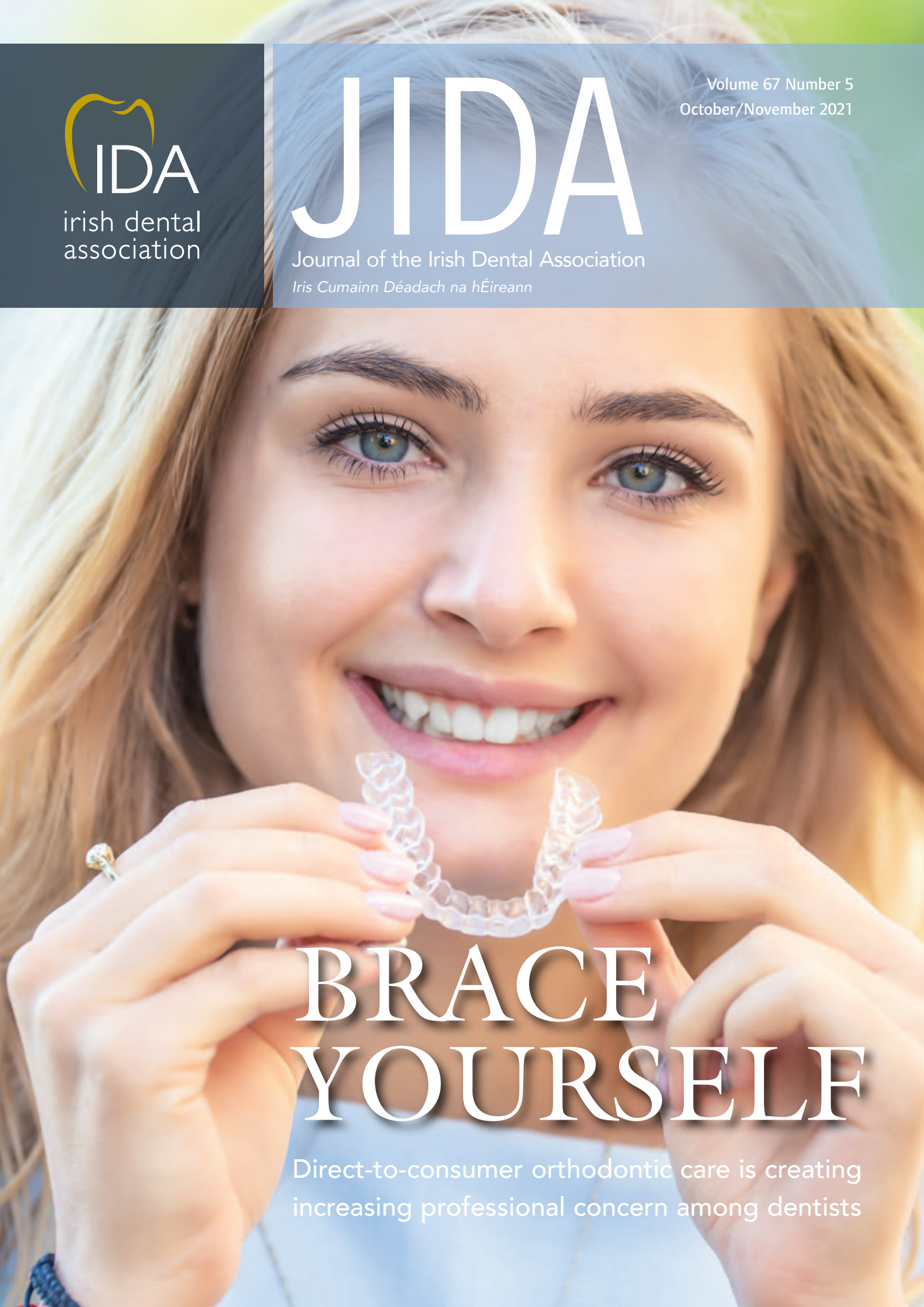
IDA
irish dental association

JIDA
Journal of the Irish Dental Association
Iris Cumainn Déadach na hÉireann

Volume 67 Number 5
October/November 2021



BRACE YOURSELF

Direct-to-consumer orthodontic care is creating increasing professional concern among dentists

THE CORD FROM THE CAPSULE

VOCO Retraction Paste

- **Thin cannula with flexible tip** – easy and pinpoint application into the sulcus
- **Viscosity Change** – paste consistency varies during application and sulcus widening
- **Good visibility** – contrasty to the gingiva
- **A clean product** – quick and easy to spray off

NEW

MADE IN GERMANY 100%

For more information please contact **Claire Austin**, Mobile: +44 7584200138

VOCO THE DENTALISTS

VOCO GmbH · Anton-Flettner-Straße 1-3 · 27472 Cuxhaven · Germany · Freecall 00 800 44 444 555 · www.voco.dental

The *Journal of the Irish Dental Association* is the official publication of the Irish Dental Association. The opinions expressed in the *Journal* are, however, those of the authors and cannot be construed as reflecting the Association's views. The editor reserves the right to edit all copy submitted to the *Journal*. Publication of an advertisement or news item does not necessarily imply that the IDA agrees with or supports the claims therein. For advice to authors, please see: www.dentist.ie/resources/jida/authors.jsp

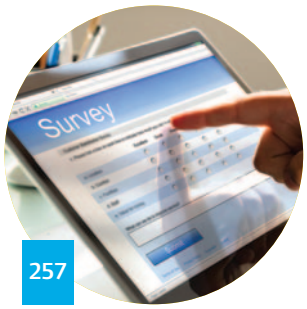
Think Media

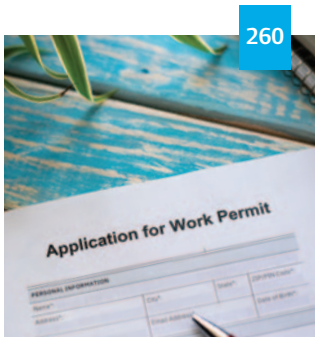
Published on behalf of the IDA by
Think Media, 537 NCR, Dublin 1
T: +353 1 856 1166
www.thinkmedia.ie

MANAGING EDITOR **Ann-Marie Hardiman** ann-marie@thinkmedia.ie
EDITORIAL **Colm Quinn** colm@thinkmedia.ie
ADVERTISING **Paul O'Grady** paul@thinkmedia.ie
DESIGN/LAYOUT **Rebecca Bohan, Tony Byrne, Tom Cullen**

abc Audit issue January-December 2019: **3,986** circulation average per issue. Registered dentists in the Republic of Ireland and Northern Ireland.

Irish Dental Association Unit 2 Leopardstown Office Park, Sandyford, Dublin 18.
Tel: +353 1 295 0072 Fax: +353 1 295 0092 www.dentist.ie
Follow us on Facebook (Irish Dental Association) and Twitter (@IrishDentists).





Colgate®

Don't forget to renew your patient's **Duraphat prescription**

Winning the fight against caries

Effective prevention for patients at increased caries risk*

High fluoride toothpastes are clinically proven to be **more effective** than a regular toothpaste in **preventing dental caries**:[1-5]

- 5000 ppm Fluoride Toothpaste **prevents cavities** by **arresting and reversing** primary root and early fissure **caries lesions**[1,3-5]

1.1% Sodium Fluoride

* Colgate® Duraphat® 5000 ppm high fluoride toothpaste for patients ≥ 16 years at increased caries risk.

References: 1. Baysan A et al. Caries Res 2001;35:41-46. **2.** Biesbrock AR et al. Community Dent Oral Epidemiol 2001;29:382-389. **3.** Ekstrand et al. Caries Res 2013;47:391–8. **4.** Schirrmeister JF et al. Am J Dent 2007;20. 212-216. **5.** Ekstrand et al. Gerod 2008; 25:67-75.

Colgate® Duraphat® 5000 ppm Fluoride Toothpaste - Name of the medicinal product: Duraphat® 5000 ppm Fluoride Toothpaste. Active ingredient: Sodium Fluoride 1.1%w/w (5000ppm F-). 1g of toothpaste contains 5mg fluoride (as sodium fluoride), corresponding to 5000ppm fluoride. Indications: For the prevention of dental caries in adolescents and adults 16 years of age and over, particularly amongst patients at risk from multiple caries (coronal and/or root caries). Dosage and administration: Brush carefully on a daily basis applying a 2cm ribbon onto the toothbrush for each brushing. 3 times daily, after each meal. Contraindications: This medicinal product must not be used in cases of hypersensitivity to the active substance or to any of the excipients. Special warnings and precautions for use: An increased number of potential fluoride sources may lead to fluorosis. Before using fluoride medicines such as Duraphat, an assessment of overall fluoride intake (i.e. drinking water, fluoridated salt, other fluoride medicines - tablets, drops, gum or toothpaste) should be done. Fluoride tablets, drops, chewing gum, gels or varnishes and fluoridated water or salt should be avoided during use of Duraphat Toothpaste. When carrying out overall calculations of the recommended fluoride ion intake, which is 0.05mg/kg per day from all sources, not exceeding 1mg per day, allowance must be made for possible ingestion of toothpaste (each tube of Duraphat 500mg/100g Toothpaste contains 255mg of fluoride ions). This product contains Sodium Benzoate. Sodium Benzoate is a mild irritant to the skin, eyes and mucous membrane. Undesirable effects: Gastrointestinal disorders: Frequency not known (cannot be estimated from the available data): Burning oral sensation. Immune system disorders: Rare (≥1/10,000 to <1/1,000): Hypersensitivity reactions. Legal classification: POM. Marketing authorisation number: PA 0320/008/002. Marketing authorisation holder: Colgate-Palmolive (U.K.) Ltd. Guildford Business Park, Midleton Road, Guildford, Surrey, GU2 8JZ. Recommended retail price: €9.36 (51g tube). Date of revision of text: April 2015.

www.colgateprofessional.ie *www.colgatetalks.com*

EDITORIAL

Dr Ciara Scott
Honorary Editor

Supporting professionals and patients

Navigating new technologies and treatment approaches can be challenging for dentists and patients, and articles in this issue offer guidance and support.

Digital technologies are often described as disruptive. The term 'disruptive technology' was coined at Harvard Business School. Digital transformation using disruptive innovations builds a 'new better' way to do business and deliver care. Ireland is rich with innovation hubs that create forums to share ideas and create new ways of working. Innovations that challenge the status quo have created many positive changes in how we live and how we work. ehealth transformation is one of the cornerstones of Sláintecare and the HSE has recently partnered with Dell to provide a free programme for healthcare workers called Digital Futures in Healthcare.

One disruptive technology of concern to the dental profession is the increasing trend for orthodontic treatment to be marketed 'direct to consumer' without the physical examination or supervision of care by a registered dentist or orthodontist. The Dental Council of Ireland published advice to the profession and patients regarding this in 2017 and the British Orthodontic Society and EFOSA, the European Federation of Specialist Orthodontists, have followed, by recently publishing their own advice. As a profession, we rely on legislation and regulation to control the qualifications and standards that are required to advertise, prescribe, manufacture and deliver custom devices to the general public. In our last issue, Roisín Farrelly outlined the new legislation on the prescription and manufacture of custom dental devices, and in this issue Dental Protection provides a useful update on direct-to-consumer orthodontics for the profession to support our decision making, and to support our patients.

Supporting behaviour change

Patients don't always listen to our advice or follow it, and the health psychology literature is rich with models to explain why. Caring is at the core of our identity as professionals, so when treatment outcomes don't meet our expectations or our patients', this can impact on us as professionals as well as on our patients.

Motivational interviewing (MI) is a technique that has been developed to support behaviour change and there is evidence that it not only supports patients, but reduces burnout for practitioners too. Having completed some training in coaching, MI and positive health, I can honestly say I am a strong advocate, as it has not only changed the conversations I have with my patients but the conversations I have with myself! So I am very grateful to Rebekah Brennan and Robert O'Driscoll for sharing their scoping review of the use of MI in oral care in this issue.

This links well with our clinical feature, in which Anthony Roberts, Lewis Winning and Peter Harrison have summarised very comprehensive new S3-level periodontal clinical guidelines, including patient behaviour change as a key step. The authors of both these articles have provided very comprehensive tables, which are not included in our print edition, but are available on our new online resource, www.JIDA.ie. While all our articles and past issues are open access and available on the IDA website, the Editorial Board has responded to the interest from both readers and authors to access individual articles. I hope you will find this new website valuable and we welcome your feedback.

Our second peer-reviewed article reports an interesting and unusual case, and I thank Gagandip Singh Dhanjal and his colleagues for sharing this with us.

A growing profession

The increasing number of pages allocated to our classified ads highlights the growing demand for dental professionals in Ireland. Our members' news section in this issue is focused on the current challenge of meeting this demand for staff. For many members, IDA events and conferences are an opportunity to reconnect with old classmates and colleagues, but for an increasing number of colleagues, it is their first opportunity to connect with the profession in Ireland, share information and create those allegiances. I moved to Ireland and registered with the Dental Council in 2001, and since joining the IDA in 2004, I have valued both the social and professional benefits of membership. I'm very grateful to our colleagues, Amalia Pahomi, Marcela Torres-Leavey, Erika Barta and Tristan Hartung for sharing their experiences of bringing their training and experience to Ireland, and the challenges and benefits of practising here, in this issue.

The Colgate Caring Dentist Awards in November offer the perfect opportunity to connect and really celebrate dental care in Ireland and I look forward to seeing you there.

IDA
irish dental association

Colgate®

Caring Dentist Awards 2021

Are you coming to the Gala Ball?

If you have been nominated for an award, book now for our Gala Ball at www.dentist.ie or ring the IDA office on 01 295 0072.

Gala Ball and Awards Ceremony
Intercontinental Hotel, Ballsbridge, Dublin 4

NOTE: NEW DATE
Saturday
November 20th

Colgate®

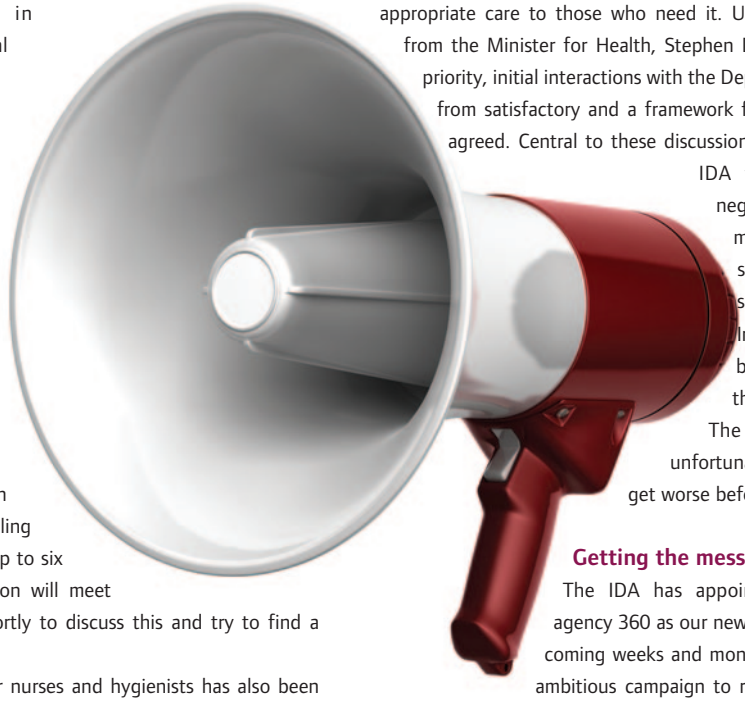
Keep Ireland Smiling

Dr Clodagh McAllister
IDA President

Raising the profile of dentistry

As the profession deals with a recruitment crisis, and with no progress on reform of the DTSS, the IDA is embarking on a major communications campaign to bring dentistry to the forefront of healthcare in Ireland.

As many of you will be all too aware, dental practices in Ireland are currently experiencing significant staff shortages, with difficulties in recruitment across the whole dental team, but particularly among dentists and dental hygienists. The IDA carried out a survey of members in September to try to get a sense of the scale and impact of this crisis. Over half of the members who responded said that their practice had tried to recruit dentists during the past 12 months, but only 50% of these had found a suitable candidate. You can read more about the results of this survey in our Members' News section in this edition. The survey identified delays in registration of dentists as a major stumbling block to recruitment; waiting times of up to six months are common. An IDA delegation will meet with Dental Council representatives shortly to discuss this and try to find a solution.



The small number of training places for nurses and hygienists has also been identified as a significant issue. Fewer than 20 dental hygienists graduate each year from the Dublin and Cork Dental Schools combined, and there is a clear need for more places to be made available. The fact that dentists and dental hygienists are not currently included on the critical skills occupations list for the purposes of obtaining a critical skills work permit is also creating difficulties for dentists attempting to recruit staff from outside Ireland. The IDA intends to make a submission on this issue in the coming months.

A multi-agency approach, involving Government departments, higher education institutions and regulatory bodies is needed to resolve this crisis, and the IDA will be to the forefront in working towards a solution.

DTSS/medical card scheme

The number of dental practices withdrawing from the Dental Treatment Services Scheme (DTSS) continues to grow. In some parts of the country there are now no dental practices operating the Scheme, with obvious consequences for vulnerable patients in need of dental care. Questions have been asked in the Dáil and in the media, as public awareness grows of this crisis.

The IDA has long argued that the DTSS is not fit for purpose, and that only a new contract can resolve long-held difficulties and enable dentists to offer appropriate care to those who need it. Unfortunately, despite assurances from the Minister for Health, Stephen Donnelly TD, that this issue is a priority, initial interactions with the Department of Health have been far from satisfactory and a framework for discussions has not yet been agreed. Central to these discussions is an agreement to afford the IDA the same protections in any negotiations that are in place for our medical colleagues. The IDA submitted a framework document similar to that negotiated with the Irish Medical Organisation (IMO), but this has not been accepted by the Department.

The system is falling apart, and unfortunately we fear that the crisis will get worse before it gets better.

Getting the message out

The IDA has appointed strategic communications agency 360 as our new communications advisors. In the coming weeks and months, we will be embarking on an ambitious campaign to raise the profile of dentistry and oral health, and place the Irish Dental Association, and the dental profession, at the centre of discussions about healthcare in Ireland. We will be asking members to get involved, and to act as advocates for the profession and for our patients. You, the members, will be vital to the success of this campaign, and I hope you will consider getting involved.

Colgate Caring Dentist Awards 2021

We are delighted that, subject to guidelines, the Colgate Caring Dentist Awards will once again take place this year. This year, we have received almost 1,000 entries, and our distinguished judging panel has begun the difficult task of choosing which dentists and dental teams will be this year's finalists. These Awards pay tribute to the exceptional work that goes on every day in dental practices all around the country. The past 18 months have been extraordinarily difficult for everyone, and we look forward to finally being able to gather to celebrate Irish dental professionals. The awards will take place on Saturday, November 20, at the InterContinental Hotel, Ballsbridge, Dublin 4, and I look forward to seeing you there.

The benefits of an adjunctive essential oil mouthwash in relation to plaque management

Johnson & Johnson Ltd., the makers of LISTERINE®, are committed to supporting dental professionals in their efforts to help patients achieve and maintain gum health. Also committed to supporting evidence-based practice, Johnson & Johnson Ltd. were pleased to see that an updated evidence base reaffirms the role of an antibacterial mouthwash in specific circumstances as an adjunct to mechanical cleaning.[1]

Worldwide, 3.9 billion people are affected by a variety of oral conditions, including untreated caries, tooth loss and periodontal disease.[2]

In fact, the Global Burden of Disease (GBD) 2010 Study, which produced comparable estimates of the burden of 291 diseases and injuries, found untreated caries in permanent teeth to be the most prevalent condition, while severe periodontitis and untreated caries in deciduous teeth ranked 6th and 10th, respectively. Severe tooth loss was found to be the 36th most prevalent condition.[2]

According to the Adult Dental Health Survey (2009), only 17% of dentate adults had very healthy periodontal tissues and no periodontal disease (defined in the survey as no bleeding, no calculus, no periodontal pocketing of 4mm or more, and in the case of adults aged 55 or above, no loss of periodontal attachment of 4mm or more anywhere in their mouth).[3]

In addition, it was found that 31% of dentate adults had obvious decay in the crowns or roots of their teeth. Further, 66% of dentate adults had visible plaque on at least one tooth.[3]

With 75% of survey respondents claiming to brush their teeth at least twice a day and, of those, a quarter reported they also cleaned interdentally every day,[3] it seems apparent that there remains an unmet need when it comes to achieving and maintaining oral health between dental appointments.

