and second episodes belong to different clades/lineages. Compared to viral genomes in GISAID, the first virus genome has a stop codon at position 64 of orf8 leading to a truncation of 58 amino acids, and was phylogenetically closely related to strains collected in March/April 2020, while the second virus genome was closely related to strains collected in July/August 2020. Another 23 nucleotide and 13 amino acid differences located in nine different proteins, including positions of B and T cell epitopes, were found between viruses from the first and second episodes.

Conclusions

Epidemiological, clinical, serological and genomic analyses confirmed that the patient had re-infection instead of persistent viral shedding from first infection. Our results suggest that SARS-CoV-2 may continue to circulate among the human populations despite herd immunity due to natural infection or vaccination. Further studies of patients with re-infection will shed light on protective correlates important for vaccine design.

Clinical Infectious Diseases 2020; ciaa1275 –

BCG vaccination protects against experimental viral infection in humans through the induction of cytokines associated with trained immunity

Arts, R.J.W., Simone Moorlag, S.J.C.F.M., Novakovic, B., Stunnenberg, H.G., van Crevel, R., Netea, M.G.

The tuberculosis vaccine bacillus Calmette-Guérin (BCG) has heterologous beneficial effects against non-related infections. The basis of these effects has been poorly explored in humans. In a randomised, placebo-controlled human challenge study, we found that BCG vaccination induced genome-wide epigenetic reprogramming of monocytes and protected against experimental infection with an attenuated yellow fever virus vaccine strain. Epigenetic reprogramming was accompanied by functional changes indicative of trained immunity. Reduction of viraemia was highly correlated with the upregulation of IL-1b, a heterologous cytokine associated with the induction of trained immunity, but not with the specific IFNg response. The importance of IL-1b for the induction of trained immunity was validated through genetic, epigenetic and immunological studies. In conclusion, BCG induces epigenetic reprogramming in human monocytes *in vivo*, followed by functional reprogramming and protection against non-related viral infections, with a key role for IL-1b as a mediator of trained immunity responses.

Cell Host & Microbe 2018; 23: 89-100.

SARS-CoV-2 vaccines in development.

Krammer, F.

Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) emerged in late 2019 in China and caused a coronavirus disease 2019 (Covid-19) pandemic. To mitigate the public health, economic and societal impacts of the virus, a vaccine is urgently needed. The development of SARS-CoV-2 vaccines was initiated in early January 2020 when the sequence of the virus became available and moved at record speed, with one Phase I trial already starting in March 2020 and currently more than 180 vaccines in various stages of development. Phase I/II trial data is already available for several vaccine candidates and many have moved into Phase III trials. The data available so far suggests that effective and safe vaccines might become available within months rather than years.

Nature 2020; Sep 23 – doi: 10.1038/s41586-020-2798-3. Epub ahead of print.

Clinical and immunological assessment of asymptomatic SARS-CoV-2 infections

Long, Q., Tang, X., Shi, Q., et al.

The clinical features and immune responses of asymptomatic individuals infected with severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) have not been well described. We studied 37 asymptomatic individuals in the Wanzhou District who were diagnosed with RT-PCR-confirmed SARS-CoV-2 infections but without any relevant clinical symptoms in the preceding 14 days and during hospitalisation. Asymptomatic individuals were admitted to the government-designated Wanzhou People's Hospital for centralised isolation in accordance with policy. The median duration of viral shedding in the asymptomatic group was 19 days (interquartile range (IQR), 15-26 days). The asymptomatic group had a significantly longer duration of viral shedding than the symptomatic group (log-rank P=0.028). The virus-specific IgG levels in the asymptomatic group (median S/CO, 3.4; IQR, 1.6-10.7) were significantly lower (P=0.005) relative to the symptomatic group (median S/CO, 20.5; IQR, 5.8-38.2) in the acute phase. Of asymptomatic individuals, 93.3% (28/30) and 81.1% (30/37) had reduction in IgG and neutralising antibody levels, respectively, during the early convalescent phase, as compared to 96.8% (30/31) and 62.2% (23/37) of symptomatic patients. Forty percent of asymptomatic individuals became seronegative and 12.9% of the symptomatic group became negative for IgG in the early convalescent phase. In addition, asymptomatic individuals exhibited lower levels of 18 pro- and anti-inflammatory cytokines. These data suggest that asymptomatic individuals had a weaker immune response to SARS-CoV-2 infection. The reduction in IgG and neutralising antibody levels in the early convalescent phase might have implications for immunity strategy and serological surveys.