Mechanical cleaning

According to the Group B consensus report of the 5th European Workshop in Periodontology, gingivitis and periodontitis are a continuum of the same inflammatory disease,[4] with plaque bacteria considered a major cause of periodontal disease.[5]

It has been established that mechanical cleaning – brushing and interdental cleaning – is the first line in the management of plaque and, hence, the prevention of periodontal disease.[6]

On this issue, Chapple and colleagues (2015) wrote: '[…] while not all patients with gingivitis will progress to periodontitis, management of gingivitis is both a primary prevention strategy for periodontitis and a secondary prevention strategy for recurrent periodontitis.'[7]

To manage the situation effectively, as elucidated by Chapple and colleagues (2015): '… the most important risk factor for periodontitis is the accumulation of a plaque biofilm at and below the gingival margin, within which dysbiosis develops and is associated with an inappropriate

and destructive host inflammatory immune response. Plaque removal and/or control is therefore fundamentally important in the prevention of periodontal diseases.'[7]

However, while mechanical cleaning dislodges the plaque bacteria that contribute to periodontal disease,[8] data suggests that, for a number of reasons, this is not enough for the majority of patients to maintain good levels of oral health.[9]

Working Group 2 of the 11th European Workshop in Periodontology further put forward that, for patients with gingivitis, in addition to toothbrushing, once-daily interdental cleaning and the adjunctive use of a chemical plaque control agent would help in the recovery of oral health. In overview, it was suggested that for some patients there are advantages to the adjunctive use of chemical agents for plaque control.[7]

More recently, looking at periodontal disease as a whole, the FDI's White Paper on Prevention and Management of Periodontal Diseases for Oral Health and General Health (2018) asserts that toothbrushing alone with a fluoride toothpaste achieves insufficient results in interdental cleanliness, stating:[10]

> 'The additional use of flosses and/or interdental brushes is essential for removal of interdental plaque. In addition, according to the Guidelines for Effective Prevention of Periodontal Diseases produced by the EFP (2015), some specific mouth rinses offer benefit in the management and prevention of gingivitis, as do certain chemical agents in dentifrices as an adjunct to mechanical plaque removal.'

Bearing all of this in mind, it seems evident that there is a case to be made for the use of an effective antimicrobial mouthrinse as an adjunct to brushing and interdental cleaning to help prevent periodontal disease.

Updated evidence base

In 2019, Figuero and colleagues conducted a systematic review and meta-analysis exploring the adjunctive use of 11 different mouth rinse formulations.[10]

They concluded that adjunctive antiseptics in mouthwash provide statistically significant reductions in plaque compared to controls at six months.[10]

They also came to the conclusion that, '… despite the high variability in the number of studies comparing each active agent and the different risks of bias, CHX [chlorhexidine] and EOs [essential oils], in mouthrinses appeared to be the most effective active agents for plaque … control.'[1]

In addition, the Figuero and colleagues' (2019) outcomes add to the pre-existing evidence base presented by Araujo and colleagues (2015), which was the first meta-analysis to demonstrate the clinically significant, site-specific benefit of adjunctive essential oil mouthwash in people within a 6-month period (that is, between dental visits).[11]

It is additionally important to note that by presenting the percentage of plaque-free tooth surfaces that achieved health, Araujo and colleagues (2015) provided a then novel form of data to help dental healthcare professionals make evidence-based decisions to manage plaque in their patients.[11]

The analysis revealed that 36.9% of subjects using mechanical methods with essential oil-containing mouthwash experienced at least 50% plaque-free sites after 6 months, compared to just 5.5% of patients using mechanical methods alone.[11]

In essence, Araujo and colleagues' (2015) meta-analysis suggests that the adjunctive use

of an essential oil mouthrinse is of clinical benefit, helping to support, '...the goals of preventive services.'[11]

They wrote: '[The] addition of daily rinsing with an EO mouthrinse to mechanical oral hygiene provided statistically significantly greater odds of having a cleaner … mouth, which may lead to prevention of disease progression.'[11]

Demonstrating efficacy

Boyle and colleagues (2014) considered the efficacy of a number of the more widely available mouthwash formulations.[9]

Chlorhexidine, for example, when used for fewer than three months, was found to be the most effective of the mouthwash variants investigated (specifically, chlorhexidine, essential oils, cetylpyridinium, triclosan and delmopinol).[9]

Based on these findings, Boyle and colleagues (2014) wrote: 'An adjunctive method of plaque control is the use of antiseptics, of which chlorhexidine is the most effective [in studies of less than three months] although its tendency to stain teeth and impair taste makes it generally unacceptable for long-term use.'[9]

When the efficacy of the five formulations was reviewed over a six-month-plus period, Boyle and colleagues (2014) deduced that essential oil-containing mouthwash equalled or exceeded the effect of chlorhexidine in controlling plaque as an adjunct to standard care.[9]

As for the remaining three active ingredients investigated: ''Mouthwash preparations containing cetylpyridinium or triclosan may […] be effective, but less than the two former [chlorhexidine and essential oils], while mouthwashes containing delmopinol are not effective for plaque and gingivitis control.'[9]

A specific formulation

In 1867, Joseph Lister had his article, 'On the antiseptic principle in the practice of surgery', published in the British Medical Journal.[12] In it he listed various antiseptic agents, including thymol and oil of eucalyptus.[13]

Universal acceptance took a little time; however it is written that, 'By 1890 nearly the whole surgical world had accepted Lister's great innovation, and by this time the microbes that caused sepsis had been identified and cultured. Many surgeons had adopted the aseptic technique…'[13]

In the meantime, in 1879, Dr Joseph Lawrence and pharmacist Jordan Wheat Lambert created an antiseptic using four essential oils. The four included the above-mentioned thymol and eucalyptol, alongside menthol and methyl salicylate. They subsequently formed the basis of LISTERINE®, so called to honour Lister's work.[14]

For many years LISTERINE® was used as a general antiseptic and marketed as suitable for a number of purposes, however between the mid-1970s and 1980s it was promoted as a mouthwash that may help to prevent plaque accumulation.[14]

Available products

At the present time, Johnson & Johnson Ltd. have two products in its LISTERINE® range that to help support patients' gum health – LISTERINE® Total Care and Advance Defence Gum Treatment.

It has been demonstrated that when used as an adjunct to mechanical cleaning, LISTERINE® Total Care, an essential oil mouthwash, manages plaque levels, to help prevent gingivitis.[9]

LISTERINE® Total Care may therefore support the efforts of a patient requiring early intervention, by virtue of its essential oil formulation consisting of eucalyptol, thymol, menthol and methyl salicylate, all of which are proven to:

- Penetrate the plaque biofilm[15]
- Manage the bacterial load of the mouth[16]
- Reduce maturation of remaining biofilm colonies.[17]

LISTERINE® Advanced Defence Gum Treatment is a twice-daily mouthwash clinically proven to treat gingivitis as an adjunct to mechanical cleaning.[18]

It is formulated with unique LAE (Ethyl Lauroyl Arginate) technology that forms a physical coating on the pellicle to prevent bacteria attaching, and so interrupts biofilm formation. When used after brushing, it helps to treat gingivitis as demonstrated by the reduction of bleeding by 50.9% ($p<0.001$) in just 4 weeks.[18]

With LISTERINE® Advanced Defence Gum Treatment clinically proven to interrupt the plaque colonisation process,[18] this may offer a viable option in terms of supporting patients' gum health.

A partnership approach

Through our range of mouthwashes, Johnson and Johnson Ltd. help dental teams work in partnership with patients, with specific products designed to improve home care routine outcomes significantly, which help to support the prevention or management of periodontal disease when used in conjunction with mechanical cleaning.

For more information visit **www.listerineprofessional.co.uk**

Acknowledgements

1. **Figuero, E., *et al.*** Efficacy of adjunctive therapies in patients with gingival inflammation: a systematic review and meta-analysis. *J Clin Periodontol* 2020; 47 (Suppl. 22): 125-143.
2. **Marcenes, W., *et al.*** Global burden of oral conditions in 1990-2010: a systematic analysis. *J Dent Res* 2013; 92 (7): 592-597.
3. **The Health and Social Care Information Centre.** Adult Dental Health Survey 2009. 2011. Available from: .
4. **Kinane, D.F., Attström, R.** Advances in the pathogenesis of periodontitis. Group B consensus report of the fifth European Workshop in Periodontology. *J Clin Periodontol* 2005; 32 (Suppl. 6): 130-131.
5. **Page, R.C., Kornman, K.S.** The pathogenesis of human periodontitis: an introduction. *Periodontol 2000* 1997; 14: 9-11.
6. **Sharma, N., *et al.*** Adjunctive benefit of essential oil-containing mouthrinse in reducing plaque and gingivitis in patients who brush and floss regularly: a six-month study. *J Am Dent Assoc* 2004; 135 (4): 496-504.
7. **Chapple, I.L.C., *et al.*** Primary prevention of periodontitis: managing gingivitis. *J Clin Periodontol* 2015; 42 (Suppl. 16): S71-S76.
8. **Barnett, M.L.** The rationale for the daily use of an antimicrobial mouthrinse. *J Am Dent Assoc* 2006; 137 (Suppl.): 16S-21S.
9. **Boyle, P., *et al.*** Mouthwash use and the prevention of plaque, gingivitis and caries. *Oral Dis* 2014; 20 (Suppl. 1): 1-68.
10. **FDI World Dental Federation.** White paper on prevention and management of periodontal diseases for oral health and general health. 2018. Available from: .
11. **Araujo, M.W.B., *et al.*** Meta-analysis of the effect of an essential oil-containing mouthrinse on gingivitis and plaque. *J Am Dent Assoc* 2015; 146 (8): 610-622.
12. **Lister, J.** On the antiseptic principle in the practice of surgery. *Br Med J* 1867; 2 (351): 246-248.
13. **Cope, Z.** Joseph Lister, 1827-1912. *Br Med J* 1967; 2 (5543): 7-8.
14. **Fine, D.H.** Listerine: past, present and future – a test of thyme. *J Dent* 2010; 38 (Suppl. 1): S1-S5.
15. **Pan, P., *et al.*** Determination of the in situ bactericidal activity of an essential oil mouthrinse using a vital stain method. *J Clin Periodontol* 2000; 27 (4): 256-261.
16. **Minah, G.E., *et al.*** Effects of 6 months use of an antiseptic mouthrinse on supragingival dental plaque microflora. *J Clin Periodontol* 1989; 16 (6): 347-352.
17. **Johnson & Johnson.** Data on file (2).
18. **Gallob, J.T., *et al.*** A randomized trial of ethyl lauroyl arginate-containing mouthrinse in the control of gingivitis. *J Clin Periodontol* 2015; 42 (8): 740-747.

DENTAPEN

by Septodont

the **PERFECT MATCH** for your practice

NEW!

CORDLESS

EFFORTLESS

PAINLESS

DENTAPEN

Beyond injection: Dentapen, the new generation of powered injector for Dental Anaesthesia.

Matches your practice needs
takes standard 2.2ml cartridges. So easy to use that your last injection of the day will be as good as your first one, for both you and your patient

Matches your patients' expectations
less pain, less anxiety, reassuring technology

Matches your routine
easy and comfortable to use, compatible with any needle, both syringe and pen-like holding possible

MANAGING PAIN FOR **YOUR PRACTICE**

septodont

www.septodont.ie or call Gerry Lavery on +44 (0)7836 255274 for an on-line demonstration

Annual Conference 2022

The Annual Conference 2022 will take place on May 12-14 at the old faithful venue of The Galmont Hotel, Galway. We are delighted this year to welcome Dr Minesh Patel, Dr Celine Higton, Dr Markuz Blatz (pictured) and Dr Wally Rene to the programme, along with many more. Further details will be announced soon.

Branches/regional groups to recommence face-to-face meetings

Following on from recent Government announcements re: Covid-19 restrictions, we are delighted to announce that branches/regions will be allowed to commence face-to-face meetings after October 22.

Branch committees are meeting to decide on speakers, venues and dates.

IDA logo

IDA members are entitled to use the 'member of IDA' logo on their website, headed notepaper, business cards, etc. The logo may only be used on the website if all dentists in the practice are IDA members. To get your copy of the most recent logo, please contact Aoife at IDA House on aoife@irishdentalassoc.ie.

IDA
irish dental association
MEMBER 2022

Dr Amalia Pahomi elected HSE President

The AGM of the HSE Dental Surgeons Group took place on October 7 via Zoom. The AGM was preceded by a fantastic lecture by Mr Paul Ashley, Paediatric Consultant at King's College London, on the topic of 'Avoiding GA for children'.

Dr Amalia Pahomi was elected President of the HSE Dental Surgeons Group at the AGM. Dr Pahomi is a Romanian dental graduate and is a general dentist at Hartstown Health Centre, Dublin 15.

Postgrad Certificate in Orofacial Pain

The Dublin Dental University Hospital's (DDUH) online Postgraduate Certificate in Orofacial Pain commenced in January of this year and the first students will graduate in November. They will receive their qualification having been taught jointly by two universities – Trinity College Dublin (TCD) and the University of Southern California (USC). Applications are open now for the 2022 course and general dental practitioners with good clinical experience are invited to apply. Students will be able to log in from anywhere to tutors who will be based in Dublin and California. Prof. Glenn Clarke of USC, who is a world-renowned researcher in orofacial pain, is a joint course director, along with Drs Dermot Canavan (pictured) and Philip Hardy of TCD. Speaking to the *Journal*, Dr Canavan said: "The course focuses 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 requirement for the Postgrad Certificate is one day a week but, of course, being online that can be completed from anywhere". The course starts in January and interested parties should contact the DDUH immediately.

IDA joins FDI response to WHO oral health strategy

The FDI World Dental Federation (FDI) and 65 other organisations, including the Irish Dental Association, have submitted a joint response to the public consultation for the World Health Organisation's (WHO) draft Global Strategy on Oral Health.

The current strategy's vision fully aligns with the FDI's Vision 2030: Delivering Optimal Oral Health for All document, and also refers to the three elements of universal health coverage (UHC) — quality, equitable access, and financial protection — in the context of oral health promotion and oral healthcare.

While commending this initial draft, the FDI and co-signatories urge the WHO to develop a global strategy that is robust, time bound, and implementation oriented, encompassing more ambitiously all the different areas that require reform in national health systems for oral health to become an integral element of UHC and noncommunicable disease (NCD) strategies.

The Global Strategy would benefit from a more comprehensive description of all the implications that the associations between oral health, NCDs and general health have for health systems. The importance of optimising the oral health workforce to achieve the vision and goal of this Global Strategy calls for a specific strategic objective on oral health workforce. Sustainability should also be included as a guiding principle.

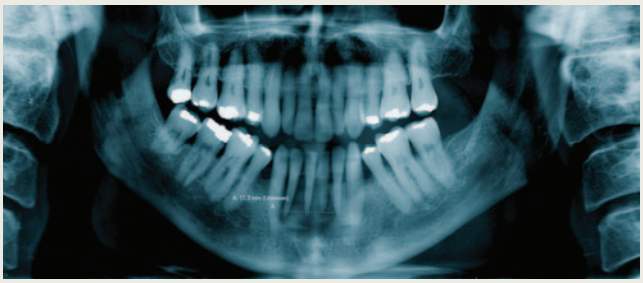
The FDI stands ready to support the WHO and member states with the development and implementation of the Global Strategy.

Quiz

Submitted by Dr Maeve Breen

A 70-year-old gentleman presents to your general dental practice complaining of increasing mobility and swelling related to his lower incisors over the past two weeks. The patient is known to have metastatic thyroid cancer. Clinical examination reveals a large, firm swelling affecting the buccal mucosa of the lower incisors. The overlying mucosa is non-ulcerated with no discharge noted.

1. What investigations would you carry out to aid your diagnosis?
2. Describe the lesion seen in the radiograph (pictured)?
3. How would you manage this lesion?



4. The lesion is biopsied and the histology reported as metastatic thyroid carcinoma. What is the most common site in the oral soft tissues for metastases?

Answers on page 266

Call for IDA ties!

Dr Nairn Wilson is looking for IDA ties for the British Dental Association (BDA) Museum. Dr Wilson is assisting the BDA Museum in creating a dental tie archive, and is specifically looking for 'club' ties, 100 years after it is understood that the first dental tie was introduced. To date, the BDA Museum Dental Necktie Archive includes c.200 different dental ties from around the world, including dental school, student society, association, federation, specialist society, sports club, anniversary, conference, and some novelty ties. Regrettably, the Archive does not have any dental ties from Ireland, including an IDA tie. The Archive is providing a valuable insight into the last hundred years of dentistry across the world, and Dr Wilson says that it would be excellent to have a strong Irish presence in the collection, so if you have a dental tie lying unused in a drawer that you would like to donate, please contact nairn.wilson@btinternet.com.

reveal™
CLEAR ALIGNERS

REVEAL THE CONFIDENCE IN A GREAT SMILE.

SO SIMPLE. SO CLEAR.

Visit henryschein.ie for more info

Clear aligners from start to finish.
Your patients want this

Engineered to provide increased clarity over leading aligners throughout the entire treatment - PLUS guaranteed not to discolour, cloud or yellow over time.

Real simplicity. Full support.
Increase your case acceptance

All the tools you need to grow your aligner revenue and give your patients a smile they love.

Comfortable fit with no need to fit unsightly attachments.
Less chair time

With a truly intimate fit to the tooth, each aligner has better control with no unsightly attachments. The scalloped, smooth edges fit securely along the gingival margin to maximise your patient's comfort.

Over 50,000 aligner cases produced
A simpler, proven approach that reduces case complexity

Perfect for all cases that do not require bite adjustments. Plus, the simpler web-based software and intuitive case submission portal let us do the treatment plan, to support you in the process.

Flexible options.

Reveal aligners are available in the following packages:

- **Standard**. 21-30 sets
- **Lite**. Less than 20 sets
- **Express**. Less than 10 sets
- **Extra aligners** also available

Email iesales@henryschein.ie
or call 01 4565288 to start your cases today
or book a free video demo

Coming soon: Reveal+
The new aligner with all the benefits of Reveal, plus additional treatment options for more complex cases.

Taking care of everything dental 01 4565288 henryschein.ie

• Business Solutions • CADCAM • Consumables • Decontamination • Digital Imaging • Education • Equipment • Laboratory • Lasers • Orthodontics • Service and Repair • Software • Surgical

BLS/medical emergencies

There has been very strong interest in our BLS/medical emergency courses in association with Safe Hands. Further dates are planned for early 2022 (see below – all courses commence at 10.00am).

Saturday, February 19, 2022	Radisson Blu Hotel, Dublin Airport
Saturday, February 26, 2022	Radisson Blu Hotel, Athlone
Saturday, March 12, 2022	Maryborough Hotel, Cork

To book, go to the CPD section on www.dentist.ie.

Medical emergencies for those offering sedation

Dentists and dental team members who offer sedation will need to complete a slightly modified course in medical emergencies (Dental ILS course). These will run as follows (all courses commence at 9.00am):

Friday, February 18, 2022	Radisson Blu Hotel, Dublin Airport
Friday, February 25, 2022	Radisson Blu Hotel, Athlone
Friday, March 11, 2022	Maryborough Hotel, Cork

To book, go to the CPD section on www.dentist.ie.

Colgate Awards Gala Ball

The Colgate Caring Dentist Awards have again proved a tremendous channel through which patients can express their gratitude for the care they receive from their dental professionals. With almost 1,000 entries to read, the members of the judging panel have a difficult task ahead of them.

If you have been nominated, you can attend the Gala Ball with your team. The Gala Ball takes place on Saturday, November 20, in the InterContinental Hotel in Ballsbridge, Dublin 4. Tickets are available on www.dentist.ie or by ringing the IDA office on 01-295 0072. The judges this year are Dr Barry Harrington, Dr Seton Menton, Dr Frances O'Callaghan, and Dr Divya Sweeney.

ISDH conference 2021

The Irish Society for Disability and Oral Health (ISDH) held its 2021 conference in June. The theme was 'Mature mouths matter' and encompassed the multifaceted oral care management of Ireland's growing elderly population. The programme consisted of three excellent virtual lectures on oral healthcare as it relates to dementia, polypharmacy and residential care home environments from Drs Vicky Jones and Patricia O'Connor, and Ms Carolyn Joyce, respectively.

The ISDH prides itself on empowering people with disadvantages and disabilities, and those who support them, to achieve oral health through advocacy, community and education. For further information see www.isdh.ie.

Dental student award winner, Eszter Lujber, presented her paper on the most effective way to deliver oral hygiene to care home residents.

North channel relay

From left: Padraig Mallon, Infinity Crossing; Mark Murnaghan, crew; Dr David Murnaghan, swimmer; Ambrose Clinton, crew; Blair Clinton, swimmer; Stephen Murphy, swimmer; Jonathan Heatherington, crew; and, David Burke, Irish long distance sea observer.

An Irish dentist recently took part in a charity relay swim across the North Channel. Dr David Murnaghan of Boyne Dental was part of the three-person Couch to Channel relay team that left Donaghadee in Co. Down in pitch black waves on September 14 to head for Scotland. Led by Infinity Channel Crossing, David, along with teammates Stephen Murphy and Blair Clinton, navigated the 34.5km direct stretch in 43km of swimming.

David and his team are the fourth three-person relay team to complete this challenge, joining one two-person team and 89 solo swimmers. There are seven channel swims in the world, and the North Channel is deemed the toughest due to a combination of distance, low temperatures and lion's mane jellyfish.

The swim raised money for the RNLI Dunmore East, and to date the team has raised €11,000. If you would like to donate to this very worthy cause, please go to: https://www.justgiving.com/fundraising/David-Murnaghan-and-friends-swim-for-DunmoreRNLI?.

UNITES FLOWABILITY AND SCULPTABILITY

*Vis*Calor
*Vis*Calor bulk

- **Unique and innovative**
  Warming of the material makes it flowable for the application and then sculptable immediately afterwards (thermo-viscous-technology)
- **High-quality application**
  Optimal flowing to margins and undercut regions
- **Time-saving**
  Efficient restorations with only one material
- **Simple handling**
  Bubble-free application with slender cannula

*Vis*Calor: 2 mm *Vis*Calor bulk: 4 mm

For more information please contact
Claire Austin · Mobile: +44 7584200138

MADE IN GERMANY 100%

TVT thermo-viscous-technology

VOCO THE DENTALISTS

VOCO GmbH · Anton-Flettner-Straße 1-3 · 27472 Cuxhaven · Germany · Freecall 00 800 44 444 555 · www.voco.dental

HOW TO CONNECT YOUR SCANNER TO MediMatch DENTAL LABORATORY

MEDIT

Available to Purchase from MediMatch

- Partners
- Search for partners 'medimatch dental lab'

iTero element

- Connect
- scan@medimatch.co.uk

3shape

- Configure
- Lab connection
- Add scan@medimatch.co.uk
- Go to communication
- scan@medimatch.co.uk
- Once connection is accepted click 'Refresh'

Dentsply Sirona

- scan@medimatch.co.uk

Carestream DENTAL

- scan@medimatch.co.uk

ANY OTHER BRAND SCANNERS:

MediMatch accepts most scanners, if your scanner is not listed above, call our digital department on 01 830 9375.