Nature Medicine. 2020; 26 (8): 1200-1204.

Quiz answers

Questions on page 220.

1. Any history of rigors, spiking temperature or malaise?
   Any issues with vision or eye movement on the right side?

2. Forced closure of the right eye.
   Restriction of right eye movement or new onset reduction in visual acuity.
   Indurated, cellulitic swelling, which is rapidly spreading.

3. Incision and drainage of the buccal abscess.
   Extraction or first stage root canal treatment (pending restorability assessment and patient preference).

4. No: source control is sufficient in the absence of systemic symptoms and red flag clinical features.

5. Cavernous sinus thrombosis.

Further reading

Scottish Dental Clinical Effectiveness Programme. Emergency dental care: dental clinical guidance. Dundee: Scottish Dental Clinical Effectiveness Programme, 2013. Available from: https://www.sdcep.org.uk/published-guidance/emergency-dental-care/.

SITUATIONS WANTED

Endodontist available for full- or part-time role in Dublin. Contact endodontist187@gmail.com.

SITUATIONS VACANT

Associates

Associate required two days per week in Abbeyleix, Co. Laois. Private and PRSI. Modern, two-surgery practice with intra-oral scanner, OPG, exact software, supportive team. Would suit someone interested in restorative dentistry. Contact info@orthodental.ie.

Associate required for busy modern practice in Cavan town. All new equipment with OPG and microscope. Hygienist and visiting periodontist. Part-time and full-time considered. Experience preferable. Contact info@mcgarritydental.ie.

Enthusiastic, friendly associates required for a busy modern Limerick city centre practice, interest in cosmetic dentistry a plus. Experienced staff, treatment co-ordinators, intra-oral scanners and cameras, OPG and CBCT. Two years' experience required. Contact nikki@3dental.ie.

Friendly, trustworthy associate required for busy, newly renovated, expanding north east practice. One hour from Belfast/Dublin. CV to mbcar06@gmail.com.

Enthusiastic associate required for a modern private practice based in south Co. Dublin. Experience preferred. Part-time with a view to full-time. Excellent support staff, fully computerised, digital scanner, CBCT, OPG, Cerec, in-house lab. Contact careers@deansgrangedental.ie.

Douglas, Cork – Opportunity for a dental associate to take over a practice in an established building. Email associatewithview@gmail.com.

Part-time associate position in Cork City practice. Experience/qualification in facial aesthetics is required. Email info@citydentist.ie.

Associate required to join busy surgery in north Dublin. Tuesdays/Wednesdays initially. Good earning potential. Must be IDC registered. Contact 1989dentalsurgeon@gmail.com.

Full-time associate required for busy, friendly, established, computerised Waterford practice. Taking over from departing colleague. Applications to waterforddentist21@gmail.com.

Part-time dental associate required for fully private practice in Stepaside, Dublin J15 M50. New practice, computerised, digital. List of patients waiting to be booked. Friendly, excellent dentist required with fluent English and great communication skills to join our small, positive team. Contact william@stepasidedental.ie.

Part-time dental associate wanted, Cork city suburb, email toothdr10@gmail.com.

Full/part-time associate opportunity for busy, three-surgery, private/PRSI dental practice in Tralee, Co. Kerry. Fully computerised, OPG, microscope, endodontist, visiting prosthdontist, hygienist. Please apply by email to seamusandhannahflynn@gmail.com.

Part-time experienced associate required Tuesday 8.00am-4.00pm and Thursday 10.00am-7.00pm for busy family practice in Dundrum, D14. Please email CV, etc., to dr.moroney@dentalclinic.ie.

Associate wanted for a weekend position with weekday hours in our busy Crumlin clinic. Applicants must be enthusiastic and caring. Competence in endo and prostho preferred. Favourable terms. Email CV to info@cleardentalcare.ie.

Part-time associate position available in a busy, established, high-earning practice in Co. Wexford. Fully computerised. Excellent support staff and full book. Experience preferable. Email CV to info@goreydentalpractice.ie.

Associate wanted, part-time position with weekday hours in our busy clinic. Applicants must be enthusiastic and caring. Favourable terms. Email CV to info@cantydental.ie.

Co. Meath – experienced (minimum one year) associate required for 2+ days position in private, general/specialist practice. Top-class facility, 40 minutes from Dublin. Email kellsdentaljob@gmail.com.

Part-time associate required for busy south Dublin practice. Applicant must be caring and enthusiastic. Please email CV to info@squaredental.ie.

Dental associate required for very busy dental practice. Modern practice with digitalised equipment, full-time and full book, great support team. Dublin 7. Email sysakroman@gmail.com.

Dublin. Associate needed with a view to long-term partnership. Modern, busy practice, four-day week and one or two Saturdays a month. Private dentistry, minimum five years' experience. Email northsidedentalclinic18@gmail.com.

Full-time associate required to replace departing colleague in busy, modern, three-person, purpose-built practice in Ireland's most rapidly expanding provincial town, Portlaoise. Computerised, digital OPG, hygienists, oral surgeon, periodontist, orthodontist. Formerly VT practice. Full book. Email info@laoisdentist.ie.

Part-time associate wanted Galway city centre. Flexible days to include occasional Saturdays. Enthusiastic, conscientious dentist with 2+ years' experience preferable. Contact dentalpositiongalway@gmail.com.

Caring, experienced part-time associate required for Dublin northside private practice. Excellent support team, fully computerised. An interest in endodontics and oral surgery an advantage but not essential. Please reply with CV to kilbarrackdublindental@gmail.com.

Advertisements will only be accepted in writing via fax (01-295 0092), letter or email (liz@irishdentalassoc.ie). Non-members must pre-pay for advertisements, which must arrive no later than **Friday, November 20, 2020**. Classified ads placed in the *Journal* are also published on our website www.dentist.ie for 12 weeks. **Please note that all adverts are subject to VAT at appropriate rate.**

Advert size	Members	Non-members
up to 25 words	€80	€160
26 to 40 words	€95	€190

The maximum number of words for classified ads is 40.
If the advert exceeds 40 words, then please contact:
Think Media, The Malthouse, 537 North Circular Road, Dublin 1.
Tel: 01-856 1166 Fax: 01-856 1169 Email: paul@thinkmedia.ie
Please note that all classified adverts MUST come under one of the following headings:

- Positions Wanted
- Positions Vacant
- Practices for Sale/To Let
- Practices Wanted
- Equipment for Sale/To Let

Classified adverts must not be of a commercial nature. Commercial adverts can be arranged by contacting Paul O'Grady at Think Media.

Leinster. Associate with a view. Experienced, part-time associate for a high-profile, busy practice. Supportive, progressive environment. Excellently equipped, superb support staff. endo, oral surgery experience very beneficial. Own transport a necessity. Contact niall@innovativedental.com.

Associate dentist required full-time/part-time for busy, well-established dental practice in Ballinasloe, Co. Galway. Excellent earning potential. Please email CV to drrothwelldental@gmail.com.

Leinster – Kildare. Experienced, flexible, empathetic part/full-time associate required. Very busy practice, computerised, digitalised with separate decontamination. Excellent support staff/equipment/facilities. Great opportunities for right personality. Must be a team player. All information confidential. Contact niall@innovativedental.com.

Experienced, motivated associate general dentist for full-time position in busy Limerick city centre practice. Send CV to info@no8clinic.ie.

Associate wanted, Clonmel, Co. Tipperary. Immediate start. Mixed private, PRSI and GMS. Status self-employed, own registration numbers. Contact westerndental@eircom.net.

Dental associate required full-time in Co. Monaghan for very busy dental clinic. Modern practice with digitalised equipment and dynamic team. Contact admin@whdentalclinic.net.

Swords, Co. Dublin. Full-time associate dentist required, minimum two years qualified. Great location, very modern, well-equipped surgery. Exact, digital OPG. Private, PRSI only. Excellent support staff. Lovely, loyal, well-established patient base. Contact info@boroimhedentalpractice.ie.

Associate dentist wanted to provide facial aesthetics sessions on Thursdays. Busy, modern dental practice with great potential to increase hours. Email www.swords-dental.ie.

Associate required for busy, friendly dental practice in the south east. Modern facilities, fully digitalised with excellent support staff. Please reply with CV to sunnysoutheastdentist@gmail.com.

Part-time associate needed for a busy, friendly and established dental practice in Waterford City. CV and cover letter to getsmilingwaterford@gmail.com.

Part-time associate needed, Blessington, Co. Wicklow. Two to three days. General practice. Computerised, digital x-rays, hygienist. Email CV to niall@blessingtondental.ie.

Associate dentist required for one to two days per week for a busy practice in Dunboyne. Experience essential and preferably in RCT. Please email CV to dunboynedentallab@gmail.com.

Colm Smith Dental and Specialist Centre, Cootehill and Monaghan. Associate required to replace departing dentist for long-established, award-winning multidisciplinary practice with specialist orthodontist, oral surgeon, general dentists and excellent support staff. Email CV to drcolmsmith@gmail.com.