We accept traditional and digital impressions

NOW ACCEPTING NEW CUSTOMERS

T: 01 830 9375 • E: questions@medimatch.ie • W: www.medimatch.ie

Bringing their brilliance

The IDA has recently launched a campaign to attract more foreign-trained dentists into Ireland. Here, we share the stories of dentists from other countries who have come to Ireland and found success in work and the Irish Dental Association.

Dr Amalia Pahomi

HSE Dental Surgeon

President of HSE Dental Surgeons Group

Amalia comes from Târgu Mure, a city in the heart of Transylvania in Romania, and studied dentistry in Cluj-Napoca: "I graduated in 1999 and just a few years later, I came to Ireland. At that time, Romania was not in the EU, so I had to sit the Irish Dental Council examinations for foreign-trained dentists and I got registered with the Dental Council in 2005".

Amalia currently works as a public dental surgeon in Hartstown Health Centre in Dublin 15. She joined the IDA soon after coming to Ireland: "I became a member of the IDA in 2005 as soon as I got registered with the Irish Dental Council. In 2014, my then Principal Dental Surgeon, Dr Jane Renehan, asked me to consider joining the IDA HSE Dental Surgeons Committee and I did".

Now, Amalia has risen through the ranks and is taking on the role of President of the Group at a time when there are serious issues within the public dental service. While HSE dentists who were seconded for Covid duties are now back at their normal work, the time they spent helping the country out has naturally resulted in delays: "I think the big issue at present is to catch up with the backlog as a result of the pandemic and resume normal services while dealing with the challenges imposed by staff shortages, redeployments, and increased demand on our services".

Amalia says that there will be challenges in the year ahead for public dentistry: "The public dental service has been severely affected by the pandemic and the HSE Committee will work hard to help and guide its members during this time. I would aim for very close co-operation between the public and private services in providing the best care for the patients".

Amalia commends HSE dentists for their extraordinary effort during the Covid pandemic, "either by being redeployed or working in the dental surgeries, and very often doing both roles at the same time".

Positive impact

Amalia says that the IDA was the biggest source of information to her about Irish dentistry when she came here first, and that the Association has helped her continuously since then: "Being an IDA member, I've had numerous opportunities to meet new colleagues, and to attend events and seminars organised by the IDA to keep up with CPD requirements and be up to

date with any dentistry-related issues. My involvement in the HSE Dental Surgeons Committee also helped me to understand better the HSE organisational structures and politics, and the work of the Committee on behalf of its members".

Considering Ireland's multicultural society, Amalia believes dentists from outside Ireland have a positive impact, both from a dental and cultural perspective: "Sharing personal and professional experiences with colleagues from other countries and cultures is beneficial, both for the patients and the dental team".

Amalia loves living in Ireland and says Irish people have made her feel very welcome. Living here has afforded her great professional and personal opportunities, but it's only natural that there are some things she misses from home: "I miss my family and friends, especially my college friends, but I had the chance to meet them again in 2019 at our 20-year reunion. I just wish I could bring the warm Romanian summers and great winter snows over here".

Advice

Amalia would like to share her positive experience of working in dentistry in Ireland with any dentists thinking about coming here: "I would encourage them to join the IDA as soon as possible because it is a great resource for meeting other dentists and finding out how dentistry works in Ireland".

Dr Marcela Torres-Leavey

Kinnegad Dental, Co. Westmeath

Marcela swapped Latin America for the Irish Midlands in the mid-00s, after meeting her now husband Aidan while he was working in her home country of Guatemala. She set up Kinnegad Dental in the Westmeath town in 2012.

Marcela's studies in Guatemala entailed six years of training, the sixth of which sees students go to work in the community to help those most in need: "It gives you a fantastic feel of the real world, going out there to practise as a dentist, and the responsibility that it takes to have somebody with you in the dental chair".

Marcela got married in 2007 and completed her Dental Council exams the following year. In 2009, she started practising. Her principal dentist at the time recommended that she join the IDA: "IDA membership for me is something I couldn't do without. I really love being part of the IDA because I am happy with the guidance they have provided for me, the support when I needed it, as well as all the courses that happen throughout the year".

Her Irish family helped her settle in the country, but another strong source of assistance was joining the IDA, both for professional and moral support: "It's a way to integrate and it's a way to not just learn clinical things, but also learn from other dentists, even from the small interactions we have at coffee breaks when we go to the seminars".

There are things she misses about Guatemala, such as her family, the food and the landscape, but she has settled in well in Ireland: "The people here in Ireland are fantastic. They're happy. The sense of humour is really similar to our sense of humour in Latin America. People here are really welcoming as well. That makes me not feel as homesick as I thought I would be".

For dentists coming here, she says prepare well. Have your documents in order, research where you want to live, and speak to the IDA: "Working and living in Ireland in my experience has been joyful and a blessing … I'm delighted that I can practise in a country that lets me do my work and provides me with the opportunities to keep learning, growing and to be respected in my field. As a woman, I came from a country where it is difficult to make your mark and to have a better life. I am delighted to be here and have a beautiful family and friends and dental friends, and obviously, I love my patients!"

Dr Erika Barta

Crown Dental, Harold's Cross, Dublin

Erika graduated in 2005 in Budapest before doing a master's in restorative and prosthetic dentistry in Debrecen, a university town in Hungary: "After getting my master's degree, I always wanted to try myself and work in another country. I decided to move to the UK and I worked there for a year. Then I was offered a position in Dublin, so I decided to move over here and I really liked it. I fell in love with the country. The place is beautiful, the people are friendly, so I stayed".

That was 12 years ago and since she came to Ireland, Erika says the IDA has been of great help

Skudexa ▽ ® 75 mg/25 mg film-coated tablets (tramadol hydrochloride/dexketoprofen). Abbreviated Prescribing Information

Please consult the Summary of Product Characteristics (SmPC) for full prescribing information.

Presentation: Film-coated tablets containing tramadol hydrochloride 75 mg and dexketoprofen 25 mg. Excipients with known effects: croscarmellose sodium and sodium stearyl fumarate

Use: Symptomatic short term treatment of moderate to severe acute pain in adult patients whose pain is considered to require a combination of tramadol and dexketoprofen.

Dosage: Adults: 1 tablet (75 mg tramadol hydrochloride/ 25 mg dexketoprofen), additional doses as needed with a minimum dosing interval of 8 hours. Maximum daily dose 3 tablets/day. Use lowest effective dose for the shortest duration necessary to control symptoms. Maximum duration of use is 5 days. Patients with mild-moderate hepatic dysfunction or mild renal dysfunction: maximum daily dose is 2 tablets/day. Elderly: initial dose is 2 tablets/day can be increased to a maximum of 3 tablets/day after good tolerance established. Use with caution in patients over 75 years.

Contra-indications: Hypersensitivity to any component or other NSAID or excipients. NSAID induced attacks of asthma, bronchospasm, acute rhinitis, or nasal polyps, urticaria or angioneurotic oedema. Known photoallergic or phototoxic reactions during treatment with ketoprofen or fibrates. History of gastrointestinal bleeding or perforation, related to previous NSAIDs therapy. Active peptic ulcer/gastrointestinal/haemorrhage or any history of gastrointestinal bleeding, ulceration or perforation, chronic dyspepsia, other active bleeding or bleeding disorders, Crohn's disease or ulcerative colitis, severe heart failure, moderate-severe renal dysfunction, severe hepatic dysfunction, haemorrhagic diathesis and other coagulation disorders, severe dehydration. Acute intoxication with alcohol, hypnotics, analgesics, opioids or psychotropic medicinal products. Concomitantly with MAO inhibitors or within 14 days of having taken them. Inadequately controlled epilepsy. Severe respiratory depression. Pregnancy and lactation.

Warnings and precautions: *Dexketoprofen:* Caution in allergic conditions. Avoid use with concomitant other NSAIDs including COX-2 selective inhibitors. Gastrointestinal bleeding, ulceration or perforation which can be fatal, have been reported with all NSAIDs at anytime during treatment, with or without warning symptoms or a previous history of serious gastrointestinal events. When gastrointestinal bleeding or ulceration occurs withdraw treatment. The risk of gastrointestinal bleeding, ulceration or perforation is higher with increasing NSAID doses, in patients with a history of ulcer, particularly if complicated with haemorrhage or perforation, and in older people. Ensure cure of oesophagitis, gastritis and/or peptic ulcer before starting treatment. Consider combination therapy with protective agents (e.g. misoprostol or proton pump inhibitors), and in patients requiring concomitant low dose aspirin, or other drugs likely to increase gastrointestinal risk. Monitor patients with a history of gastrointestinal toxicity, particularly when elderly, for unusual abdominal symptoms (especially gastrointestinal bleeding) particularly in the initial stages. Caution in patients receiving oral corticosteroids, anticoagulants, SSRIs or anti-platelet agents. Caution in patients with impairment of renal function, receiving diuretic therapy or those who could develop hypovolaemia. Ensure adequate fluid intake. Caution in liver impairment. Appropriate monitoring and advice required with history of hypertension and/or mild to moderate heart failure. Special caution in patients with cardiac disease, especially episodes of previous heart failure. Only treat patients with uncontrolled hypertension, congestive heart failure, established ischaemic heart disease, peripheral arterial disease, and/or cerebrovascular disease after careful consideration. Similarly for risk factors for cardiovascular disease (e.g. hypertension, hyperlipidaemia, diabetes mellitus, smoking). Caution in haematopoietic disorders, systemic lupus erythematosus, connective tissue disorders, impairment of hepatic and/or renal functions, history of hypertension and/or heart failure, diuretic therapy, the elderly. Older people are more likely to be suffering from impaired renal, hepatic and cardiovascular function. Serious skin reactions (some of them fatal), including exfoliative dermatitis, Stevens-Johnson syndrome, and toxic epidermal necrolysis were reported very rarely. Particular caution is required in patients with congenital disorder of porphyrin metabolism, dehydration, directly after major surgery. Severe acute hypersensitivity reactions have been observed on very rare occasions. Discontinue treatment at the first signs of severe hypersensitivity reactions. Can cause asthma attacks or bronchospasm, particularly in subjects allergic to acetylsalicylic acid or NSAIDs. Avoid use in case of varicella. Do not use with warfarin, other coumarins or heparin. Can mask the symptoms of infectious diseases. *Tramadol:* Use with particular caution in patients with an addiction, head injury, shock, reduced level of consciousness of uncertain origin, disorders of respiratory centre or function or increased intracranial pressure. Use with caution in patients sensitive to opiates. Care should be taken in treating patients with respiratory depression, with concomitant CNS depressant drug administration or significant excess of the recommended dose as resulting respiratory depression cannot be excluded. Convulsions have been reported with recommended doses of tramadol, this risk may increase when exceeding the recommended upper daily dose limit (400mg). Seizure risk increases in patients taking other seizure threshold lowering medications. Only treat patients susceptible to seizures with tramadol if circumstances are compelling. Tolerance, psychic and physical addiction may develop. For patients with abuse/dependence potential only treat for short periods under strict medical supervision. Consider tapering dose gradually when discontinuing treatment to prevent withdrawal symptoms. Tramadol in combination with other serotonergic agents or alone can cause serotonin syndrome. Opioids can cause sleep-related breathing disorders including central sleep apnoea (CSA) and sleep-related hypoxemia consider decreasing the total opioid dosage in patients with CSA. Opioid analgesics may occasionally cause reversible adrenal insufficiency requiring monitoring and glucocorticoid replacement therapy. CYP2D6 deficiency may reduce the analgesic effect, whereas ultra-rapid metabolisers of CYP2D6 incur risk of opioid toxicity even at commonly prescribed doses. Extreme caution and close monitoring for opioid toxicity required when administering tramadol to children for post-operative pain relief. Not recommended in children with compromised respiratory function. *Skudexa:* Not for use in children and adolescents. Concomitant use with sedative medicines such as benzodiazepines or related drugs should be reserved for patients with no alternative treatment options, using the lowest effective dose and an as short as possible treatment duration while following them closely for signs of respiratory depression and sedation.

Interactions: *Dexketoprofen:* Other NSAIDs, anti-coagulants, heparins, corticosteroids, lithium, methotrexate, hydantoines and sulphonamides, diuretics, ACE inhibitors, antibacterial aminoglycosides and angiotensin II receptor antagonists, pentoxyfilline, zidovudine, sulfonylureas, beta-blockers, cyclosporin and tacrolimus, thrombolytics, anti-platelet agents and SSRIs, probenecid, cardiac glycosides, mifepristone, quinolone antibiotics, tenofovir, deferasirox, pemetrexed. *Tramadol:* MAOIs, coumarin derivatives (e.g. warfarin), mixed agonists/antagonists opioid receptors (e.g. buprenorphine, nalbuphine, pentacozine), SSRIs, SNRIs, tricyclic antidepressants, antipsychotics and other seizure threshold-lowering medication (e.g. bupropion, mirtazapine, tetrahydrocannabinol), sedative medicines such as benzodiazepines, centrally depressant medications or alcohol, cimetidine, carbamazepine, ondansetron (5-HT3 antagonist) and substances inhibiting CYP3A4 (e.g. ketoconazole, erythromycin).

Pregnancy and lactation: Contra-indicated during pregnancy and lactation. Do not use in women attempting to conceive.

Side-effects: *Skudexa: Common (≥ 1/100, <1/10):* dizziness, nausea, vomiting. *Uncommon (≥ 1/1000, <1/100):* thrombocytosis, laryngeal oedema, hypokalaemia, psychotic disorder, headache, somnolence, periorbital oedema, vertigo, tachycardia, hypertensive crisis, hypotension, abdominal distension, constipation, dyspepsia, raised LFTs, face oedema, hyperhidrosis, urticaria, haematuria, asthenia, chills, discomfort, feeling abnormal, BP increased, increased alk phos, increased LDH. For less frequent side effects and side effects associated with the individual constituents see SmPC.

Pack size: 15 tablets. **Legal category:** POM A **Marketing authorisation number:** PA 865/20/1

Marketing authorisation holder: Menarini International Operations Luxembourg S.A., 1 Avenue de la Gare, L-1611 Luxembourg. **Marketed by:** A.Menarini Pharmaceuticals Ireland Ltd Further information is available on request to A Menarini Pharmaceuticals Ireland Ltd, 2nd Floor, Castlecourt, Monkstown Farm, Monkstown, Co. Dublin Co. Dublin, Ireland A96 T924 or may be found in the SmPC.

Date of preparation: August 2021

▽ This medicinal product is subject to additional monitoring. This will allow quick identification of new safety information. Healthcare professionals are asked to report any suspected adverse reactions via the HPRA Pharmacovigilance website: www.hpra.ie. Adverse events should also be reported to A. Menarini Pharmaceuticals Ireland Ltd. Phone no: 01 284 6744.

A.MENARINI PHARMACEUTICALS IRELAND LTD *Healthcare for Life*

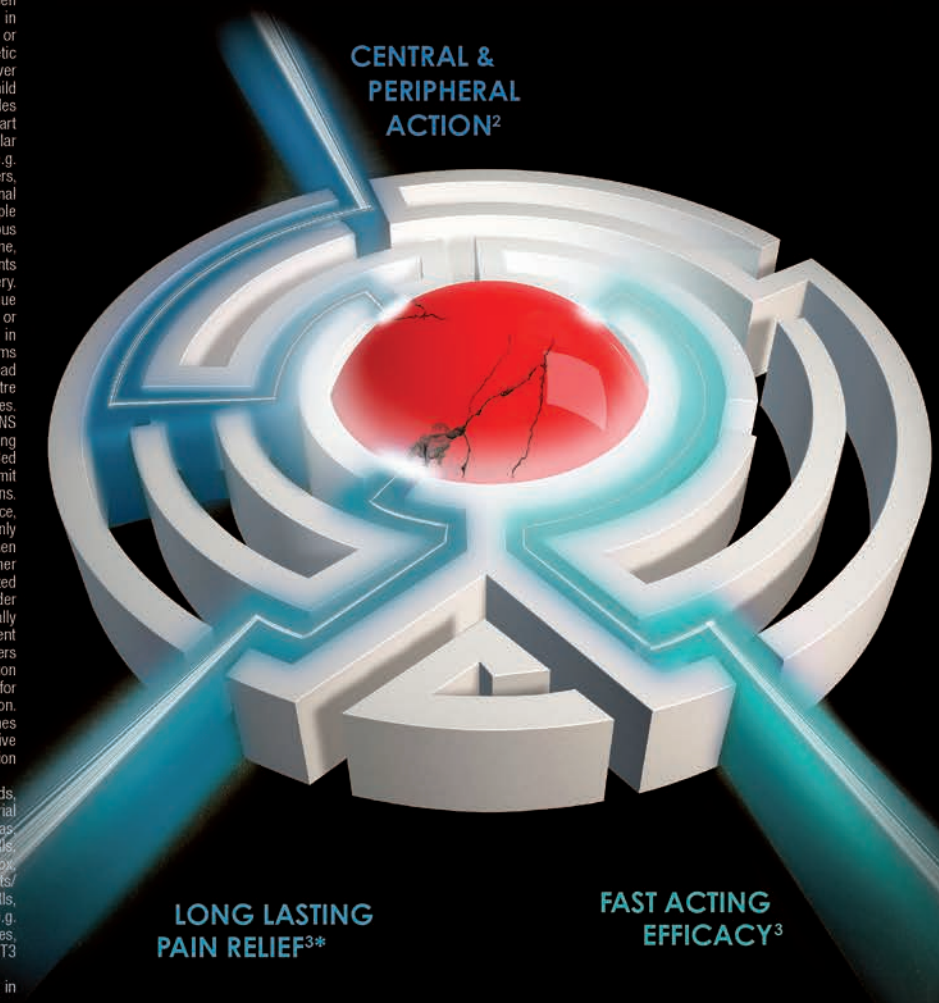
20 YEARS A.MENARINI PHARMACEUTICALS IRELAND LIMITED

SKUDEXA® ▽

Tramadol Hydrochloride + Dexketoprofen

75mg/25mg film-coated tablets

Fixed Dose Combination for Moderate to Severe Acute Pain[1]



Multimodal analgesia with **central** and **peripheral** action.[2,4,5]

* In a model of acute pain (third molar extraction) Skudexa demonstrated a median duration of action of 8.1 hours post-dose[3]

References: 1. Skudexa Summary of Product Characteristics, August 2021 2. Moore RA et al. BMC Anaesthesiol. 2016; 16:9 3. Moore RA et al. The Journal of Headache and Pain. 2015; 16:60 4. McQuay HJ et al. Br J Anaesthesia. 2016; 116:269-276 5. Gay-Escoda C et al. BMJ OPEN 2019; 9:e023715. doi 10.1136/bmjopen-2018-023715

Date of item: September 2021. IR-SKU-14-2021

to her: "When I moved over from the UK, I wanted to get familiar with the local regulations and obviously, I was trying to find courses to improve my skills as well. One of my colleagues recommended checking out the IDA courses, so I did. But I found out they offered a lot more than just courses, so I joined and that's how it started".

She says the IDA has been of assistance to her especially since she became a practice owner, offering help on aspects like tax, marketing and HR issues, which dentists aren't trained for in dental school: "Also, IDA membership has helped me network and meet dental colleagues and learn from them too. It's really nice to know that I have colleagues that I can meet at IDA events and keep in touch with for advice and support". Erika misses her family and friends in Hungary and the summers of her home country: "However, I think people in general are a lot more laid back over here and they tend to appreciate small things more in general than say in Hungary". For any dentists thinking about coming to Ireland, Erika says now is a good time: "I think Ireland is a great place to practise dentistry. The registration process is quite straightforward and I think especially now, dentistry is really busy so finding a job is easy enough. I would definitely recommend taking the plunge and moving to Ireland. Even if someone is thinking of it for a short-term period, it's still worthwhile trying yourself and you might just learn different techniques or you might figure out that this is the place for you and want to stay here forever".

Dr Tristan Hartung

Eyre Square Dental, Galway

Tristan was born and raised in Hamburg, Germany, to a German father and Irish mother, and as soon as he finished his dental training in Hannover Medical School, he made the move to Ireland. Now, he is working in Eyre Square Dental in Galway.

Having an Irish mother, Tristan spent a lot of time here growing up: "I spent many holidays in Kilkenny, where my Mam's family is from, while growing up but I had never really lived here. After college, I guess I was adventurous and I was happy to give it a try. Thankfully, if you qualify in the European Union, you can work anywhere else if you speak the language. It was very easy to make the switch in that way".

There are things that are different in Germany and Ireland, but what might be considered an advantage of one place can seem different from another's perspective: "When I go back, it's a very different feeling in Germany. Everything seems more organised and more streamlined, but I myself perceive that as a big benefit of living in Ireland, in that you don't have to be as organised. Nobody expects you to be as German as the Germans might expect you to be".

When Tristan first moved over, the IDA proved a great help: "I got in touch with the IDA office and they had just published a document for young dentists starting dentistry in Ireland … It was a really good help for me to get started and to get set up for insurance, indemnity, and get registered. That was my first exposure to the IDA".

Starting off, Tristan says it was a great help to have some friendly people to speak to in the IDA, but that in general: "It's really good representation for general dentistry in Ireland because we all tend to be so focused on our local practice and maybe what we prefer to do in terms of treatments and techniques. Dentistry can be a very isolated job if you're just working for yourself, so having a body that unifies everyone and works for the more general good of dentistry, I think it's very valuable".

Making sure you give yourself enough time is the most important advice Tristan has for dentists thinking about moving to Ireland: "Getting registered with the Dental Council, I had a really good experience with them, but it just takes a while to get registered and get the indemnity and everything sorted. Getting a job as well, it can take a couple of months".

Colm Quinn
Journalist with Think Media

invis is expanding your dental portfolio

Well-aligned teeth are the foundation of a healthy smile. The Invisalign Go system is designed for General Dentists to incorporate the treatment of mild to moderate misalignment cases into their comprehensive treatment plans. You can plan treatments with confidence knowing that our patented SmartTrack material and SmartForce features allow for more predictable tooth movement.* By offering your patients Invisalign treatments you can provide a solid foundation for improved oral health.[1]

Find out more at
www.invisalign-go.ie/dentist - Republic of Ireland
www.invisalign-go.co.uk/dentist - Northern Ireland

invisalign go

*Compared to Invisalign aligners made previously from single layer .030 inch EX30 material

1. Pacheco-Pereira C, Brandelli J, Flores-Mir C. Patient satisfaction and quality of life changes after Invisalign treatment. Am J Orthod Dentofacial Orthop. 2018 Jun;153(6):834–41.

Manual handling training

Dr Jane Renehan of Dental Compliance Ltd reminds dentists to include a manual handling policy in their safety statement. Practice owners are required to risk assess each employee's work activity to determine if its characteristics or ergonomic conditions involve risk, particularly of back injury. Consequently, clinical staff will require training in patient moving and handling, while administration staff may require training in handling of inanimate objects.

Regarding training, Jane advises that the Health, Safety and Welfare at Work (Regulations 2007) make it clear that manual handling training is not mandatory for all staff, but where there is a risk of injury the employer needs to act. One-third of all workplace injuries reported to the Health and Safety Authority (HSA) are caused by manual handling activities.

The HSA recommends engaging a recognised training provider and providing refresher training at least every three years. Jane recommends, where possible, that training be carried out in the workplace, and specific to the tasks involved.

All dental environments involve some form of manual handling, including lifting, pushing or pulling a load, either an inanimate object or a person. Activities posing an injury risk include:

- manoeuvring certain patients such as small children, pregnant or elderly persons, persons with restricted mobility or sight impairment, and weighty or sedated patients; and,
- moving inanimate objects, for example heavy containers of chemicals, objects of an awkward size or shape such as large bags of waste, and lifting objects from heights or off the ground, for instance boxes of dental records.

Working within a restricted space is commonplace for dentists. When additional limiting factors such as PPE, pregnancy, previous neck or back injury, or patients with behaviour management issues are superimposed, this increases the risk of injury.

For information on mandated health and safety training in dentistry, contact www.dentalcompliance.ie.

Time to take stock

Coltene states that now is a good time to audit your stock. According to the company, when you choose high-quality materials, which can be multifunctional, you can do more in less time, and save money and space.

According to Coltene, its SoloCem self-adhesive is multi-use and offers one-step cementation and reliable strength for various indications. The company recommends using this with its One Coat 7 Universal for bonding.

Also available from Coltene is Brilliant Componeer, which is comprised of prefabricated, pre-shaped shells for chairside treatments. The company states that the product is innovative and easy to use. According to the company, the product proves that enduring results can be delivered cost effectively.

Colgate Total

Empower patients to achieve superior biofilm control[1,2,*] at home with **Colgate Total®**

Left uncontrolled, biofilms produce negative effects that can damage all mouth surfaces, yet most toothpastes[†] cannot defend against biofilms.

Colgate Total® protects the whole mouth from biofilm damage[3-5,‡]

✔ Teeth ✔ Tongue ✔ Cheeks ✔ Gums

Superior reductions in oral conditions

- Plaque **34.4%**[6,§,¶]
- Gum problems **26.6%**[6,§,¶]
- Calculus **40.1%**[7,§,#]
- Malodour **30.8%**[8,§,**]

Empower patients to achieve **Whole Mouth Health**[‡] at home.

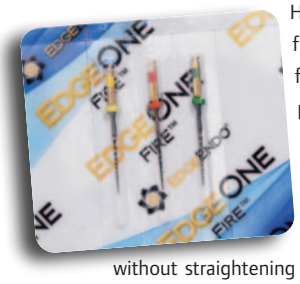
*Colgate Total® provides superior *in vitro* delivery, penetration, and retention of Zinc through Arginine technology for biomass reductions vs Zinc control toothpaste. [†]Defined as non-antibacterial fluoride toothpastes. [‡]Statistically significant greater reduction of cultivable bacteria on teeth, tongue, cheeks and gums with Colgate Total® vs. non-antibacterial fluoride toothpaste at 4 weeks, 12 hours after brushing. [§]6-month plaque and gingivitis study. Tested on UK Oral-B Pro-Expert: Stannous Fluoride and Sodium Fluoride formula. Results vs non-antibacterial fluoride toothpaste ($p<0.001$). [¶]6-month plaque and gingivitis study. Results vs non-antibacterial fluoride toothpaste ($p<0.001$). [#]Results at 12 weeks. $p<0.001$. **Patients brushed continuously for 3 weeks. Results taken 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.** Prasad K, et al. *J Clin Dent.* 2018;29(Spec Iss A):A25-32. **4.** Makwana E, et al. J Dent Res. 2019,98(Spec Iss A):3202. **5.** Ben Lagha A, et al. J Oral Microbiol 2020, 12:1. **6.** Li X, et al. J Dent Res 2019;98 (Spec Iss A):3444. **7.** Seriwatanachai & Mateo, September 2016, internal report. **8.** Hu D, et al. *J Clin Dent.* 2018;29(Spec Iss A)A41-45.

www.colgateprofessional.ie *www.colgatetalks.com*

PROFESSIONAL
ORAL HEALTH

Henry Schein enlarges endo portfolio



Henry Schein Ireland has launched the new EdgeFile X7 from EdgeEndo, one of the world's largest NiTi rotary file suppliers. According to the company, EdgeEndo's patented FireWire heat-treating process gives the EdgeFile X7 canal contouring technology, which makes the files flexible and reduces shape memory and bounce back. The company states that the flexible EdgeFile X7 closely follows the anatomy of the canal without straightening out, reducing the risk of ledging, transportation, and perforation. According to Henry Schein, the flexible shaft reduces the need for excessive straight-line access, allowing more tooth structure to be preserved.

The product is offered in 4% and 6% tapers in 21mm, 25mm and 29mm lengths. Among the products in the EdgeEndo line are NiTi files, carrier-based obturators, and paper points. The company states that the files and obturators are excellent alternatives to the current products on the market, and can be used with most existing endodontic motors and obturator ovens in the practice. The EdgeEndo systems EdgeTaper, EdgeTaper Platinum, EdgeGlidePath, EdgeOne Fire, EdgeOne Fire GlidePath and the new EdgeFile X7 are all available exclusively through Henry Schein in the Republic of Ireland and can all be ordered in sterile packaging.

VOCO retraction paste

VOCO states that the basis for a perfect impression is an exposed and dry sulcus. With VOCO Retraction Paste, which is applied directly from the cap into the sulcus, VOCO states that it is introducing a product for the effective, temporary opening of the sulcus and its isolation from moisture. According to the company, this product is also the ideal complement to the V-Posil impression material. VOCO states that the Retraction Paste offers the prerequisites for successful classic or digital precision impressions, as well as for cavity preparation of class II or V restorations, but also for either permanent or temporary cementing of restorations.

According to VOCO, the retraction paste impresses users through results and handling. The company gives an example of how the shade contrasts well against the gingiva, facilitating the work in hard-to-see areas. VOCO states that thanks to the very slender and slightly flexible cannula, the material can be easily dosed and applied, whereby the paste is easy to press out and subsequently has good flow viscosity, coupled with uniform stability for opening of the sulcus. According to the company, during application, the aluminium chloride paste with astringent effect temporarily fills the sulcus, stops any bleeding, and eliminates moisture.

OPENING SOON IN THE GREATER DUBLIN AREA

shields

DENTAL & IMPLANT CLINIC

PARTNERSHIP OPPORTUNITIES

BECOME A PARTNER IN THE SHIELDS DENTAL & IMPLANT CLINIC GROUP

Joining Shields Dental & Implant Clinic as a partner would mean that you are joining a third generation of a family of distinguished dentists.

You would be part of a multidisciplinary team of GDPs and specialists that provide safe, complex, and innovative dentistry by embracing the very latest in dental technologies and clinical coaching into which Shields dental group consistently invest.

Shields are a family dental group that live and work through the values of trust, clinical excellence, personal growth and outstanding patient care.

Conor and Cormac Shields founded Shields Dental & Implant Clinic in 2005 when they relocated to Limerick after 10 successful years in London running their private dental practice.

Since 2016 Shields Dental Group has grown significantly and has increased in size by a multiple of 8 with plans in the near future to double the size again.

The partnership program was created out of a recognition that growth for the group can only come through having the right mix of highly motivated and rewarded clinicians. The program, the first of its type in the ROI and UK, rewards skill levels, grossing performance and loyalty.

We know the partnership program which ultimately leads to equity participation in the group is unusual and the mechanics will need explaining so please talk to either Conor or Cormac who will be happy to spend time discussing the opportunity with you.

To register you interest please email conor.shields@shieldsdentalclinic.ie

10 Ashdown Centre,
Courtbrack Avenue,
South Circular Road, Limerick

061 480 070
www.shieldsdentalclinic.ie

To register you interest please email conor.shields@shieldsdentalclinic.ie

DENTAL CARE IRELAND
Your Local Practice

Join our Team

Dental Care Ireland currently has full and part-time vacancies for general and specialist dentists across a number of locations nationwide.

careers@dentalcareireland.ie

www.dentalcareireland.ie/careers

Risky business?

Direct-to-consumer orthodontic care carries a number of risks for patients, and this is creating increasing professional concern among dentists.

The growing popularity of adult orthodontic treatment has resulted in increased activity from companies offering orthodontic services directly to patients in many of the countries where Dental Protection has members.

The restrictions on practice arising from the Covid-19 pandemic, coupled with patients becoming accustomed to accessing remote healthcare services, may lead to more patients seeing orthodontic treatment through a direct-to-consumer (DTC) approach as an attractive option.

Dr Yvonne Shaw

Yvonne is Dental Underwriting Policy Lead at Dental Protection

Irish guidance

In the face of increasing professional concerns surrounding DTC orthodontics, the profession has looked to its professional regulators to consider and address the risks that patients may be exposed to. Of the countries in which we have members, the Dental Council of Ireland was one of the first regulators to respond, issuing a statement in 2017[1] providing advice for both patients and dentists. Of significance:

- the Dental Council stressed that orthodontics is the practice of dentistry and best undertaken under the supervision of a dentist or specialist orthodontist for the duration of the treatment;
- obtaining an appliance without appropriate examination or ongoing dental support could compromise treatment and possibly dental health; and,
- dentists working for companies supplying appliances directly to patients still owe the same duty of care to patients as they would if the patients attended their practice, including the need to ensure that:
  - the patient has given full informed consent to the treatment, including information about the benefits and risks;
  - full and proper records are maintained; and,
  - appropriate indemnity or insurance arrangements are in place that include remote provision of dental care.

UK approach

In May 2021, the UK regulator, the General Dental Council (GDC), provided clarity on its position, reflecting the sentiments of the Dental Council of Ireland's statement but going further to state that it is necessary for a full face-to-face assessment of the patient's oral health to have taken place to ensure that the patient is suitable for orthodontic treatment. In addition, the GDC's guidance states that the patient must know the full name of the dental professional responsible for their treatment, and be able to make contact with that person. The latter point is an issue that has clearly caused patients concern, particularly where treatment is unsuccessful, and there is no obvious way of identifying who is ultimately responsible for the patient's treatment.

Additional clarity from dental regulators about the expected professional standards is welcomed, particularly at this time, when the profession has been exposed to a sea change in healthcare provision, as remote consultation and telehealth are a recognised part of practice. Remote healthcare, and the regulatory and legal framework in which it is provided, are inevitably going to develop and grow. In the interim, dentists continue to ask questions about the safety of remote orthodontic care and their obligations towards their patients.

Acting in the patient's best interests

Central to the dentolegal questions that members pose about DTC services is the risk of harm to patients. Concerns range from a patient not understanding the implications or limitations of treatment, to the risks relating to the treatment itself, such as:

- progression of pre-existing dental conditions such as periodontal disease or caries;
- root resorption;
- exacerbation or development of temporomandibular joint dysfunction; and,
- adverse tooth movement such as creation of anterior or lateral open bites and changes to occlusion.

Of course, all of the above risks can apply to any course of orthodontic treatment and these types of complications form the basis of some of the claims we deal with. However, the risk of a problem developing, or not being identified at the outset, is likely to be significantly increased if a patient has not had a full clinical examination prior to commencing treatment.

Dental dilemma

The Dental Council's advice that orthodontics is best undertaken under the supervision of a dentist or orthodontist for the duration of the treatment implies that a professional duty rests with clinicians involved in the patient's orthodontic care to ensure that this has taken place.

A question we are often asked is what a clinician should do if they become aware that a patient is, or is contemplating, undergoing treatment provided through a DTC setting. In this situation it would be appropriate to make patients aware of the potential risks of proceeding with a course of treatment in the absence of a face-to-face orthodontic examination taking place.

To assist in communicating the risks, members may find it helpful to direct patients to websites that provide objective information about orthodontic care. The Dental Council's statement and advice for patients may be a starting point in communicating this information. Other sites such as Safe Brace,[2] a joint initiative developed by the British Orthodontic Society and the Oral Health Foundation, www.orthodontist.ie (the Orthodontic Society of Ireland's site), and www.dentalhealth.ie (the Dental Health Foundation) may also help to educate patients about orthodontic treatment options and risks from 'DIY' treatment.

It is also important to consider that patients may fail to disclose that they are, or have been, undergoing treatment with aligners obtained directly from a DTC provider. This could impact on the assessment of a dental problem or provision of dental care where tooth position may not be stable. This may now become a more common scenario due to patients not attending for routine dental care during the Covid-19 pandemic and having proceeded with DTC orthodontic treatment in the interim. Dentists may therefore wish to consider asking specific questions to elicit whether a patient has had any form of dental treatment, including any 'DIY' approaches, as part of their assessment process.

Access to records

Another question that arises is how to respond to a request from a patient, or DTC orthodontic provider, to supply written confirmation that a patient is fit to proceed with orthodontic treatment. This is in effect asking a dentist to make a decision on whether or not a patient is suitable for treatment that the practitioner themselves will play no part in planning or delivering.

Even if a patient has attended recently for a dental examination, this does not equate to a patient being fit to proceed with a specific course of orthodontic treatment. It is Dental Protection's view that it would not be appropriate for a clinician to comment on whether a patient is fit to proceed with orthodontic treatment where that clinician has no involvement in the clinical assessment, treatment planning or provision of that course of treatment. In this scenario, it would be in the patient's interests to advise that a clinical examination, with an appropriately trained orthodontic clinician, would be required to ensure that all treatment options and specific risks are considered.

However, patients may instead request a copy of their records or provide authority for these to be disclosed to a third party. If the patient has made such a request, and provided a signed form of authority, then the disclosure of information should be dealt with in accordance with data protection legislation. If the records are to be disclosed with a view to dental treatment being provided elsewhere, a courtesy call to the patient confirming receipt of the request would allow a discussion to take place into what treatment the patient is seeking and whether this is in their interests. A clear note of any discussion with the patient regarding what was advised should be recorded in the patient's records.

Finally, as highlighted by the Dental Council, it is important that any clinician involved in the provision of remote healthcare ensures that they have appropriate indemnity arrangements in place, which will help protect them and their patients. For clinicians who are considering moving into this area of practice, it is important that they ensure they are not straying outside of their Code of Practice and professional standards, and speak to their indemnity provider to ensure that they have the appropriate protection in place.

Further advice and support

Dental Protection members affected by the issues outlined in this article can call our dentolegal advice service, which is open to members with urgent queries and dentolegal emergencies 24 hours a day, 365 days a year.

References

1. **Dental Council of Ireland**. Statement on Orthodontic Devices Provided Directly to the Public. 2017. Available from: http://www.dentalcouncil.ie/Orthodontic_Devices.php.
2. See: https://www.dentalhealth.org/this-is-safe-brace.

Volume 67 Number 5
October/November 2021

MEMBERS' NEWS

IDA survey highlights dental sector staffing shortage

Recruiting dentists

Over half of members who responded said that their practice had tried to recruit dentists in the past 12 months. However, of those who said they had attempted to recruit dentists, only 50% had found a suitable candidate, with a further 50% reporting that the practice was unable to find a dentist to recruit. For members who were unable to find a candidate, the main reasons cited were a shortage of suitable candidates, unwillingness of candidates to relocate and, probably, to meet the candidate's expectations in terms of salary.

registration was required when hiring a new dentist, over half of respondents (58%) reported that their experience of getting a non-Irish graduate registered with the Dental Council was unsatisfactory or very unsatisfactory. Just 17% said that the process was satisfactory or very satisfactory.

Recruiting other dental team members

Most respondents (80%) said that they had tried to recruit other dental team members in the past 12 months.

The majority used word of mouth and websites such as Indeed and social media, as well as the *JIDA*/IDA website, in their recruitment process. They reported that websites such as Indeed and social media, and word of mouth, were the most effective methods of recruiting.

Two-thirds said they had found a suitable candidate, while one-third had not. For those who could not find a suitable candidate, they reported that there is a shortage of suitable candidates or that they couldn't meet the candidate's expectations in terms of salary. The average length of time for the recruitment process was four months. Nearly all (95%) of the dental team members had previously worked in Ireland.

Solutions?

Some respondents said they had offered new incentives to attract dentists and other staff members. Respondents reported offering increased pay, flexible working hours, increased annual leave and training.

Many members surveyed said that there is a need for more dental graduates in Ireland. This was also an issue identified regarding other dental staff, with many respondents saying there is a need for additional training places for dental nurses and hygienists to increase supply of other dental team members.

Some respondents were unsure how the Association can assist in helping members to overcome the issue of staffing shortages. Others suggested that the Association should lobby for more dental nurse training courses, promote careers in dentistry and dental nursing, and work with recruitment agencies in Ireland and internationally.

Dental Council meeting

The Irish Dental Association will meet with the Dental Council in the coming weeks to discuss registration issues, among other matters. We also intend to make a submission on work permit categories in the coming months.

IMPORTANT UPDATE: Self-audit of amalgam waste disposal

Dentists who fail to return a self-declaration audit to their local authority face court proceedings, hefty fines and the possibility of an inspection visit to their practice, the department responsible for environmental affairs warned in a meeting with the IDA in September.

Members should ensure that they have completed and returned a self-declaration form on dental amalgam waste disposal. If members believe that this form is not applicable to them, they must still ensure that they contact the relevant local authority [illegible]

Final letter

Earlier this year all local authorities sent a self-declaration form on dental amalgam waste disposal to dental practices. At a meeting with the IDA in September, the waste enforcement section of the local authorities informed the Association that the majority of dental practices have returned the self-declaration form. The local authorities and the Department of the Environment, Climate and Communications welcomed this, and acknowledged dentists' efforts to comply with the mercury regulations. However, about 200 dentists have yet to respond.

The local authorities will send a final reminder letter to those who have yet to respond giving them 14 days to reply. Following this, an enforcement letter will be issued and an inspection will be carried out.

All dentists who receive the form must respond. Members are advised that it is an offence not to respond and may result in court proceedings, fines and other penalties.

Not having an amalgam separator does not exempt you from the need to respond or from inspection from the local authorities. Equally, if you believe the letter has been sent to you in error, you are still responsible for contacting the relevant waste enforcement official to inform them as to why the self-declaration form is not [illegible]

Work permits and employing non-EEA nationals

As the profession faces a skills shortage, dentists should be informed of the different types of work permits and the eligibility rules that apply.

Under the Employment Permits Acts 2003 and 2012 a non-European Economic Area (EEA) national may not work in the State without an employment permit. It is an offence for both an employer and an employee where employment is entered into in the absence of the required employment permit. The EEA comprises the European Union together with Iceland, Norway and Liechtenstein.

CanalPro™ Jeni

Digital assistance system for canal preparation

Includes pre set programme settings for HyFlex and MicroMega rotary files

NEW

Autonomous 'navigation' using revolutionary software

The new CanalPro Jeni endomotor has a patent-pending digital assistance system for canal preparation, which uses complex algorithms to control the file movement at millisecond intervals. The rotary motion and speed are continuously controlled based on current intensity and torque.

Different routes, obstacles and situations

CanalPro Jeni is named after its developer Prof. Dr. Eugenio Pedullà and guides you safely through the traffic like a navigation system. As such, the Jeni system automatically adapts to the individual root canal anatomy, working in unison with the mechanical and chemical preparation every step of the way.

"The CanalPro Jeni is the best all-in-one endo motor and apex locator on the market.