Part-time including one late night and Saturday. 2 years+ exp associate for busy three-associate/specialist orthodontist practice in Kilkenny City. OPG equipped. Excellent supporting team. Contact brianjpagni@gmail.com.

Part-time associate with view to full-time. Private book, 3D printing, CEREC, microscopes, CBCT-equipped. Looking a team player with good hand skills and wants to practice high-quality ethical dentistry Experience essential, portfolio of work preferential. Contact daniel@docklandsdental.ie.

Modern, busy, friendly practice looking for associate covering full time maternity leave from January 2021 going to part-time, possible full-time, hours from July 2021. Private/PRSI, RA, IV, facial aesthetics, hygienist. OPG, Invisalign, visiting implantologist. Great team! Contact eleanor@ocdental.ie.

Experienced associate required for a busy practice in Ennis, Co. Clare. Part-time options considered. Modern practice with excellent support staff. Full PPE. Contact careers@dentalcareireland.ie.

Experienced associate required for a leading private practice in Co. Kilkenny. Full-time/part-time options considered. Modern practice with excellent support staff and on-site specialists. Strong book with a mix of private and PRSI. Contact careers@dentalcareireland.ie.

Progressive, motivated, caring associate required three to four days for modern, friendly, computerised practice. Hygienist, excellent support staff, great location, free parking Email kilkennydentist2019@gmail.com.

North Cork. Part-time associate required three days a week for a busy, modern practice with digitalised equipment and dynamic team. Contact ursulalysaght@gmail.com.

Full-time associate required. Very busy, modern practice in Wexford Town. Amazing longstanding support staff. Digital, Exact/ExaminePro, OPG, implant surgeon, hygienist. Loyal, well-established patient base. Full book. Contact rwfoyle@gmail.com.

Position available for associate dentist in Carndonagh, Co. Donegal. Rural practice with overfull book. Good mix of medical card/private/PRSI. Would suit dentist with some experience looking for part-time leading to full-time. Email donegaldental@yahoo.ie.

Dentists

Kiwi Dental in Carlow town is looking for an enthusiastic, outgoing dentist to join our expanding team. Position is part-time including Saturdays. Looking to work in a fun environment and enjoy dentistry again? Then get in touch! Contact caroline@kiwidental.ie.

Roscommon Town – part-time and full-time dentists required for our newly built clinic in Roscommon Town. 90% private, with active advertising and social media marketing. Fully computerised, digital X-rays, good support team. Email CV to jobs@alexandradental.ie.

Experienced dentist wanted for full-time role in a private, well-established practice in Wicklow. Excellent terms and equipment. Contact info@rathdrumdental.ie.

Two to three days full book replacing relocating colleague, Co. Wexford. Modern, well-equipped, spacious, computerised, extra-oral suction, Viruskiller. Seeking motivated self-starter with very professional outlook for wide ranging perio work. New graduates welcome, good remuneration terms. Contact quirkedental@gmail.com.

We're welcoming dentists to join our growing teams across our Cork, Waterford and Kilkenny locations. Part-time positions with excellent pay and hours. The right candidate will be experienced in botulinum toxin, dermal filler and Profhilo. Contact elaine@eden-medical.ie.

Dentist required for a busy two-surgery practice in Donegal for two to three days per week (possible full-time). Expanding practice, new equipment, fully computerised. Contact twintowndentist@gmail.com.

Full-time position available in Co. Galway, five weekdays and every second Saturday half day. Established book. Looking for someone with long-term view. Experience essential. Contact: seaportdental@hotmail.com.

Galway – Smiles Dental (part of Bupa Dental) is looking for a passionate dentist to join our well-established, state-of-the-art practice in Galway. Position offers five days per week, established list, great earning potential. Contact joanne.bonfield@smiles.co.uk.

Kilkenny – experienced (minimum one year) dentist required for three/four-day per week position in private busy practice. Full book. Excellent facility. Generous terms. Email kilkennydentaljob@gmail.com.

Full-time position available. High-tech practice, south Dublin, with Cerec, 3D printer, CT, 3Shape scanner, lab on site. Minimum two years' experience needed. Email ed@seapointclinic.ie.

Dentist required for busy, well-established practice in Leixlip, 30 minutes from Dublin city centre. Immediate start. Email oaklawndentalpractice@gmail.com.

Newly qualified dentist required urgently for two days per week (Tuesdays and Thursdays) in a busy clinic at the city centre. Contact drpeterdwyer@gmail.com.