As a dentist with practice limited to endodontics, I need reliable instruments, and the CanalPro Jeni is exactly that. This high quality machine has it all- accurate, crisp apex locator that responds to the file movements and gets very little interference from metal restorations, the motor responds immediately to wireless foot pedal, it has multiple file systems already installed and options to add more file systems, including reciprocation, if you wish. The motor adjusts itself according to the canal morphology, which helps reducing file separation. I highly recommend this all-in-one endomotor for beginners and experienced alike."

Dr Sagi Shavit
DMD, MSc(Endodontology), MFGDP(UK), Dip.Dent.Imp

Order a CanalPro Jeni motor and choose from **one of the following FREE* refill pack selections:**

4 x HyFlex CM
8 x HyFlex EDM
5 x MicroMega One Curve

Only available through your Territory Manager

Jeni - ready - go!

CanalPro Jeni, complete set REF 60023659

includes: 1 × Control unit, 1 × Motor with apex measuring contact, 1 × Fully insulated angled handpiece 1:1, 1 × Bluetooth foot switch, 1 × Power supply, 1 × Apex cable set, 1 × Holding bracket for apex cable

LEARN MORE

Contact Nick O'Keeffe on **+353 8641 35766** or **nicholas.okeeffe@coltene.com** for a demonstration.

***Promotional offer valid to 31.12.2021**

BDIA CSIDI COUNTERFEIT AND SUBSTANDARD INSTRUMENTS AND DEVICES INITIATIVE

Call: +44(0)1444 235 486
INFO.UK@COLTENE.COM WWW.COLTENE.COM

COLTENE Upgrade Dentistry

Periodontitis: all change please? Introduction to the new S3-level treatment guidelines

Précis: This article reviews the recently published EFP S3-level clinical practice guideline for the management of Stage I-III periodontitis, highlighting aspects of interest to dental professionals.

Abstract: In 2020, the European Federation of Periodontology published an S3-level clinical practice guideline for the management of Stage I-III periodontitis. This guideline discusses four steps of periodontal therapy and provides 62 individual recommendations for prevention and management of disease. Supporting information about the strength of recommendation and level of consensus for each recommendation is also provided. The S3 guideline represents a major milestone in the specialty, and is likely to play a major role in enhancing and standardising the approach to periodontal care among educators and clinicians. This article provides a review of the meeting framework and a commentary on the clinical practice guideline, highlighting key recommendations of interest to the dental team in each treatment step.

Introduction and background

In November 2019, a European Federation of Periodontology (EFP)-led workshop was held in Spain to form a consensus on clinical guidelines for the treatment of periodontitis. This was the first attempt to produce an evidence-based treatment guideline to assist clinicians in their management of patients with Stage I-III periodontitis. The 15 systematic reviews that were undertaken to form the basis of the treatment guideline documents were subsequently published in July 2020.[1]

The guideline recommends four steps of periodontal therapy, to be undertaken sequentially, alongside 62 individual recommendations that are rated according to the strength of consensus and grade of recommendation of each working group. The purpose of this article is to raise awareness among all clinicians in relation to contemporary thinking in the treatment of periodontitis, and to summarise the key aspects of the guideline document. The Spanish, German and British periodontal societies have been working through an 'adolopment' process (adopt-adapt-develop) as part of implementation within their local frameworks, with publications emerging.

Ninety experts met in November 2019 at the European Federation of Periodontology (EFP)-led workshop in Spain, to form a consensus on clinical guidelines for the treatment of periodontitis.

Prof. Anthony Roberts
Professor of Restorative Dentistry
Cork University Dental School and Hospital/UCC
Wilton, Cork

Dr Lewis Winning
Associate Professor in Restorative Dentistry & Periodontology
Dublin Dental University Hospital
Lincoln Place, Dublin 2

Dr Peter Harrison
Associate Professor in Restorative Dentistry & Periodontology
Dublin Dental University Hospital
Lincoln Place, Dublin 2

Corresponding author: Prof. Anthony Roberts, Cork University Dental School and Hospital, Wilton, Cork. E: a.roberts@ucc.ie T: 021-490 1165

Table 1: Grading scheme used for treatment guidelines (grade of each recommendation provided in online edition).

Grade of recommendation	Description	Syntax
A	Strong recommendation	We recommend (↑↑) We recommend not to (↓↓)
B	Recommendation	We suggest (↑) We suggest not to (↓)
0	Open recommendation	May be considered (↔)

Overview of the new framework

It is important to understand that a rigorous approach was undertaken to derive the clinical practice guideline. The guideline is 'S3-level', which is the highest quality level for the formulation and development of guidelines and centres on periodontitis Stages I (mild), II (moderate) and III (severe), as outlined in the 2017 classification of periodontal and peri-implant diseases and conditions.[3,4] Several articles have recently been published in this *Journal* to summarise the 2017 classification,[5,6] and to provide case examples of its suggested implementation in dental practice.[7,8]

Alongside the sequential treatment steps in the EFP clinical treatment guideline, the original publication also provides the 'Grades of Recommendation' and 'Strength of Consensus'. The recommendations consider the evidence but also cost-effectiveness and environmental effects. For example, recommendations on the use of systemic antibiotics were formed in the context of the impact of antibiotic stewardship. Clinicians can interpret the strength of recommendation using grades provided by the workshop (**Table 1**). The clinical guideline does not provide information on Stage IV periodontitis, which is the most severe disease with the potential for loss of the dentition and with complexities that need greater consideration. This will be the subject of a separate workshop and further EFP publication in due course, since Stage IV cases will frequently require prosthodontic, orthodontic and implant treatments as part of overall management.

The four treatment steps

Patients with periodontitis Stages I-III should be treated utilising a step-wise approach to therapy. Each step includes different interventions and builds incrementally on previous steps; the disease stage and response to treatment will impact on the interventions required.

Clinicians should discuss the periodontal diagnosis, risk factors, treatment alternatives, and the risks and benefits of treatment with each patient, and then agree a personalised care plan for each patient. A summary of the treatment steps approach is outlined in **Table 2**.

Table 2: Explanation of treatment steps approach.

Treatment step	Aim	Comments	Considerations
1	Guide behavioural change by motivating the patient to undertake: ▸ supra-gingival biofilm removal; and, ▸ risk factor control.	▸ **All** periodontal patients (irrespective of stage) ▸ Reviewed and reinforced regularly ▸ This step is critical to allow appropriate response to ensuing steps	May include: ▸ supragingival biofilm control; ▸ OHI +/- adjunctive therapies for gingival inflammation; ▸ clinician removal of supragingival plaque and calculus + plaque-retentive features that impair OH; and, ▸ risk factor control – behaviour change to eliminate/mitigate risk factors for onset/progression of disease (e.g., smoking cessation, improved metabolic control of diabetes).
2	Control/eliminate subgingival biofilm and calculus (i.e., subgingival instrumentation).	▸ **All** periodontal patients (irrespective of stage) ▸ Individual response assessed once tissues are healed (periodontal re-evaluation) to assess if desired end points of therapy achieved	What are the desired end-points of therapy?: ▸ no PPD >4mm with BOP; and, ▸ no PPD >5mm. Scenario A: End points achieved → Enrol patient in supportive periodontal care (SPC) Scenario B: End points not achieved → Step 3
3	Treatment of areas not responding adequately to Step 2: ▸ allow further access to subgingival instrumentation.	▸ Patients with **non-responding** sites – not all patients require this step ▸ Individual response assessed once tissues are healed (periodontal re-evaluation) ▸ Ideally, this step should achieve desired end points of therapy	▸ Repeated sub-gingival instrumentation ▸ Surgery (performed by a periodontal specialist or a dentist with additional appropriate training): – access flap; – resective surgery; and, – regenerative surgery.
4	Maintain periodontal stability in treated periodontal patient.	▸ All **treated** periodontal patients ▸ Delivered regularly and personalised to patient's needs ▸ Combines preventive (Step 1) and therapeutic (Step 2) interventions (depending on perio status)	Characterise patient needs in association with assessment of periodontitis stability: ▸ stable; ▸ remission; or, ▸ unstable.

COMPLETE TABLE 3 AVAILABLE HERE

Table 3: Summary of key recommendations.

Focused questions			Expert consensus-based recommendation
Intervention: supragingival dental biofilm control (by the patient)	1.1	What are the adequate oral hygiene practices of periodontitis patients in the different steps of periodontitis therapy?	We recommend that the same guidance on oral hygiene practices to control gingival inflammation is enforced throughout all the steps of periodontal therapy including supportive periodontal care.
Intervention: supragingival dental biofilm control (professional)	1.4	What is the efficacy of supragingival professional mechanical plaque removal (PMPR) and control of retentive factors in periodontitis therapy?	We recommend supragingival professional mechanical plaque removal (PMPR) and control of retentive factors, as part of the first step of therapy.
Intervention: risk factor control	1.6	What is the efficacy of tobacco smoking cessation interventions in periodontitis therapy?	We recommend tobacco smoking cessation interventions to be implemented in patients undergoing periodontitis therapy.
General recommendations for periodontal surgical procedures	3.6	What is the importance of adequate self-performed oral hygiene in the context of surgical periodontal treatment?	We recommend not to perform periodontal (including implant) surgery in patients not achieving and maintaining adequate levels of self-performed oral hygiene.
Intervention: management of furcation lesions	3.10	What is the adequate management of molars with Class II and III furcation involvement and residual pockets?	We recommend that molars with Class II and III furcation involvement and residual pockets receive periodontal therapy.
Supportive periodontal care: preliminary considerations	4.1	At what intervals should supportive periodontal care visits be scheduled?	We recommend that supportive periodontal care visits should be scheduled at intervals of three to a maximum of 12 months and ought to be tailored according to the patient's risk profile and periodontal conditions after active therapy.
Intervention: supragingival dental biofilm control (by the patient)	4.4	How should we choose an appropriate design of manual, powered toothbrushes and interdental cleaning devices?	We recommend taking into account patients' needs and preferences when choosing a toothbrush design, and when choosing an interdental brush design.
	4.6	How should interdental cleaning be performed?	If anatomically possible, we recommend that tooth brushing should be supplemented by the use of interdental brushes.
Intervention: risk factor control	4.18	What is the role of tobacco smoking cessation interventions in SPC?	We recommend tobacco smoking cessation interventions to be implemented in periodontitis patients in supportive periodontal care.

Examples of the most relevant recommendations (as determined by the authors) to general dental practitioners with 'Grade A/Strong recommendation' and with a 'Strong' or 'Unanimous consensus'.

Recommendations by treatment step

The following sections describe the four steps of periodontitis management, as well as highlighting those elements of most interest to clinicians. A summary of key recommendations is presented in **Table 3**. A more detailed table, which overviews the individual recommendations – including information on the grade of recommendation and strength of consensus associated with each – is presented as an Appendix to this paper (**Appendix 1 – available on www.jida.ie**).

STEP 1: Guiding behaviour change by motivating the patient to undertake successful removal of supragingival dental biofilm and risk factor control.
Number of recommendations: 10.
Most relevant to dental healthcare professionals in daily practice: Questions 1.1, 1.4, 1.6, 1.7.

Summary

There was strong consensus that professional oral hygiene instruction (OHI) should be provided to patients; the same guidance can be provided/reinforced throughout the steps of care. Patients should be motivated to engage in the behavioural changes needed to maintain good plaque control.

There was unanimous consensus on the role of supragingival instrumentation to remove biofilm and calculus deposits (now often referred to as professional mechanical plaque removal, or PMPR) as an essential component of the first step of therapy. Plaque-retentive factors associated with inadequate restorative margins or complex tooth anatomy should also be addressed at this stage.

The workshop also strongly supported risk factor control interventions as part of the first step of therapy. Aligning with the formal incorporation of smoking and diabetes as risk factors for periodontitis in the 2017 classification, the workshop recommended implementation of tobacco smoking cessation interventions and diabetes control interventions in patients undergoing therapy for periodontitis. Conversely, consensus indicates that in the case of interventions aimed at increasing physical exercise, dietary counselling or interventions aimed to deliver weight loss through lifestyle modification, additional research is required before we can confirm that these methods may have a positive effect in periodontitis therapy.

STEP 2: Cause-related therapy, aimed at controlling (reducing/eliminating) the subgingival biofilm and calculus (subgingival instrumentation).

Number of recommendations: 16.

Most relevant to dental healthcare professionals in daily practice: Questions 2.3, 2.4, 2.7, 2.16.

Summary

There was unanimous consensus on the beneficial effect of subgingival instrumentation for the treatment of periodontitis. Subgingival instrumentation delivers pocket depth reduction and reduction in inflammation (as evidenced through reductions in bleeding on probing, or BOP). The desired end point of treatment is "pocket closure"; in periodontitis patients, this refers to probing pocket depths ≤4mm and absence of BOP.

Subgingival instrumentation can be performed with hand or powered instrumentation, alone or in combination, and evidence suggests that treatment outcomes are not dependent on whether instrumentation is provided in a traditional quadrant-wise protocol or using a full-mouth treatment protocol (i.e., within 24 hours).

The workshop considered newer treatment approaches that have been suggested as adjuncts to subgingival instrumentation. There is insufficient clinical evidence to recommend adjunctive use of lasers and photodynamic therapy. Furthermore, in the context of the paucity of information on patient-reported outcomes, and the additional costs associated with use of these adjunctive approaches, the workshop consensus is to suggest not to use these adjunctive approaches in periodontitis patients, based on current evidence. The workshop also considered a variety of agents proposed in the literature as adjuncts to subgingival instrumentation (including but not limited to statins, probiotics, sub-antimicrobial-dose doxycycline, bisphosphonates and NSAIDs). Participants concluded that use of these agents adjunctive to subgingival instrumentation is not recommended at this time. Conversely, the use of antiseptic agents, specifically chlorhexidine mouth rinses, may be considered as a time-limited adjunctive agent to instrumentation in selected cases.

Adjunctive use of locally and systemically delivered antimicrobial agents was also considered. Locally delivered sustained-release chlorhexidine and specific antimicrobials may be considered as adjuncts to subgingival instrumentation in periodontitis patients. However, it must be recognised that evidence to support the benefit of such agents is generally short term (six to nine months), and in addition to a paucity of longer-term data, research study designs in this area exhibit significant heterogeneity. Consequently, the workshop provided open recommendations on this subject. Due to concerns about the impact of their use on patients (through side effects) and public health (through antibiotic resistance), routine adjunctive use of systemic antibiotics is not recommended, despite some evidence to suggest that clinical outcomes may be improved with some antibiotic agents. The use of systemic antibiotics may still be considered in specific categories of patients, for example in young patients with generalised severe (Stage III) periodontitis.

STEP 3: Treating areas that do not respond adequately to the second step of therapy, to gain further access to subgingival instrumentation or aiming at regenerating or resecting lesions that add complexity to the management of periodontitis (intra-bony and furcation lesions).

Number of recommendations: 16.

Most relevant to dental healthcare professionals in daily practice: Questions 3.1, 3.3, 3.6, 3.10.

Summary

Step 3 considers evidence on a range of interventions, which may or may not be necessary following completion of steps 1 and 2. A full periodontal re-evaluation, carried out three months after the completion of Step 2, is a prerequisite before potentially progressing to Step 3.

The guideline suggests that residual pockets of 4-5mm should be managed by repeated subgingival instrumentation with or without adjunctive therapies, whereas pocketing of ≥6mm would benefit from surgical management, such as access flap surgery, resective periodontal surgery (pocket elimination), or regenerative periodontal surgery. The guideline recommends that surgical periodontal procedures be performed by a periodontal specialist, or a dentist with the additional appropriate training.

Periodontal surgery should be considered on a patient-, tooth-, and defect-specific basis. The desired end point of Stage 3 is the same as Stage 2 (pocket depths ≤4mm and absence of BOP); however, this may be more difficult to achieve based on severity and extent of disease. Some of the key recommendations in relation to specific periodontal surgery procedures included:

- evidence favoured resective (pocket elimination) periodontal surgery over access flap surgery – this is due to the observed greater pocket probing depth reduction; however, a greater increase in gingival recession

associated with resective procedures should be a consideration;
- there was strong consensus that surgery should not be considered in patients who do not achieve and maintain adequate levels of self-performed oral hygiene; and,
- periodontal surgery should be considered in teeth with residual pocketing associated with Grade II and III furcation involvement – furcation involvement itself should **not** be considered an indication for extraction of teeth.

STEP 4: Supportive periodontal care (SPC), aimed at maintaining periodontal stability in all treated periodontitis patients, combining preventive and therapeutic interventions defined in the first and second steps of therapy, depending on the gingival and periodontal status of the patient's dentition.
Number of recommendations: 20.
Most relevant to dental healthcare professionals in daily practice: Questions 4.1, 4.4, 4.6, 4.11, 4.18, 4.19.

Summary

SPC comprises the continued monitoring of periodontal health, reinforcement of OHI, patient motivation towards continuous risk factor control, professional mechanical plaque removal, and localised subgingival instrumentation at residual pockets if required. In statements analogous to those for Step 1 of therapy, there was strong recommendation and strong consensus on the value of risk factor control and interventions for tobacco smoking cessation in SPC, with more limited evidence to suggest that periodontitis patients may benefit from promotion of diabetes control. Additional research is needed to determine if interventions aimed at increasing physical exercise, dietary counselling, or interventions aimed to deliver weight loss through lifestyle modification, may have a positive effect in SPC.
Regarding SPC interval, evidence suggested a patient-specific approach of between three and 12 months, with individual frequency determined by each patient's risk profile and periodontal status after Steps 1, 2 (and 3). Evidence suggested that SPC every three months may be sufficient to control periodontitis progression after periodontal surgery.
The guideline also covered practical issues such as professional oral hygiene recommendations. There was strong consensus that a powered toothbrush may be considered as an alternative to a manual toothbrush during SPC. Toothbrushing should also be accompanied by the use of interdental brushes (where anatomically possible) for all patients in SPC. However, there was unanimous consensus that the use of dental floss as the first choice method of internal dental cleaning should **not** be recommended. The use of other dental cleaning aids for interdental areas not reachable by brushes should be considered. There was consensus that use of adjunctive antiseptics may be considered in specific cases to help control gingival inflammation during SPC.

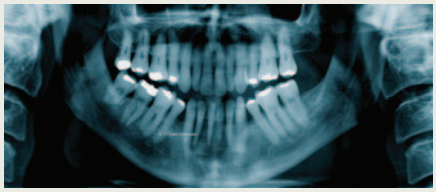
Comments and implications for dental practice

The EFP S3-level clinical treatment guideline summarised here represents the first comprehensive, evidence-based guideline for the management of patients with periodontitis. The guideline aims to improve the overall quality of periodontal treatment in Europe, reduce associated tooth loss, and improve overall systemic health and quality of life. The guideline currently applies to periodontitis Stage I-III, with a further workshop planned for the management of Stage IV periodontitis (2022). Stage IV periodontitis presents unique challenges due to the associated complex restorative rehabilitation issues, necessitating a multidisciplinary approach to management.
The workshop revealed areas of periodontitis management where there was currently lack of evidence, which meant that consensus on a recommendation was difficult to achieve. There was recognition that as future evidence emerges this may change, and guidelines should evolve as the evidence does.
From the practitioner's perspective, it is important to note that the S3-level treatment guidelines are indeed just that: 'guidelines'. Individual judgement and adaptation can of course be applied at the practitioner's discretion. However, the fact that these guidelines now exist and are currently being adopted by national societies and stakeholders across multiple European jurisdictions allows for standardisation and transparency in our approach to the management of periodontitis. This will be of benefit to both patients and practitioners alike.

References

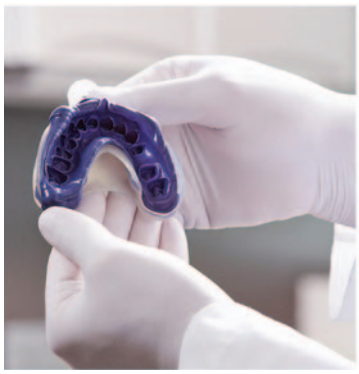
1. **Sanz, M., Herrera, D., Kebschull, M., *et al.*** Treatment of stage I–III periodontitis – The EFP S3 level clinical practice guideline. *J Clin Periodontol* 2020; 47: 4-60.
2. **West, N., Chapple, I., Claydon, N., *et al.*** BSP implementation of European S3-level evidence-based treatment guidelines for stage I-III periodontitis in UK clinical practice. *J Dent* 2021; 106: 103562.
3. **Caton, J.G., Armitage, G., Berglundh, T., *et al.*** A new classification scheme for periodontal and peri-implant diseases and conditions – introduction and key changes from the 1999 classification. *J Clin Periodontol* 2018; 45 (Suppl. 20): S1-S8.
4. **Papapanou, P.N., Sanz, M., Buduneli, N., *et al.*** Periodontitis: Consensus report of workgroup 2 of the 2017 World Workshop on the Classification of Periodontal and Peri-Implant Diseases and Conditions. *J Clin Periodontol* 2018; 45 (Suppl. 20): S162-S170.
5. **Lee Kin, R., Reynolds, I.** Introduction to the new classification of periodontal and peri-implant diseases and conditions. *J Ir Dent Assoc* 2019; 65 (4): 202-207.
6. **Roberts, A., Milward, M.R., Harrison, P.** Periodontitis: implementation tools for daily practice. *J Ir Dent Assoc* 2021; 67 (1): 20-24.
7. **Reynolds, I., Naughton, D., Winning, L., Harrison, P.** Application of the new periodontal classification: generalised periodontitis. *J Ir Dent Assoc* 2020; 66 (6): 292-295.
8. **Nolan, M., Aljudaibi, S., Harrison, P., Winning, L.** Application of the new periodontal classification: Part 2. *J Ir Dent Assoc* 2021; 67 (1): 30-32.