Exciting opportunities for enthusiastic, self-motivated and experienced dentists in D8 area. Full/part-time positions available. Also looking for experienced orthodontist. Modern, well-equipped practices, fully computerised. Email diamondsmilejobs@gmail.com.

Newly qualified dentist required urgently two days per week (Tuesdays and Thursdays) to provide mainly hygiene and preventive care. Contact drpeterdwyer@gmail.com.

Ambitious dentist required, immediate start, for two rapidly expanding, modern Cork City practices. Massive earning potential. Aesthetic interest a bonus. Contact colintobinenterprises@gmail.com.

Ambitious, newly qualified dentist required for busy, fully private, state-of-the-art clinic in Clane, Co. Kildare (30 minutes from Dublin). Immediate start available. Continuous training provided in all aspects of dentistry including Invisalign. Excellent support staff. Contact louise@clearbraces.ie.

Dentist required for holiday cover in busy west Dublin practice from 28/09 to 02/10. Long-term position also available two days a week working up to full time. Reply with CV to dentalpost1@gmail.com.

Dentist required for maternity leave two days a week from October to December inclusive in busy Tipperary practice. Possibility of full-time position two days a week for the right candidate. Reply with CV to dentalposition057@gmail.com.

Dentist required for one to two days per week in a friendly family practice in Swords. Some experience and good English preferred. Immediate start. Contac: swordsvillagedental@hotmail.com.

Experienced dentist required for two days (Monday-Tuesday) per week in a friendly practice in Dublin city centre. Contact contact@freedomdental.ie.

Are you a dynamic, confident dentist who puts patient care first? If so, we have a two-day position available in Bray, Co. Wicklow. Private dental practice with excellent support staff. Please email CV and cover letter to dentist2required@gmail.com.

Part-time dentist required for busy practice in the north east one hour from Dublin/Belfast. Experience preferable. CV to mbcar06@gmail.com.

Full-time general dentist required for a busy and modern practice in south Co. Dublin. Experience in cosmetic dentistry is ideal. Please reply with CV to drerikawhitesmile@gmail.com.

Dental clinic in Limerick and Tralee are recruiting for a full/part-time dentist, very busy practices, competitive percentage, computerised, X-rays, e-marketing. Contact limerick@bio-force.ie.

Experienced dentist required to cover maternity leave in Co. Clare. Feb 1 to August 2021. Full-time position with excellent earning potential. May be an opportunity for an ongoing position thereafter. Enquiries to clarelocum@gmail.com.

Dentist required part-time Saturday/Sunday for busy, rapidly expanding private practice in north Co. Dublin to provide FA treatments. Excellent supporting team. Contact brianjpagni@gmail.com.

Recently qualified, enthusiastic dentist with interest in orthodontics required, full-time position in a beautiful, state-of-the-art, modern orthodontic and multidisciplinary practice in north Dublin. Excellent working conditions alongside our specialist orthodontist in our fully equipped orthodontic studio. Contact specialistdentalpracticehr@gmail.com.

Galway – Smiles Dental (part of Bupa Dental) is looking for a passionate dentist to join our well-established, state-of-the-art practice in Galway. Position offers five days per week, established list, great earning potential. Email joanne.bonfield@smiles.co.uk.

Cork – Smiles Dental (part of Bupa Dental) is looking for a passionate dentist to join our well-established, state-of-the-art practice in Cork. Position offers three days per week – Tuesday, Thursday and Saturday. Established list, great earning potential. Email joanne.bonfield@smiles.co.uk.

Part-time dentist required in a modern multidisciplinary practice in north Dublin located 15 minutes from city centre. Excellent working conditions and opportunities for career development. Please email your CV to northdublindentalassociate@gmail.com.

Specialist/limited practice

Are you interested in joining a growing team? We are looking for specialists to join our Castleknock and Dentalhouse, Dublin 2, teams. Email manager@dentalhouse.ie.

We require an experienced short-term ortho provider to join our busy practice. Treatment co-ordinators, photography suite, iTero and Primescan, on-site lab, full book. Excellent remuneration. Part-time/full-time considered. Contact shauna@3dental.ie.

Orthodontist required for state-of-the-art, expanding practice one hour from Dublin/Belfast. North east. CV to mbcar06@gmail.com.

Orthodontist required to join our specialist team in south east Leinster. Busy, fully private clinics treating with both Invisalign and fixed braces. Full existing book. Excellent support staff. Itero, full digital workflow. All enquiries treated in absolute confidence. Contact bpm.gmedical@gmail.com.

Part-time oral surgeon/implantologist required at modern city centre practice. Must be on Specialist Register. CV to info@novadent.ie.

Full book crowns/implant restorations available for prosthodontist in state-of-the-art clinic with 3Shape scanner, 3D printer, own laboratory. South Dublin. Contact Ed@seapointclinic.ie.

Endodontist wanted. High-income position. Specialist clinic, Killarney, Co. Kerry. To join periodontist, implantologist, oral surgeon and prosthodontist. Ultra-modern, high street practice. On-site CBCT scanner, endodontic microscope, IV and inhalation sedation and more. Rare opportunity. www.kingdomclinic.ie. Contact tomas.allen@kingdomclinic.ie.

We require an experienced implant specialist to join our busy city centre practice. Treatment co-ordinators, onsite lab, full book. Part-time/full-time considered. Immediate start. Contact nikki@3dental.ie.

Periodontist/dental implant specialist required to join a high-profile multidisciplinary team in a beautiful, state-of-the-art, fully digital practice in Dublin. Existing waiting list of referrals and patients requiring implants as part of ongoing interdisciplinary treatments. Contact specialistdentalpracticehr@gmail.com.

Specialist orthodontist and endodontist required for multi-specialty practice in Co. Wicklow. Please reply to louisdevereux@msn.com.

Orthodontic therapists

Orthodontic therapist required for a beautiful, state-of-the-art, modern orthodontic and multidisciplinary practice in north Dublin. Excellent working conditions including flexibility on hours and days to suit your personal and family schedule. Free secure underground parking. Contact jobs@ncdental.ie.

Are you fed up with general dentistry? Trainee orthodontic therapist required for specialist orthodontic practice in Dublin. May suit qualified dentist seeking change in career. Part-time position leading to full-time. Replies to orthodontictherapistreplies@gmail.com.

Dental nurses/managers/receptionists

Full-time dental nurse required to cover one month's holidays in a busy south surgery. Experience in orthodontics preferable. CV to drerikawhitesmile@gmail.com.

Qualified dental nurse required for Kilkenny City endodontic practice. Hours: 1.00pm-6/7.00pm, Monday to Friday. Computer and administrative skills desirable. Call Naomi on 086-839 1746 or email kkdentist.irl@gmail.com.

Full-time, experienced dental nurse required at Molloy Dental, Santry, Dublin 9. Computer and administrative skills. Good attitude and excellent teamwork are essential. Email CV to grace@molloydental.ie.

Nurse/nurse trainee required for busy specialist practice in Naas. Position is part time, minimum two days. Excellent opportunity for qualification development. Role includes clinical and administrative duties. Email Sonja at info@periodontalsuite.ie.

Full-time dental nurse required to work in a busy south Dublin surgery. Good attitude and teamwork. Please send CV to drerikawhitesmile@gmail.com.

Part-time dental nurse required for developing endodontics practice in Athlone area. Endo training provided for suitable candidate. Contact eoinomorain@gmail.com.

Practice manager, Dublin 18, €32k-€45k. A fantastic opportunity for a candidate with exceptional management skills to lead our friendly team in a modern, computerised general practice, to ensure the business operation runs efficiently and continues to grow. Contact eddiegoggins@gmail.com.

Dental nurse required for private Limerick city centre practice. Friendly, organised and good team skills essential. Will be working with dentist and one other nurse. Contact dentalpostlimerick@gmail.com.

Registered dental nurse required for Saturday sessions in a busy dental practice in Charleville, Co. Cork. Contact nualacagneydental@gmail.com.

Full-time/part-time dental nurse required for busy practice in Tallaght. Experience required. Please send CV to annedental@hotmail.co.uk.

Part-time dental nurse required two to three days a week. State-of-the-art modern practice in Charleville, Co. Cork. Contact nualacagney@gmail.com.

Practice manager required for busy Ballincollig practice. We are a large multidisciplinary team with a great working atmosphere. This is a fantastic opportunity for a candidate with exceptional management skills to lead our modern, computerised practice. Contact roanne@corkdentalclinic.com.

Full-time dental nurse required for specialist dental practice in Waterford. Role includes clinical and administrative duties. Must be computer literate with excellent communication, teamwork and organisational skills. Training provided. Please email CV to dentalclinicwaterford@gmail.com.

Full-time/part-time dental nurse required for busy dental practice in Longford. Experience required. Please send CV to annedental@hotmail.co.uk.

Dublin South. Nurse/nurse trainee, full-time required, fully private dental surgery, south Dublin. Enthusiastic, empathetic, efficient, professional, team player required. Modern facilities. Computer proficient a must. Good remuneration for suitable candidate. Contact niall@innovativedental.com.