Quiz answers



Questions on page 240

1. Radiographs, and sensibility testing of associated teeth.
2. A poorly defined unilocular radiolucency affecting LR2, LR1, LL1, LL2. This does not cause resorption of the associated dentition; however, it does appear to have caused mild displacement of LR2.
3. Referral to your local oral and maxillofacial surgery unit for urgent biopsy.
4. In the oral soft tissues, gingiva is the most common site. This suggests the possible role of inflammation in attraction of pre-circulating malignant cells. Lesions regularly mimic simple odontogenic infections.



Impregum Impression

Impregum and Pentamix

Impregum Super Quick

Impression materials:
why they still deserve a place in your product selection

Dr John Rafelt of 3M talks to leading dentist **Dr Kunal Shah** about the benefits of impression materials.

Are there clinical situations where traditional impression materials are better suited than digital alternatives? Dr Kunal Shah, principal at Leo Dental, explains certain situations where he prefers traditional impression materials:

"I do a lot of implant work in my practice and for many cases I use traditional impression materials as they definitely offer an advantage. Although digital scanners are impressive, they can struggle to capture accurate subgingival detail. I find that physical impressions are a better choice for these cases as they flow into the areas that a scanner can't reach – this helps ensure that these all-important details are as accurate as possible, giving everyone involved in the treatment process the best information available.

"I also find physical impressions to be the better choice for retainers. This is because they are a more affordable option and can achieve exceptional detail capture. For retainer work, dental laboratories often incorporate the cost of the impression into the price, meaning that if you use a digital scanner this can effectively double what you would pay for the same outcome as there is a surcharge for them to print models. These outgoings can quickly add up!

"Ultimately, there are a number of benefits to physical impression materials that mean they should definitely remain in a modern dentist's armamentarium. Digital scanners aren't always as timesaving as people believe, and you can achieve a similarly accurate result in less time with an impression material. For subgingival detail impression materials are invaluable – until digital technology can reliably capture this it means that for such cases, physical impressions can't be beaten."

3M has a diverse portfolio of impression materials available:

3M Impregum Penta Polyether Impression Material

A trusted solution for complex cases and dental implant placement, Impregum Penta Polyether Impression Material is the result of decades of research and remains a solid choice for professionals who want reliable, reproducible results.

Imprint 4 Dispensing

Imprint 4 Impression

3M Impregum Penta Soft/Soft Quick Polyether Impression Material

Following the success of the original Impregum, 3M developed Impregum Penta Soft Polyether Impression Material. Impregum Penta Soft Polyether Impression Material has a setting time of either 4 or 6 minutes and has been specifically formulated for easier removability and better handling.

Kunal Shah comments: "Impregum Penta Soft Quick Polyether Material is my go-to for cases that require exceptional detail reproduction. I love its enhanced handling and removability and the fact that it's such a reliable choice time and time again."

3M Impregum Penta Super Quick Polyether Impression Material

The latest addition to the Impregum portfolio combines the outstanding performance and predictability of a polyether with the fast-setting speed of a VPS material. With 45 seconds working time and a two-minute setting time, Impregum Super Quick streamlines the impression-taking procedure and increases patient comfort. Kunal Shah comments: "I use Impregum Penta Super Quick Polyether Impression Material for my smaller cases because it has exceptional handling capabilities and provides greater patient comfort due to its swift setting time and appealing minty flavour."

3M Imprint 4 VPS Impression Material

Imprint 4 is a multi-award-winning** VPS impression material specially formulated to ensure that you always have enough working time to achieve outstanding results. Innovative chemistry means that Imprint 4 only starts to set when the working time is over. Advanced hydrophilicity means that Imprint 4 displaces moisture instantly, aiding accurate detail reproduction in moist environments.

To learn more or arrange a trial of 3M impression materials, please contact chayes@mmm.com.

* 3M internal data.

** https://www.dentaladvisor.com/awards/

A necrotic orofacial lesion presenting in an immunocompromised patient in the UK: case review with features of noma

Précis: Noma in the 'developed world' is rare. An awareness of the condition is essential for clinicians, as oral hygiene and antibiotics can prevent severe morbidity.

Abstract: Noma is a gangrenous and destructive orofacial disease. It comes from the Greek word *nomein*, meaning 'to devour'. Caused by a rapidly spreading opportunistic infection, noma has a strong affiliation to extreme poverty and is infamously known as the 'face of poverty'. It is predominantly endemic to children between the ages of two and six who are malnourished, and is incited by disease. However, there is rare precedent of this disease emerging in adulthood in more economically developed countries, with noma-like lesions in the UK doubling since 2015. We report on a 90-year-old patient who initially presented to their general medical practitioner for a necrotic lip ulcer, which was originally thought to be a cold sore. The patient was later admitted to hospital due to reduced mobility and severe anaemia, with underlying features of sepsis, malnutrition, immunosuppression, oral necrosis and progressive ulceration over three weeks. Immediate treatment began following admission, including intravenous antibiotics, oral care and nutritional supplementation, before a definitive clinical diagnosis of noma was made after a biopsy, which ruled out malignancy. The rapid treatment response, albeit before a diagnosis was confirmed, allowed for the disease process to halt. This atypical presentation in a UK hospital highlights the need for periodic review of such lesions, so that current knowledge of their presentation and management is maintained.

Journal of the Irish Dental Association October/November 2021; 67 (5): 268-271

Case report

A 90-year-old bed-bound Caucasian man was admitted to hospital due to a mechanical fall and pyrexia of 38.7°C. He also reportedly complained of a three-week history of a sore, swollen tongue, and a non-healing, painful and progressive lip 'ulcer', which was concurrent with his admission (**Figure 1**).

His medical history included: hypertension; previous basal cell carcinoma of the right tragus and squamous cell carcinoma (SCC) of the dorsum of the nose; actinic keratosis; chronic kidney disease (Stage III); and, myelodysplastic syndrome (MDS). He was immunocompromised, having had 84 cycles of chemotherapy with azacitidine (Vidaza) over a period of 11 years. MDS represents a group of cancers that result from ineffective haemopoiesis, leading to blood cytopaenia, and have potential to progress into acute myeloid leukaemia.[1]

The patient visited their general practitioner a week prior to hospital admission, who believed the oral lesion to resemble *Herpes labialis*. The lesion failed to improve with conservative management and increased in size involving the inside and outside of the lip. An urgent cancer referral was raised to the oral and maxillofacial surgery department at Diana, Princess of Wales Hospital, Grimsby, in January 2020.

Gagandip Singh Dhanjal
MChD BChD BSc MFDS (RCSEd) BEng
Dental Core Trainee in Oral and Maxillofacial Surgery

Kelvin David Mizen
BDS MBChB FDSRCS (Ed & Eng) FRCS (Eng) FRCS OMFS
Consultant in Oral and Maxillofacial Surgery

Jerome Nigel Philip
MB BS DDS FRCS (OMFS) FFDRCSI (OSOM)
Consultant in Oral and Maxillofacial Surgery

Hull University Teaching Hospitals NHS Trust, Department of Oral and Maxillofacial Surgery, Castle Hill Hospital, Castle Road, Cottingham, HU16 5JQ, United Kingdom

Corresponding author: Jerome Nigel Philip jerome.philip@hey.nhs.uk

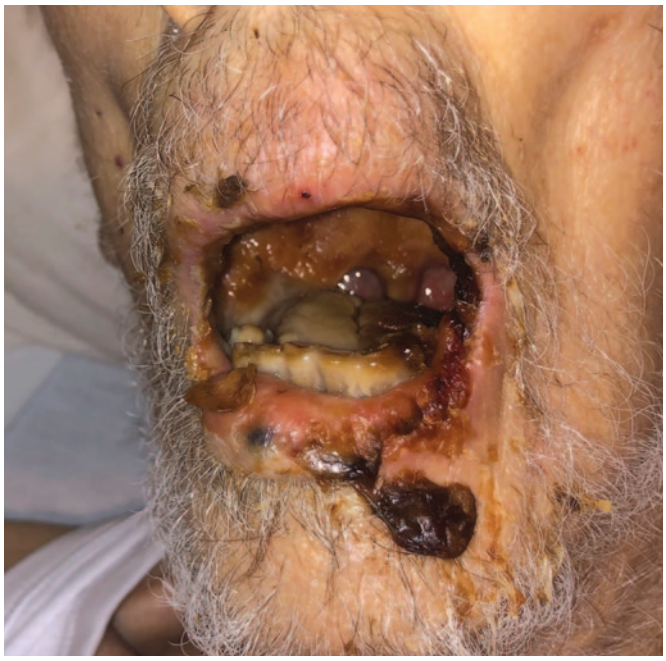


FIGURE 1: Clinical photograph of lower lip lesion. Picture demonstrates ecchymosis and blood-filled blisters surrounded by haemorrhagic crusting. There was also loss of lip competence. Photograph taken after treatment was initiated.

On examination, the patient was febrile and reported difficulty in mouth opening and pain on speaking. There was no history of trauma. The patient appeared to be suffering from an 'SCC-like lesion' on the lower lip, with features of induration, ulceration and non-healing nature. The lesion appeared to devour the left labio-buccal commissure, affecting extra- and intra-oral structures. There was no associated lymphadenopathy. The patient had lost lip competency, with teeth and gingivae easily visible at extraoral examination. Longstanding lack of oral hygiene was characterised by generalised calculus and erythematous mucosa. Features of pseudomembranous candidiasis – wipeable creamy plaques on the dorsum surface of the tongue – were apparent. Trismus of approximately 15mm and a pronounced oral foetor was present. The gingivae were ulcerated and inflamed akin to necrotising ulcerative gingivitis (NUG); however, a full intra-oral examination was not possible due to restricted mouth opening. Cachexia and cutaneous purpura on the neck and arms, secondary to MDS and chemotherapy, were also noted.

Haematological tests on admission revealed that the patient's MDS was refractory with anaemia, thrombocytopaenia and general pancytopaenia (**Table 1**). The patient had clinical signs of dehydration and malnourishment according to a Malnutrition Universal Screen Tool (MUST) score of 2.

Further investigations included blood cultures, which failed to show any growth, and bacteriology swabs, which showed normal flora. An urgent incisional biopsy showed necrosis and acute inflammation with a query of a pyogenic reaction but no malignancy, which was discussed at our local tumour board meeting.

Oral manifestations of MDS are known to cause mucosal ulceration and gingival bleeding with increased susceptibility to oro-infections secondary to immunocompromise.[2] However, the patient's sepsis, malnourishment and enduring immunosuppression, with clinical features of oral necrosis and poor oral hygiene, including foetor oris, allowed a diagnosis of noma to be made.

Table 1: Haematological and biochemical results.

Type of test	Patient's value	Reference levels
Laboratory		
Urea	14.2 ↑	2.5-7.8mmol/L
Creatinine	142 ↑	59-104µmol/L
GFR	37 ↓	90-200mL/min
Haemoglobin	42 ↓	132-170g/L
Platelets	23 x 10^9	150-400 x 10^9/L
WCC	15.1 ↑	4.3-11.2 x 10^9/L
Neutrophils	11.33 ↑	2.1-7.4 x 10^9/L
MCV	112 ↑	81-97fL
C-reactive protein	144 ↑	0-5mg/L
Albumin	25 ↓	35-50g/L
Microbiology		
Culture and sensitivity	Negative	Not applicable

Empirical treatment had begun following admission, before a definitive diagnosis of the lesion was confirmed, for severe symptomatic anaemia and sepsis. Red blood cells and platelets were transfused. Analgesics and antibiotic treatment commenced with intravenous meropenem due to his febrile MDS and then later switched to co-amoxiclav (1.2g every eight hours) for the progressive oral necrosis. Nystatin suspension, benzydamine and chlorhexidine digluconate mouthwashes were also introduced for symptomatic and bacterial control. Due to oro-mucosal pain irritated by oral candidiasis, there had been a marked reduction in oral intake. Dieticians regularly reviewed nutritional uptake with supplementation, and a naso-gastric tube was considered if he failed to improve.

After a period of 15 days (four days after biopsy) involving antimicrobial treatment, fluid resuscitation and re-feeding, the oral necrosis began to improve with features of granulation and healing (**Figure 1**). Local debridement of the necrosis was not required at this time, and the patient was subsequently discharged for palliative care. Sadly, the patient passed away due to longstanding illnesses 39 days after hospital admission.

Discussion

First described in the fifth century by Hippocrates, noma is defined by the World Health Organisation (WHO) International Classification of Diseases (ICD-10) under code A69.0 as "necrotising ulcerative stomatitis".[3] It is a non-communicable necrotising disease that leads to severe tissue necrosis of the face, mouth and other neighbouring structures. Rapid treatment is required to prevent death, and those who survive tend to live with heavy sequelae such as facial disfigurement.[4]

Reported cases largely reside within the 'noma belt', a term used by the WHO to label countries with the highest burden of disease, namely in Burkina Faso, Ethiopia, Mali, Niger, Nigeria and Senegal.[5] Some 90% of global cases develop before the age of ten.[6] It has been effectively eradicated from the 'developed world' due to improvements in healthcare and sanitation. However, there are

increasing reports of noma presenting in adulthood in high-income countries. Since the millennium, the occurrence of noma in the 'developed world' has been reported at least ten times,[7] with cases of noma-like lesions in the UK doubling since 2015.[8,9]

No specific infectious agent or illness has been identified as the single cause of noma due to the rapidity of necrosis and secondary infections.[3] The pathogenesis of noma is believed to be polymicrobial and multifactorial in nature. The role of bacteria has been cited as critical, which is made evident by oral foetor. NUG, a type of periodontal disease characterised by gingival necrosis, pain, bleeding and halitosis, is a known precursor to noma.[10-12] If left untreated, NUG can progress to necrotising periodontitis (NP) that involves the periodontal attachment apparatus. Beyond this, necrotising stomatitis (NS) can follow with or without the presence of NUG/NP, which affects the buccal/labial/lingual/palatal mucosa.[13] In turn, NS without rapid antimicrobial therapy may cause obliteration of the soft and hard tissues. This demarcated lesion is known as noma.[14]

Referral for medical/dental consultation may be indicated for a finding of NUG in primary care, which is nonresponsive to treatment for possible underlying conditions such as leukaemia and malignancy.[15] There is an important acknowledgement for the role of the dentist to prescribe antibiotics (metronidazole 400mg three times a day for three days in adults) in those who are immunocompromised or feature signs of systemic involvement such as fever, malaise and lymphadenopathy.[16] This would be adjunct to local measures (oral hygiene care and debridement) and to assessment of treatment outcomes in 24 hours.[15] Patients with underlying health conditions and sudden deterioration should be referred for urgent medical care, with sustained close monitoring. If the patient was initially seen at a primary dental care setting, intra-oral examination may have likely identified gingival necrosis and thus oral hygiene and possible antimicrobial therapy may have been initiated earlier. Regular general dental input may have prevented this advanced presentation altogether.

One factor or theory for this patient's presentation was sepsis with signs of malnutrition, which acted synergistically with MDS to permit an immunosuppressive state and provide opportunity for a 'superinfection'.[17,18] Systemic infections such as malaria and measles are common precursors to noma in low-income countries, whereas in the high-income countries, sporadic cases of noma and precursor lesions (in adults) have been largely associated with, but not limited to, other concomitant illnesses such as HIV/AIDS, leukaemia and hepatitis B.[7]

As with the current case, a 68-year-old male in 2006 was identified to have NS with underlying lack of oral hygiene, malnourishment and occult hypothyroidism. The patient also had cutaneous purpura, as did our patient. As treatment began early, noma failed to develop.[19] In 2015, researchers in Denmark published a case of noma in a 38-year-old male with a history of alcoholism-induced malnutrition and acute pancreatitis.[7]

Although scarce, there are haematological malignancies reported in the literature concerning patients with noma or noma-like lesions.[20,21] In 2017, a 70-year-old patient with MDS was suspected of having noma following trauma to the corner of their mouth.[9] Both vermillion borders were reportedly destroyed to the level of the labiomental fold. Lip commissures were obliterated, with necrosis to underlying muscle. Similarly to the current case, haematological tests showed anaemia as well as histopathology identifying chronic inflammation with no evidence of malignancy. Cultures, however, showed heavy growth of *Staphylococcus aureus*. Candida species were identified in both the 2017 and the current case.

Cases of noma in high-income countries are associated with poor oral hygiene, malnourishment and immunosuppression. As the latter is often difficult to manage, oral hygiene and nutrition are the key controllable factors to help prevent and delay the threat to life and morbidity associated with noma. A multidisciplinary approach involving dentist, maxillofacial surgeon and medical practitioner is needed.[22]

The classical symptoms of noma include severe pain, fever, oral ulceration, trismus, mucosal oedema, purulent discharge and extreme halitosis. Noma is generally diagnosed on clinical presentation rather than microbiological findings.[7] It has been noted that speed of noma and its precursor lesions in high-income countries appears to be somewhat slower than its poorer counterparts.[21]

The differential diagnoses of noma included SCC, necrotising fasciitis and acute herpetic gingivostomatitis. Other possible diagnoses include streptococcal gangrene, syphilitic yaws, mucormycosis and midfacial lymphoma (Stewart's granuloma).[17] Favourable management requires early diagnosis and immediate treatment with broad-spectrum antibiotics, oral hygiene instruction, rehydration, and correction of haematological and nutritional imbalances.

Conclusion

This case highlights that noma and its precursor lesions, despite its unequivocal rarity in high-income countries, can develop in patients who are immunocompromised, lack oral hygiene and are malnourished. Misdiagnosing noma can lead to high morbidity and mortality due to its rapidly progressing nature and effect on bodily function. The relevance of noma, particularly to primary care service providers, is due to the likelihood of initial lesions being identified by dentists or general practitioners. An appreciation of noma and a periodic reminder of the disease, its signs, symptoms and treatment among clinicians, dentists and medical colleagues working in high-income countries is needed and should permit its inclusion as a differential diagnosis.

References

1. **Adès, L., Itzykson, R., Fenaux, P.** Myelodysplastic syndromes. *Lancet* 2014; 383 (9936): 2239-2252.
2. **Ficarra, G., Miliani, A., Adler-Storthz, K., Woods-Francis, K., Mistro, A., Rossi, A., *et al.*** Recurrent oral condylomata acuminata and hairy leukoplakia: an early sign of myelodysplastic syndrome in an HIV-seronegative patient. *J Oral Pathol Med* 1991; 20 (8): 398-402.
3. **Baratti-Mayer, D., Pittet, B., Montandon, D., Bolivar, I., Bornand, J.E., Hugonnet, S., *et al.*** Noma: an "infectious" disease of unknown aetiology. *Lancet Infect Dis* 2003; 3 (7): 419-431.
4. **Naidoo, S., Chikte, U.M.** Noma (cancrum oris): case report in a 4-year-old HIV-positive South African child. *SADJ* 2000; 55 (12): 683-686.
5. **FDI World Dental Federation.** The Challenge of Oral Disease – A call for global action. 2015. Available from: https://www.fdiworlddental.org/oral-health-atlas.
6. **Adolph, H.P., Yugueros, P., Woods, J.E.** Noma. *Ann Plast Surg* 1996; 37 (6): 657-658.
7. **Rokkjaer, M.S., Klug, T.E.** Noma (cancrumoris) in the Western World. *Ann Otolaryngol Rhinol* 2015; 2 (9) :9-12.
8. **Baniulyte, G., Mcallister, P.** Atypical orofacial necrosis of unknown aetiology: a case report with features similar to NOMA. *Int J Oral Maxillofac Pathol* 2019; 10 (2).

9. **Garg, M.M., Paterson, T., Jattan, R.** Trauma, infection and the immunocompromised patient – a vicious triad causing a destructive oro-facial lesion. *Br J Oral Maxillofac Surg* 2017; 55 (10): e161.
10. **Enwonwu, C., Falkler, W., Idigbe, E., Savage, K.** Noma (cancrum oris): questions and answers. *Oral Dis* 2008; 5 (2): 144-149.
11. **Enwonwu, C.O., Falkler, W.A., Phillips, R.S.** Noma (cancrum oris). *Lancet* 2006; 368 (9530): 147-156.
12. **Malek, R., Gharibi, A., Khlil, N., Kissa, J.** Necrotizing ulcerative gingivitis. *Contemp Clin Dent* 2017; 8 (3): 496.
13. **Feller, L., Wood, N.H., Raubenheimer, E.J.** Necrotising stomatitis in a HIV-seropositive patient: report of a case and a review of the literature. *Periodontal Pract Today* 2005; 2 (4): 285-291.
14. **Masipa, J.N., Baloyi, A.M., Khammissa, R.A.G., Altini, M., Lemmer, J., Feller, L.** Noma (cancrum oris): a report of a case in a young AIDS patient with a review of the pathogenesis. *Head Neck Pathol* 2013; 7 (2): 188-192.
15. **Atout, R.N., Todescan, S.** Managing patients with necrotizing ulcerative gingivitis. *J Can Dent Assoc* 2013; 79: d46.
16. **Health Service Executive.** Acute necrotising ulcerative gingivitis. 2019. [Internet]. [cited 2020 Nov 24]. Available from: https://www.hse.ie/eng/services/list/2/gp/antibiotic-prescribing/conditions-and-treatments/dental/acute-necrotising-ulcerative-gingivitis/.
17. **Tonna, J.E., Lewin, M.R., Mensh, B.** A case and review of noma. *PLoS Negl Trop Dis* 2010; 4 (12): 1-2.
18. **Barmes, D.E., Enwonwu, C.O., Leclercq, M.-H., Bourgeois, D., Falkler, W.A.** Editorial: The need for action against oro-facial gangrene (noma). *Trop Med Int Heal* 1997; 2 (12): 1111-1114.
19. **Buchanan, J.A.G., Cedro, M., Mirdin, A., Joseph, T., Porter, S.R., Hodgson, T.A.** Necrotizing stomatitis in the developed world. *Clin Exp Dermatol* 2006; 31 (3): 372-374.
20. **Brady-West, D.C., Richards, L., Thame, J., Moosdeen, F., Nicholson, A.** Cancrum oris (noma) in a patient with acute lymphoblastic leukaemia. A complication of chemotherapy induced neutropenia. *West Indian Med J* 1998; 47 (1): 33-34.
21. **da Silva Santos, P.S., Del Neri, N.B., Chiattone, C.S.** Noma-like lesion in a patient with acute promyelocytic leukemia. *Rev Bras Hematol Hemoter* 2011; 33 (4): 321-322.
22. **Auluck, A., Pai, K.M.** Noma: life cycle of a devastating sore – case report and literature review. *J Can Dent Assoc* 2005; 71 (10): 757.

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. What drug is the mainstay of treatment for myeloid dysplastic syndrome?

- ○ A: Rivaroxaban
- ○ B: Metformin
- ○ C: Azacytidine
- ○ D: Losartan

2. The classical symptoms of Noma include:

- ○ A: Severe pain, fever, oral ulceration, trismus, mucosal oedema, purulent discharge and extreme halitosis
- ○ B: Pain, bleeding, rapidly growing lesion
- ○ C: Red pulsatile lesion, asymptomatic, expansile and found in the upper lip
- ○ D: Erosive lesion of the lip with a mass found in the neck

3. Management of Noma consists of:

- ○ A: Wide local excision and neck dissection
- ○ B: Biopsy to rule out cancer, meticulous oral hygiene and antibiotics
- ○ C: Disease is self-limiting and there is no treatment
- ○ D: Dental clearance

A scoping review of the use of motivational interviewing in oral healthcare settings

Précis:

Motivational interviewing (MI) training contributes to practitioner confidence and professionalism. Improved dental outcomes in patients were noted. Further research is recommended into developing optimal MI training delivery.

Abstract:

Statement of the problem: Recently, attention has been given to the use of motivational interviewing (MI), a therapeutic approach that helps people to change, in the oral healthcare setting. MI can be used to evoke positive change in oral health practices using a patient-centred approach that supports dental practitioner-patient relationship building. This can include a broad focus on oral hygiene, nutrition and lifestyle behaviours, or can be specific to elements of oral healthcare such as periodontal treatment. However, the research literature on the efficacy of MI in this context is sparse.

Purpose of the study: The purpose of this study is to collate what is currently known on the use of MI in the oral healthcare setting.

Materials and methods: This comprehensive scoping review collated 50 published articles on this topic. Articles were scrutinised and analysed using thematic analysis.

Results: Findings indicate that there is a heterogeneous literature base on the use of MI in the oral healthcare setting of varying quality. However, evidence is building for positive outcomes where MI training has contributed to increased confidence, professionalism and relationship building in oral healthcare practitioners, and improved oral healthcare outcomes in patients across a range of oral health issues and oral healthcare prevention.

Conclusion: Further research is recommended into what constitutes optimal MI training delivery to ensure best practice and outcomes for patients and professionals.

Journal of the Irish Dental Association October/November 2021; 67 (5): 272-276

Introduction

Motivational interviewing (MI) is described as a form of collaborative conversation that strengthens a person's own internal motivation and commitment to change. MI is also a patient-centred but directive intervention that supports people who want to resolve their ambivalence and move towards a healthier lifestyle change.[1] MI uses a person-centred approach[2] that relies critically on an atmosphere of acceptance and compassion in the context of a caring relationship that is experienced as a partnership between a professional and a patient.[1] This is what Miller and Rollnick[1] call the spirit. It is the spirit of MI that brings the technical elements to life.

Dr Rebekah Brennan
School of Applied Social Studies
University College Cork

Dr Robert O'Driscoll
Senior Addiction Counsellor
S.ACI/Coordinator
UCC/HSE Diploma in Substance Misuse and Addiction Studies

Corresponding author: Dr Rebekah Brennan rebekah.brennan@ucc.ie

MI includes staged processes of engaging, focusing, developing, and planning, which are underpinned by empathic communication. It seeks to dissolve the power imbalance that may exist between a professional and patient, and promotes a collaborative and participatory relationship, which creates an atmosphere favourable to change. It challenges traditional intervention approaches by emphasising that individuals generally know what is best for themselves, and that the professional should work to support an individual's freedom of choice to act on that inner knowledge.[3] Although MI was originally developed as a response to problematic substance use,[4] it has been demonstrated to be effective across a wide range of healthcare settings as a behaviour change method.[5]

A healthcare professional practising MI must make space for the patient's perspective and allow them to self-monitor their own behaviour change process, while acknowledging that they have the right to make no change.[6] Central to the MI technique is the use of OARS (open-ended questions; affirmations; reflective listening; summaries). OARS are used to evoke change talk (talking in the direction of change) and to soften or reduce sustain talk (talking in the direction of sustaining the behaviour) in the patient. Reflecting what the patient is saying demonstrates that the professional is listening and provides clarification for the patient. Affirmations, such as "I appreciate your openness and honesty today"; "I know you really care about your child's oral health"; "your smile is really important to you" are strength focused and notice any positive action on the part of the patient. More advanced techniques within the practice of MI include decisional balancing, which helps a patient to weigh up the benefits and costs of a particular action, and goal setting, which provides the direction for the conversation.[6,7] Traditionally, oral healthcare practitioners have employed methods of health education that relied upon advice giving rather than collaboration. This may lead to a close-ended transaction, which has been found to lack efficacy.[6]

Recently, attention has been given to the use of MI in the oral healthcare setting.[8] MI can be used to evoke positive change in oral health practices using a patient-centred approach that supports dental practitioner/patient relationship building. This can include a broad focus on oral hygiene, nutrition and lifestyle behaviours, or be specific to elements of oral healthcare such as periodontal treatment.[9] Cognitive dissonance may exist in some dental patients around their own dental care. As an example, a patient may want to achieve 'straight teeth' or perfect occlusion, but is fearful or worried about wearing orthodontic appliances for the required time that it would take to achieve their goal. In MI, this cognitive dissonance (ambivalence) is at the heart of behavioural change rather than a barrier to it. Change is accepted as taking place at the patient's pace, and will occur when the patient resolves their ambivalence and embraces the change.[4] As such, MI can be used as a brief intervention around specific oral health behaviours,[10] or as a more comprehensive intervention that encompasses general health and well-being.[11] Challenges in learning MI may include limitations in resources such as time, competence, and ongoing support for oral healthcare practitioners to integrate MI into their established intervention methods.[12] There is a growing body of evidence to support the efficacy of MI in oral healthcare; however, further research is needed.[9] This scoping review aims to collate the relevant literature to answer the research question: "What do we know about the use of motivational interviewing in oral healthcare settings?"

Methods

Scoping reviews are appropriate where broader research questions exist.[13-16] They are used to identify gaps in knowledge, examine the extent (i.e., size), range (i.e., variety), and nature (i.e., characteristics) of the evidence on a certain topic or question (in this case, use of MI in oral healthcare settings), summarise findings from a wide range of sources, and make research and policy recommendations.[13,15, 17-19] The research team for this review adhered to Arksey and O'Malley's[13] five-stage iterative process scoping review methodology. These stages included the following:

1. Identifying the essential research question.
2. Identifying relevant studies.
3. Study selection.
4. Charting the data.
5. Collecting, summarising, and reporting the results.

The process was underpinned by the research question ("What do we know about the use of motivational interviewing in oral healthcare settings?") and reviewed all available published empirical and grey literature in the English language on this topic. There was no restriction on date of publication or study type. The search was implemented in June 2020. The following databases were accessed: Web of Science; Cochrane Library; MEDLINE; PsycINFO; Social Science Citation Index; PubMed; Science Direct; and, Researchgate. Key search terms informed the search strategy: "motivational interviewing" in conjunction with "oral healthcare", "dental practice", "oral hygiene", and "dental care".

Eligibility criteria focused on the use of MI in oral healthcare settings. Inclusion and exclusion criteria were discussed and agreed with all members of the research team. The initial search identified 8,552 articles, and following initial screening, 5,785 were removed for lack of relevance, with the remaining 2,767 screened for inclusion in the study. Finally, duplicates (1,902) and further records were removed, which were not relevant (815), leaving 50 records in total. The 50 records were charted and thematically analysed, as per Arksey and O'Malley.[13]

A table was created to chart relevant data (year of publication, author, location, method and aim, key findings) and to analyse the extracted data thematically to identify commonalities, emergent issues, and gaps in the literature. The textual dataset was re-read numerous times in order to become familiar with the data, and identify and code emerging themes. Thematic manual coding then organised the data and subsequently structured it into themes through patterns identified in associated categories.[20] Three themes emerged from the review:

1. Suitability of MI training in oral healthcare settings.
2. Evidence of the impact of MI training on oral healthcare outcomes.
3. Challenges encountered in MI training.

Results

Profile of studies reviewed

Fifty studies were included in this scoping review and are comprised of ten randomised controlled trials (RCTs), seven case control studies, four qualitative studies, three quantitative studies, one mixed-methods study, 14 systematic literature reviews, six narrative/scoping literature reviews, four editorials, and one book chapter (**see table here on www.jida.ie**). The findings from these will be presented here under headings that directly relate to the research question: "What do we know about the use of motivational interviewing in oral healthcare settings?"

THEME 1:

Suitability of MI training in oral healthcare settings

While it has previously been suggested that the evidence for suitability of MI training in oral healthcare practice is limited, and perhaps an adapted model should be considered for this setting,[4] this review found that there is a building body of evidence for the suitability of MI training for oral healthcare professionals. Included in this review are RCTs,[3,21-25] which have found positive results in terms of dental practitioner-patient relationships and subsequent oral health outcomes. Further, two case control studies that focused on professionals' experiences of MI training[26,27] found that training was successful in developing MI skills. Some positives noted in the literature are the promotion of self-confidence, professionalism and protection against burnout in oral healthcare professionals.[28,29]

It was also suggested that professionals may reconceptualise their roles as "oral health coaches" to align themselves with the helping nature of their profession, and that MI is a valuable tool in revisiting this ethos.[6,30] The dental team, in order to benefit from MI training, must be open to placing the patient's perspective at the heart of their approach to behaviour change.[27,31] In terms of MI delivery, MI was said to be easiest to adapt into oral healthcare practice when delivered in a structured manner to retain the authenticity of MI.[4] However, one RCT found that one eight-hour training course was sufficient to develop the MI skills of oral healthcare professionals and increased their use of open-ended questions, affirmations, and reflective listening.[21] Conversely, one study found that while improvements were noted in use of open-ended questioning, complex reflections, and MI adherence, there was no impact on change talk or reflections to questions ratio.[32]

THEME 2:

Evidence of the impact of MI training on oral healthcare outcomes

While the heterogeneity of the studies limits a conclusive finding, there is evidence that MI training results in improved oral healthcare outcomes. The most comprehensive literature review conducted on MI and oral health that this study found included 16 studies, and found improvements across oral health outcomes such as carious lesions and oral health prevention.[12] These findings were largely echoed across the reviewed literature. Areas where improvements in specific oral health outcomes were noted included: self-efficacy of interdental cleaning;[27] reduction in plaque;[33,34] enhanced general oral hygiene;[23,35-39] tooth brushing;[24,40] dietary practice and dental attendance;[25] reduction in new dental carious lesions;[41,42] perceptions of oral health; gingival bleeding;[37] reduction in the consumption of sugar-sweetened beverages;[43] periodontal disease;[9,31,44] adolescent oral health behaviours;[45] and, parental efficacy in improving children's oral health behaviours.[22] Some evidence for lasting positive change is in two studies, where improved oral health outcomes remained stable at four-month[25] and six-month dental follow-ups.[23] In one case, a single MI intervention was reported as more successful in changing oral health behaviours when compared to traditional oral health education approaches.[39] However, multiple MI sessions were found to be most effective in another study.[10]

Improvement in oral health outcomes using MI was seen in literature that focused on: people with severe mental health issues;[3] people from lower socioeconomic backgrounds;[7,46] people with alcohol use disorders,[47] and, vulnerable families.[48] However, one study found that MI did not result in higher dental attendance among lower-income females,[49] and the weight and influence of other sociocultural factors on families who struggle to engage with oral healthcare professionals was underscored in Blue *et al.*'s[50] study.

THEME 3:

Challenges encountered in MI training

Challenges described in the reviewed literature included an increased need for resources to deliver MI training, specifically time,[7,51] financial cost,[49] and ensuring that training is appropriately delivered, for example by a skilled MI practitioner.[7] The need for training programmes to be evaluated to test the fidelity of the intervention was noted by Asimakopoulou and Newton,[4] but evaluation was not commonplace across training programmes. A need for stakeholder engagement to ensure the success of MI programmes was highlighted by Murphy *et al.*[52] Specific challenges were described when working with people from lower socioeconomic backgrounds experiencing adversity and marginalisation, and the need for wraparound services and support was highlighted.[46,50] Attitudes among oral healthcare professionals towards MI were also noted as a potential barrier to success in implementation of MI programmes in two studies,[53,54] where the authors found that prior experience or knowledge of MI, and experience of difficulty with initiating behaviour change in patients through traditional oral health education modalities, resulted in better outcomes.

Discussion

While MI is a longstanding therapeutic approach, which originated in the treatment of problematic substance use,[1] use of this approach in the oral healthcare setting has attracted recent research attention.[8] Traditionally, oral healthcare practitioners have employed methods of health education that relied on advice giving rather than collaboration, which is at the heart of the MI approach. This may alienate some patients, particularly those with reduced literacy or other difficulties,[48] and has been seen to lack efficacy where patients struggle to engage with this potentially closed-ended approach.[6] The benefits intended through using MI are to evoke positive change in patient oral healthcare behaviours, and this is largely achieved through successfully strengthening the dental professional–patient relationship, creating a space where the patient feels heard and their perspective is understood and valued. This is achieved through utilising a number of techniques, including OARS in the context of a collaborative relationship where the patient feels accepted, and the clinician is compassionate and empathic in their communication.[1] It is recommended that the role of the oral healthcare professional be aligned with MI principles of patient-centred collaboration and empathy.[6,30]

While limited in its conclusions due to the heterogeneity of the studies reviewed, this comprehensive scoping review is one of the largest conducted to date on the literature on use of MI in oral healthcare settings and included 50 studies conducted internationally. Although the quality of the studies included varies, there is some strong evidence, including from RCTs and case control studies, that MI results in positive outcomes compared to traditional oral healthcare education techniques employed in the oral healthcare setting. These outcomes include increased work satisfaction among professionals through developing confidence, relationship building and observing better outcomes in patients,[28,29] and improved oral health in patients across a range of dental issues.[9] The efficacy of MI in this setting appears to be reliant on a structured approach,[4] open-mindedness towards professionals' using MI, and adequate resources and time to deliver a quality programme,[7,49,51] although some success

has been evidenced even with short-term training. Moreover, MI may be seen as a good investment for the oral healthcare setting to evoke behaviour change in patients[55] and to promote inclusive healthcare in general.

The need for further research is clear, particularly in the Irish context, where the literature base is particularly sparse on use of MI in the oral healthcare setting. This review was unable to identify any empirical research conducted in Ireland on this topic. Evaluation of such programmes is recommended in order to continue to build quality evidence in this area, including the suitability of the busy oral healthcare sector for MI delivery, whether oral healthcare practitioners are already practising some elements of MI without calling it such, and the impact of the current climate of Covid-19 on MI delivery in this sector.

Conclusion

There is a heterogeneous literature base on the use of MI in the oral healthcare setting of varying quality. However, evidence is building for positive outcomes where MI training has contributed to increased confidence, professionalism and relationship building in oral healthcare practitioners, and improved oral healthcare outcomes in patients across a range of oral health issues and oral healthcare prevention. Further research is recommended into what constitutes optimal MI training delivery to ensure best practice and more longitudinal research with follow-ups into professional and patient progress and behaviour change sustainment.

Acknowledgments

This research is funded by the Health Service Executive, National Oral Health Office. The researchers would like to acknowledge the support of Dr Myra Herlihy, Principal Dental Surgeon.

References

1. **Miller, W., Rollnick, S.** *Motivational Interviewing: Helping People Change (3rd ed.)*. New York: Guilford Press, 2012.
2. **Rogers, C.** *Client-Centered Therapy: Its Current Practice, Implications and Theory*. London: Constable, 1951.
3. **Almomani, F., *et al.*** Effects of an oral health promotion program in people with mental illness. *J Dent Res* 2009; 88 (7): 648-653.
4. **Asimakopoulou, K., Newton, T.** Success with motivational interviewing techniques in the dental clinic: a case for the use of iMI-GPS. *Dental Update* 2018; 45 (5): 462-468.
5. **Lundahl, B.W., *et al.*** A meta-analysis of motivational interviewing: twenty-five years of empirical studies. *Research on Social Work Practice* 2010; 20 (2): 137-161.
6. **Antoniadou, M., Varzakas, T.** Diet and oral health coaching methods and models for the independent elderly. *Applied Sciences* 2020; 10 (11): 4021.
7. **Bhujel, N., Rajan, S.** Motivational interviewing in managing dental caries in children. *Dental Update* 2019; 46 (7): 686-693.
8. **McNeil, D.W., Addicks, S.H., Randall, C.L.** Motivational interviewing and motivational interactions for health behavior change and maintenance. In: **McNeil, D.W., Addicks, S.H., Randall, C.L.** *Motivational Interviewing and Motivational Interactions for Health Behavior Change and Maintenance*. Oxford Handbooks Online. 2017. Available from: https://www.oxfordhandbooks.com/view/10.1093/oxfordhb/9780199935291.001.0001/oxfordhb-9780199935291-e-21 Accessed on 16/08/2020.
9. **Kopp, S.L., Ramseier, C.A., Ratka-KKrüger, P., Woelber, J.P.** Motivational interviewing as an adjunct to periodontal therapy – a systematic review. *Front Psychol* 2017; 8: 279.
10. **Manoranjitha, B.S., Mallikarjuna, S.K., Pushpanjali, K.** A systematic review of health education theories and approaches in improving the oral health behaviour among adults. *International Journal of Community Medicine and Public Health* 2017; 4 (2): 286-293.
11. **Gillam, D.G., Yusuf, H.** Brief motivational interviewing in dental practice. *Dent J (Basel)* 2019; 7 (2): 51.
12. **Gao, X., *et al.*** Motivational interviewing in improving oral health: a systematic review of randomized controlled trials. *J Periodontol* 2014; 85 (3): 426-437.
13. **Arksey, H., O'Malley, L.** Scoping studies: towards a methodological framework. *International Journal of Social Research Methodology* 2005; 8 (1): 19-32.
14. **Khalil, H., *et al.*** An evidence-based approach to scoping reviews. *Worldviews Evid Based Nurs* 2016; 13 (2): 118-123.
15. **Levac, D., Colquhoun, H., O'Brien, K.K.** Scoping studies: advancing the methodology. *Implementation Sci* 2010; 5 (1): 69.
16. **Peters, M.D.J., *et al.*** Guidance for conducting systematic scoping reviews. *Int J Evid Based Healthc* 2015; 13 (3): 141-146.
17. **Brandt, S.D., King, L.A., Evans-Brown, M.** The new drug phenomenon. *Drug Test Anal* 2014; 6 (7-8): 587-597.
18. **Daudt, H.M.L., van Mossel, C., Scott, S.J.** Enhancing the scoping study methodology: a large, inter-professional team's experience with Arksey and O'Malley's framework. *BMC Med Res Methodol* 2013; 13 (1): 48.
19. **Tricco, A.C., *et al.*** A scoping review on the conduct and reporting of scoping reviews. *BMC Med Res Methodol* 2016; 16: 15.
20. **Crossley, M.** Narrative analysis. In: **Lyone, E., Coyle, A. (eds.).** *Analysing Qualitative Data in Psychology*. London; SAGE Publications, Ltd, 2007: 131-144.
21. **Faustino-Silva, D.D., *et al.*** Effectiveness of motivational interviewing training for primary care dentists and dental health technicians: results from a community clinical trial. *J Dent Educ* 2019; 83 (5): 585-594.
22. **Jiang, S., *et al.*** Motivational interviewing to prevent early childhood caries: a randomized controlled trial. *J Dent* 2020; 97: 103349.
23. **Rigau-Gay, M.-M., *et al.*** Effectiveness of motivational interviewing to improve oral hygiene in orthodontic patients: a randomized controlled trial. *J Health Psychol* 2020; 25 (13014): 2362-2373.
24. **Smithers, L.G., *et al.*** Diet and anthropometry at 2 years of age following an oral health promotion programme for Australian Aboriginal children and their carers: a randomised controlled trial. *Br J Nutr* 2017; 118 (12): 1061-1069.
25. **Naidu, R., Nunn, J., Irwin, J.D.** The effect of motivational interviewing on oral healthcare knowledge, attitudes and behaviour of parents and caregivers of preschool children: an exploratory cluster randomised controlled study. *BMC Oral Health* 2015; 15 (1): 101.
26. **Johansson, A.C., *et al.*** Dental hygienist students' learning about motivational interviewing. *Dentistry Journal* 2014; 2 (2): 65-77.
27. **Woelber, J.P., *et al.*** Training of dental professionals in motivational interviewing can heighten interdental cleaning self-efficacy in periodontal patients. *Front Psychol* 2016; 7: 254.
28. **Mills, A., *et al.*** Dental hygiene students' perceptions of importance and confidence in applying motivational interviewing during patient care. *J Dent Hyg* 2017; 91 (1): 15-23.
29. **Szczekala, K., *et al.*** Benefits of motivational interviewing application for patients and healthcare professionals. *Polish Journal of Public Health* 2018; 128 (4): 170-173.
30. **Hancocks, S.** Motivating motivation. *Br Dent J* 2017; 222 (1): 27.
31. **Faustino-Silva, D.D.** Changes in oral health behaviors. Is motivational interviewing an alternative? *J Oral Res* 2016; 5 (5): 186-187.