Full- and part-time experienced nurse/assistant required to join friendly practice in Dublin 13. Email CVs to amanda.naylor@smartdentalcare.co.uk.

Qualified dental surgery assistant required for specialist dental practice in Galway City. Position available immediately. No previous experience necessary. Please send CV to Michelle at obrienandmolloy@gmail.com.

Full-time dental nurse required for Limerick city centre specialist orthodontic practice. Role includes clinical and administrative duties. Must be computer literate. Contact eamon@signaturesmiles.ie.

Full-time dental nurse required for a busy dental practice in south Co. Dublin. The ideal candidate must be qualified, friendly, possess excellent interpersonal skills, fantastic organisational skills, along with the ability to work as part of a team. Contact careers@deansgrangedental.ie.

Dental nurse required for immediate start in long-established family practice on Main Street, Dundrum, D14. No experience necessary, full training given! Please send CV to dr.moroney@dentalclinic.ie.

Southgate Dental Drogheda is hiring a full-time dental nurse to work in our busy multidisciplinary practice. Experience with implants, orthodontics and Exact an advantage. Contact ciarar@sgdental.ie.

Dental nurse required for full-time work at an orthodontic clinic in Dublin 1 (Monday to Friday), to start ASAP. Contact drpeterdwyer@gmail.com.

Dental nurse required for busy Galway City private practice, working with implants, endodontics and cosmetic dentistry. Ideal candidate should be friendly, enthusiastic, efficient, good organisational skills and a team player. CV and covering letter to info@galwaydentalclinic.ie.

Part-time dental nurse required for busy north Co. Dublin general practice. Experience required. Contact Sfngsale@gmail.com.

Exciting opportunity for full-time receptionist/nurse in an award-winning practice, located in Meath. We are looking for a motivated, organised and dynamic individual to join our reception team. Start October 2020. Contact dentaljobireland1@gmail.com.

Hygienists

Experienced dental hygienists required for full-time and part-time hours to take over busy book in a modern, well-established practice in Ballsbridge. Immediate start. Friendly, supportive team, full PPE provided. Contact office@pembrokedentist.ie.

Experienced, flexible dental hygienist required for part-time position in a periodontal practice. Great patients and excellent support staff in a modern, computerised practice in Naas, Co. Kildare. Email Sonja at info@periodontalsuite.ie.

Motivated, caring and friendly dental hygienist required for a part-time position in a busy dental clinic in Dublin 12 to replace a departing colleague returning to college. CV to info@cleardentalcare.ie.

Full-time hygienist required for busy, modern practice. Lovely patients. Friendly staff. Applicants need good technical skills and a motivational personality to maintain and monitor our long-term patients. Experience preferable. Rate negotiable. Please email info@rathfarnhamdental.com with CV.

Dental hygienist required urgently for two days per week (Tuesdays and Thursdays) in a busy clinic in the city centre. Contact drpeterdwyer@gmail.com.

Hygienist required for maternity cover three days per week, starting early September. Full book, busy, friendly practice with long-established hygiene position. Excellent support staff, full PPE and air-purifying system provided. New graduates welcome. Contact info@rogersdental.ie.

Hygienist required for two sessions per week, Monday and Wednesday afternoons, 2.30pm-8.00pm, in busy private practice in Malahide. Very busy book. Full PPE provided (FFP2 masks, gowns, caps, etc.). Cavitron scaler and excellent support staff. Contact helenmarielane@ivorydental.ie.

Renmore Dental. Hygienist required for busy, newly renovated private practice in Galway City. Part-time with a view to potential full-time position. Please email CV to aoife@renmoredental.ie.

Modern dental/orthodontic practice urgently requires a time hygienist 2.00pm-7.00pm Tuesday and Thursday, one Saturday a month. Full PPE and nurse provided. Contact info@dublinorthodontist.ie.

Dental hygienist required for one to two days per week for busy, friendly dental practice in Cavan Town. Excellent support staff and air purifying systems in all surgeries. Full book with high demand for periodontal treatment. Email churchstdental@gmail.com.

Colm Smith Dental and Specialist Centre. Hygienist required for long-established, award-winning eight-surgery multidisciplinary practice with specialist orthodontist, oral surgeon, general dentists and excellent support staff. Email CV to drcolmsmith@gmail.com.

Hygienist required part-time to work in state-of-the-art practice in Clonmel. Full book. Full PPE, with air ventilation system, Radic 8 purifier and vacusation available. Email CV to jackie@orthodonticsbyjackie.ie.

Full-time/part-time dental hygienist required for a busy dental practice in beautiful Westport. Please apply with CV to reception@drrosemarysmith.com.

Part-time hygienist required, two days per week, in busy specialist practice in the heart of Dublin city centre. Email CV and cover letter to info@harcourtdentalclinic.ie.

Maternity cover – part-time hygienist, one day a week from October. Kilkenny city centre. Full book in busy, established friendly practice. Three associates/specialist ortho. Full PPE. Email CV to brianjpagni@gmail.com.

Part-time hygienist position available in Birr, Co. Offaly. Modern, friendly dental practice with excellent support team. Initially one to two days/week with scope for further days in future. Full book in busy practice. Contact jamiegcummins@gmail.com.

Hygienist required to cover maternity leave for nine months starting December. Two days a week, full book in a long-established Midlands practice. Possibility for a permanent position. Full PPE. Email CV to info@tullamoredental.com.

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Special care dentist

Dr Danielle McGeown is a Senior Dental Surgeon (Special Needs) with the HSE in Cork.

How did you come to work in special care dentistry?

I graduated from Trinity in 2008. I worked in private practice in Dublin but then the crash hit and I went to Australia for a couple of years. I worked in community health services attached to a psychiatric hospital there, and that was where I started getting interested in special care dentistry. I wanted to do more training, so I came back to the Dublin Dental Hospital and did a three-year doctorate in special care dentistry.

I then moved to Cork and joined the HSE, and I've been there since. I run a weekly general anaesthetic list and a sedation list. I've also established a service for patients with inherited bleeding conditions, attached to the Haematology Department at Cork University Hospital.

What are the particular challenges in special care dentistry in Ireland?

In special care dentistry in Ireland, there's always room for improvement. In some areas we have really good services, and in other areas services are limited and outcomes have not been good. We know that patients with disabilities have poorer oral health so there are always more resources needed, more trained staff, more targeted care. Waiting lists for treatment under general anaesthesia can be a challenge. For a lot of people with special needs, general anaesthetic is something they will always need for their dental treatment.

In addition, a lot of younger patients now expect more from services. In the past a lot of general anaesthetic services were just extractions; now, people want to keep their teeth, so we're doing more advanced treatments, and trying to hold onto patients' teeth. This leads to an ongoing struggle with waiting times. Limited access to intravenous sedation nationally also increases this problem. I think Covid has probably set a lot of that back as well. A lot of staff were redeployed, and I couldn't criticise that initially, but as time goes on you start to be more critical because you won't have any dental services running. Dentistry is not optional; it's a quality of life issue, and it's frustrating that special care gets so little attention from Government.

How important is community care for patients with special needs?

All of our research shows that most people that come under the special care umbrella, whether it's people with specific bleeding disorders, or people with intellectual disabilities, or dental phobia, want to be treated in the community. They don't want to have to go to hospital. The mainstay of special care is in community services, whether in general practice or in the HSE community dental service. However, for this cohort the medical card has not been fit for purpose for a long time. If someone has additional needs the main thing you need to give them is time, and if you're being paid a very minimal fee you don't have that time.

What do you think are the implications of the oral health policy on your work?

It's very positive where it's saying the community is the home for care, but with clear pathways for people to move into HSE services or specialist services. When we look at other countries that have good special care systems, that is how it works. However, the issue is how do we get there without huge investment of funds and training? When I look at what it could achieve for patients with disabilities, I think the policy is very positive.

I have often said special care is the easy thing to implement; it's about training more specialists, getting very clear pathways, having that support and training. A lot of it is already there; a lot of GDPs and HSE dentists see these patients all the time, they just need more support and pathways.

What would you like to see the IDA doing for special care dentistry?

For special care dentistry a lot of it is training and exposure and mentoring. I am involved in the Irish Society for Disability and Oral Health where we do a lot of that kind of training, but generally, while there would be some general dentists there, it would be more HSE dentists who are seeing these patients every day. I really think there's huge scope for small clinical training for general dentists who aren't looking to become a specialist or see special care patients all the time, but are seeing them in their practices and just want to get better at that. That's where the IDA comes in because they do training really well, and even a small amount of training reduces stress on dentists.

Danielle lives in Fermoy with her husband Dr Ryan Hennessy, who is a general dentist, and their three children. She is currently on maternity leave, and is due to return to work before Christmas. While there's not a lot of relaxation going on with three kids under five, she tries to get out for a run on a nearby track to get a break from the madness.

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