32. **Croffoot, C., *et al.*** Evaluating the effects of coaching to improve motivational interviewing skills of dental hygiene students. *J Dent Hyg* 2010; 84 (2): 57-65.
33. **Mohammadi, T.M., Hajizamani, A., Bozorgmehr, E.** Improving oral health status of preschool children using motivational interviewing method. *Dent Res J (Isfahan)* 2015; 12 (5): 476-481.
34. **Werner, H., *et al.*** Psychological interventions for poor oral health: a systematic review. *J Dent Res* 2016; 95 (5): 506-514.
35. **Kay, E.J., *et al.*** Motivational interviewing in general dental practice: a review of the evidence. *Br Dent J* 2016; 221 (12): 785-791.
36. **Lundahl, B., *et al.*** Motivational interviewing in medical care settings: a systematic review and meta-analysis of randomized controlled trials. *Patient Educ Couns* 2013; 93 (2): 157-168.
37. **Neves, P.C.B., *et al.*** The impact of motivational interviewing in reducing plaque and bleeding indices on probing in adult users of the family health strategy. *Pesquisa Brasileira em Odontopediatria e Clínica Integrada* 2015; 15 (1): 183-196.
38. **Martins, R.K., McNeil, D.W.** Review of motivational interviewing in promoting health behaviors. *Clin Psychol Rev* 2009; 29 (4): 283-293.
39. **Kapoor, V., Gupta, A., Arya, V.** Behavioral changes after motivational interviewing versus traditional dental health education in parents of children with high caries risk: results of a 1-year study. *J Indian Soc Pedod Prev Dent* 2019; 37 (2): 192-197.
40. **Dermen, K.H., Ciancio, S.G., Fabiano, J.A.** A pilot test of motivational oral health promotion with alcohol-dependent inpatients. *Health Psychol* 2014; 33 (4): 392-395.
41. **Menegaz, A.M., Silva, A.E.R., Cascaes, A.M.** Educational interventions in health services and oral health: systematic review. *Rev Saude Publica* 2018; 52: 52.
42. **Cascaes, A.M., *et al.*** Effectiveness of motivational interviewing at improving oral health: a systematic review. *Rev Saude Publica* 2014; 48 (1): 142-153.
43. **Mallonee, L.F., Boyd, L.D., Stegeman C.** A scoping review of skills and tools oral health professionals need to engage children and parents in dietary changes to prevent childhood obesity and consumption of sugar-sweetened beverages. *J Public Health Dent* 2017; 77 (Suppl. 1): S128-S135.
44. **Järvinen, M., *et al.*** Behavioural interventions that have the potential to improve self-care in adults with periodontitis: a systematic review. *Acta Odontol Scand* 2018; 76 (8): 612-620.
45. **Wu, L., *et al.*** Motivational interviewing to promote oral health in adolescents. *J Adolesc Health* 2017; 61 (3): 378-384.
46. **Taormina, M., *et al.*** Perception of dental caries and parental difficulties in implementing oral hygiene for children aged less than 6 years: a qualitative study. *Dent J (Basel)* 2020; 8 (3): 62.
47. **Neff, J.A., *et al.*** A brief motivational intervention for heavy alcohol use in dental practice settings: rationale and development. *J Health Psychol* 2013; 18 (4): 542-553.
48. **Kay, E.J., *et al.*** A qualitative exploration of promoting oral health for infants in vulnerable families. *British Dent Jour* 2019; 227 (2): 137-142.
49. **Riedy, C.A., *et al.*** Dental attendance among low-income women and their children following a brief motivational counseling intervention: a community randomized trial. *Soc Sci Med* 2015; 144: 9-18.
50. **Blue, C.M., *et al.*** Using motivational interviewing to reduce parental risk related behaviors for early childhood caries: a pilot study. *BMC Oral Health* 2020; 20 (1): 90.
51. **Weinstein, P., *et al.*** Treatment fidelity of brief motivational interviewing and health education in a randomized clinical trial to promote dental attendance of low-income mothers and children: Community-Based Intergenerational Oral Health Study "Baby Smiles". *BMC Oral Health* 2014; 14: 15.
52. **Murphy, M., *et al.*** Considerations and lessons learned from designing a motivational interviewing obesity intervention for young people attending dental practices: a study protocol paper. *Contemp Clin Trials* 2013; 36 (1): 126-134.
53. **Cook, P.F., Manzouri, S., Aagaard, L., O'Connell, L., Corwin, M., Gance-Cleveland B.** Results from 10 years of interprofessional training on motivational interviewing. *Eval Health Prof* 2017; 40 (2): 159-180.
54. **Kim, S.Y.** The effect of recognition of need and participation intent of motivational interviewing education in dental hygiene students experiencing clinical practice. *Journal of Korean society of Dental Hygiene* 2016; 16 (5): 807-814.
55. **Wilder, R.S., Bray K.S.** Improving periodontal outcomes: merging clinical and behavioral science. *Periodontol 2000* 2016; 71 (1): 65-81.

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. In motivational interviewing (MI), what does OARS stand for?

- ○ A: Open-ended questions, affirmations, reflective listening, summaries
- ○ B: Observing, attending, reflective listening, summaries
- ○ C: Open-ended questions, affirmations, rationalisation, summaries

2. What does the research show that oral health practitioners gain from using MI?

- ○ A: Relationship building with colleagues
- ○ B: Self-confidence, professionalism and protection against burnout
- ○ C: Counselling skills

3. What are the key benefits of MI in oral healthcare?

- ○ A: To evoke compliance in the patient
- ○ B: To upskill oral healthcare practitioners
- ○ C: To evoke positive change in patient oral healthcare behaviours and strengthen the dental professional–patient relationship

Welcome to

Dubco Credit Union Limited

now amalgamated with Irish Dental Credit Union Limited

No wait period or minimum savings required for members who wish to borrow!

THE NEW CREDIT UNION FOR DENTISTS, THEIR COLLEAGUES & EXTENDED FAMILY

DUBCO LOAN RATES

COVID-19 BUSINESS SUPPORT LOAN	6.97% (7.20% APR*)		
BUSINESS IMPROVEMENT LOAN	**5 year term** 5.97% (6.14% APR*)	**7 year term** 6.47% (6.67% APR*)	**10 year term** 6.97% (7.20% APR*)
INCOME TAX LOAN	6.47% (6.67% APR*)		
PERSONAL LOAN	7.97% (8.27% APR*)		
CAR LOAN	**Standard Car 5 to 7 year term** 5.97% (6.14% APR*)	**Electric Car 5 to 10 year term** 4.97% (5.08% APR*)	
HOME IMPROVEMENT LOAN	**5 year term** 5.97% (6.14% APR*)	**7 year term** 6.47% (6.67% APR*)	**10 year term** 6.97% (7.20% APR*)
EDUCATION LOAN	4.97% (5.08% APR*)		
COVERED LOAN (SAVINGS HIGHER THAN LOAN)	4.97% (5.08% APR*)		
HOME LOAN	**LTV < 50%** 3.40% (3.45% APRC**)	**LTV < 80%** 3.60% (3.66% APRC**)	

*The APR (Annual Percentage Rate) included is an example only; all APR examples are based on a €10,000 loan over a period of 60 monthly repayments.
**The APRC (Annual Percentage Rate of Charge) included is an example only; all APRC examples are based on €200,000 over a period of 300 months. 1st legal charge will be required.

To join:

Visit www.dubco.ie/join and sign up online

Call us on 01 887 0400

Download a Membership Pack from www.dubco.ie/membership

Dubco Credit Union Limited is regulated by the Central Bank of Ireland

DUBCO

Together We're Better

Little Green Street, Dublin 7

Malahide Road, Coolock, Dublin 5 (for Mondelez employees only)

Tel: 01 887 0400 **Email:** info@dubco.ie **Website:** www.dubco.ie

ABSTRACTS

The origins of SARS-CoV-2: a critical review

Holmes, E.C., Goldstein, S.A., Rasmussen, A.L., Robertson, D.L., Crits-Christoph, A., Wertheim, J.O., et al.

Abstract

Since the first reports of a novel severe acute respiratory syndrome (SARS)-like coronavirus in December 2019 in Wuhan, China, there has been intense interest in understanding how severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) emerged in the human population. Recent debate has coalesced around two competing ideas: a 'laboratory escape' scenario and zoonotic emergence. Here, we critically review the current scientific evidence that may help to clarify the origin of SARS-CoV-2.

Cell 2021: S0092-8674(21)00991-0. doi: 10.1016/j.cell.2021.08.017. Epub ahead of print.

A vaccine-induced public antibody protects against SARS-CoV-2 and emerging variants

Schmitz, A.J., Turner, J.S., Liu, Z., Zhou, J.Q., Aziati, I.D., Chen, R.E., et al.

Abstract

The emergence of SARS-CoV-2 antigenic variants with increased transmissibility is a public health threat. Some variants show substantial resistance to neutralisation by SARS-CoV-2 infection- or vaccination-induced antibodies. Here, we analysed receptor-binding domain-binding monoclonal antibodies derived from SARS-CoV-2 mRNA vaccine-elicited germinal centre B cells for neutralising activity against the WA1/2020 D614G SARS-CoV-2 strain and variants of concern. Of five monoclonal antibodies that potently neutralised the WA1/2020 D614G strain, all retained neutralising capacity against the B.1.617.2 variant, four also neutralised the B.1.1.7 variant, and only one, 2C08, also neutralised the B.1.351 and B.1.1.28 variants. 2C08 reduced lung viral load and morbidity in hamsters challenged with the WA1/2020 D614G, B.1.351, or B.1.617.2 strains. Clonal analysis identified 2C08-like public clonotypes among B cells responding to SARS-CoV-2 infection or vaccination in 41 out of 181 individuals. Thus, 2C08-like antibodies can be induced by SARS-CoV-2 vaccines and mitigate resistance by circulating variants of concern.

Immunity 2021: S1074-7613(21)00345-9. doi: 10.1016/j.immuni.2021.08.013. Epub ahead of print.

COVID-19 – the impact on wellbeing of the dental team in a secondary care urgent dental hub

Sandhu, B., Blanchard, J., Koshal, S.

Abstract

Introduction: Dentistry in the UK has been thrown into turmoil as Covid-19 made its mark on the nation. The sudden shift in daily life has had a huge impact on the dental workforce. As the pandemic continues to ravage across the globe, we must look at ways of maintaining patient care and the well-being of staff. It becomes prudent to reflect on experiences to date and lessons learnt, which is illustrated through this study investigating the effect on the well-being of the dental team in a single unit hospital setting.

Materials and methods: Fourteen focus groups were held including multiple grades on a voluntary basis, with a discussion schedule including suitable prompts. Responses were transcribed, maintaining anonymity throughout, and thematic analysis was performed on the verbatim transcript to identify common themes and direct quotes.

Results: Key themes that were highlighted included anxiety, safety concerns, teamwork, family and redeployment. The themes of anxiety and safety were further explored, identifying participant discussion of feeling isolated, confusion, and specific concerns about PPE and transport to work.

Conclusion: This study identifies reasons to establish support networks for the dental workforce across the UK, highlighting the true adaptability of the dental team and the ability to break barriers to aid in combating a global pandemic.

British Dental Journal 2021 – https://doi.org/10.1038/s41415-021-3317-0.

SARS-CoV-2 B.1.617.2 Delta variant replication and immune evasion

Mlcochova, P., Kemp, S., Dhar, M.S., Papa, G., Meng, B., Ferreira, I.A.T.M., et al.

Abstract

The SARS-CoV-2 B.1.617.2 (Delta) variant was first identified in the state of Maharashtra in late 2020 and spread throughout India, outcompeting pre-existing lineages including B.1.617.1 (Kappa) and B.1.1.7 (Alpha). *In vitro*, B.1.617.2 is six-fold less sensitive to serum-neutralising antibodies from recovered individuals, and eight-fold less sensitive to vaccine-elicited antibodies as compared to wild type (WT) Wuhan-1 bearing D614G. Serum-neutralising titres against B.1.617.2 were lower in ChAdOx-1 versus BNT162b2 vaccinees. B.1.617.2 spike pseudotyped viruses exhibited compromised sensitivity to monoclonal antibodies against the receptor binding domain (RBD) and N-terminal domain (NTD). B.1.617.2 demonstrated higher replication efficiency in both airway organoid and human airway epithelial systems compared to B.1.1.7, associated with B.1.617.2 spike in a predominantly cleaved state compared to B.1.1.7. The B.1.617.2 spike protein was able to mediate highly efficient syncytium formation that was less sensitive to inhibition by neutralising antibody as compared to the WT spike. Additionally, we observed that B.1.617.2 had higher replication and spike-mediated entry as compared to B.1.617.1, potentially explaining B.1.617.2 dominance. In an analysis of over 130 SARS-CoV-2-infected healthcare workers across three centres in India during a period of mixed lineage circulation, we observed reduced ChAdOx-1 vaccine effectiveness against B.1.617.2 relative to non-B.1.617.2, with the caveat of possible residual confounding. Compromised vaccine efficacy against the highly fit and immune-evasive B.1.617.2 Delta variant warrants continued infection control measures in the post-vaccination era.

Nature 2021. doi: 10.1038/s41586-021-03944-y. Epub ahead of print.

SITUATIONS VACANT

Associates

Associate dentist required in busy, two-surgery practice in north Dublin. Full-time available for the right person. Some experience required. Must be IDC registered. Immediate start available for suitable applicant. Please apply to rahenydentalcentre@outlook.com.

Enthusiastic associate dentist required in well-established, busy, two-surgery practice in south Dublin. Full-time and part-time positions available. Very supportive work environment, fully computerised. Contact squaredentalpractice@gmail.com.

Associate dentist required for modern, multi-surgery practice in south Co. Wicklow. PRSI and private only. Full book replacing departing colleague. Full-time or part-time. Contact Positionavailable2020@yahoo.com.

Part-time associate dentist required for specialist/general practice in Naas. Minimum five years' experience. Intra-oral scanner, operating microscope and onsite dental lab. Contact info@naasdental.ie.

Monasterevin, Co. Kildare. Part-time associate required, two days a week, busy practice, computerised. Experience required. Email drniallcollins@gmail.com.

Full- and part-time associates required for busy and growing, well-established clinics in Maynooth and D2. Modern, fully private practice. Excellent opportunity for a driven and motivated associate in a supportive and team-based environment. Applications via email to john@dentalhouse.ie.

Limerick – we are looking for a talented associate to join our team. New graduates considered. Fully private, high-end practice with excellent equipment, facilities and staff. Full book. Four to five days ideally. Generous terms for the right candidate. Contact limerickdentaljob@gmail.com.

Associate required for busy private practice in Galway. Modern, digital, full book. Enjoyable working environment with a great team. Contact drrothwelldental@gmail.com.

Limerick City. Associate required for city centre dental practice to replace departing colleague. Full- or part-time. Contact eamonnnoonan@hotmail.com.

Associate required, starting two days per week, for busy family practice in Athlone, preferably with interest in implants and endo. Great working conditions and terms. Contact campbelldentald@yahoo.ie.

Experienced dental associate required in Waterford City. Full-time position in private, well-established clinic. Be part of a great multidisciplinary team with visiting specialists. Excellent backroom support. CEREC, in-house laboratory, digital scanner, CBCT. Please send CV to Bpm.gmedical@gmail.com.

Part-time associate required for busy, modern practice one hour from Cork City. Full book, excellent remuneration package, days are flexible. Contact westcorkdentist@hotmail.com.

Experienced dental associate required to work two to three days/week in general practice in Dublin north. Private/PRSI. Good earning potential. Immediate start possible. Endo experience very beneficial. Please email CV to dublinsmilecenter@gmail.com.

Great high earning opportunity for experienced associates to join our modern, fully equipped practices. Flexible full- and part-time options available. Strong, established books. Supported by experienced staff. If interested please email careers@dentalcareireland.ie.

Full- or part-time associate dentist required for busy practice in Athlone. Central location one hour from Dublin or Galway. Supportive, relaxed and friendly working environment. 50% remuneration. New graduates welcome to apply. Email info@westsidedental.ie.

Saturday position available for associate dentist in busy general practice in Dublin 9. Private and PRSI. Exact software. Great support team. Apply with CV to niamh@drumcondravillagedental.ie.

Associate dentist required for busy, modern private practice in Ballinasloe, located 30 mins from Galway City on M6. Fully digital, OPG, visiting Endodontist, hygienist, exceptional support staff, high earning potential. Contact: drrothwelldental@gmail.com.

Experienced dental associate required for busy dental practice in Midleton. Wednesdays and Fridays 9.30-5.00. Private and PRSI only. Full book. Forward CV if interested to carmel@corabbeydentalclinic.ie.

Associate required for very busy, family-friendly practice in Fermoy. Four to five days per week. Immediate start. Remuneration 50% gross. Experienced support staff. New graduates welcome. Contact Matt at ballinvoher96@gmail.com.

Associate wanted for busy expanding practice in Longford/Mullingar. Part/full-time. Private/PRSI/medical card. Software of Excellence. Great support staff. Immediate start. Contact longdentcent@gmail.com.

Part-time associate required Tuesdays and Wednesdays for long-established practice in Dundrum, D14. Modern, three-surgery practice including SOE Exact software, digital radiography, and new A-Dec and Belmont chairs. Immediate start available, excellent remuneration! Contact dr.moroney@dentalclinic.ie.

Associate wanted with an interest in prosthodontics and endodontics. Busy and modern practice in Cavan Town. Please apply with CV to churchstdental@gmail.com.

Dental associate required for two to three days a week in busy practice in Abbeyfeale, Co. Limerick. Private/PRSI/medical card. 50% renumeration. Contact lyonsoconnordental@mail.com.

Seeking a motivated, caring dental associate for a part-time position in our Dublin 12 clinic. Experience in endodontics and basic prosthodontics preferred. Email CV to info@cleardentalcare.ie.

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 19, 2021**. 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:

- Situations Wanted
- Situations 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.

Associate dentist wanted to join busy practice in Cavan Town. Please apply with CV to churchstdental@gmail.com.

Experienced associate required for a busy private practice – Tuesday, Wednesday, Thursday, Friday, 9.30am-5.00pm. Multidisciplinary practice. Excellent support. Please forward CV to carmel@corabbeydentalclinic.ie.

Experienced associate dentist required for a busy award-winning practice within an hour of Dublin. Full- or part-time. Private/PRSI only. Email dentalsurgerynortheast@gmail.com for further details.

Associate required, part-time, 50% of gross, partnership later if required. Contact drjjconneely@gmail.com.

Experienced associate dentist position has opened at our fabulous state-of-the-art Donaghmede practice. Fantastic opportunity, with fabulous earning potential and a full patient list! Apply today at RECRUITMENT@smartdentalcare.co.uk.

Associate required for modern, digitally equipped practice in Dublin 2. Fully private/PRSI. Team player required. Immediate start available, four days per week, Tuesday-Friday. Contact: john@dentalhouse.ie.

Associate position available. Modern, computerised mixed practice SW Dublin. Digital X-rays, OPG. Full-time role. Contact ciaranburke500@gmail.com.

Experienced, conscientious, part-time associate (possibly with a view) required for busy practice in thriving seaside town of Clonakilty, West Cork. Contact westcorkdentist@gmail.com.

Part-time dental associate required for Killester practice, Dublin 3 (no GMS). Modern digitalised practice. Excellent terms. Experience preferred but not essential. Email CV to pauleggles@gmail.com.

South Dublin. Experienced, part/full-time associate for a strong-profile, very busy practice, no GMS. Supportive, progressive environment. Hygienist. Modern digitalised equipment, computerised Endo, experience very beneficial. High demand for cosmetic/restorative treatments. Right candidate, excellent remuneration. Contact niall@innovativedental.com.

Associate position available, Gorey, Co. Wexford. One day/week. No medical card. Qualified support staff. Computerised. Digital X-rays/OPG. Hygienist service, 50 minutes south of Dublin. Start October. Friendly relaxed practice. Email adecdental365@gmail.com.

Dentists

Exciting opportunity to join our team in Dublin 16. We are looking for an enthusiastic dentist with an interest in composite veneers. Full/part-time. Contact kbmdental.grange@gmail.com.

Experienced part-time dentist wanted for computerised practice in Dublin 6. Sessions available Tuesday, Wednesday and Thursday. Contact chloe@clonskeaghdental.ie.

Dental Care Ireland – high earning opportunities for experienced dentists. Strong established books with flexible full- and part-time options available. Multiple locations due to company expansion. Supported by skilled and experienced teams. Contact careers@dentalcareireland.ie.

General dentist required for a busy dental office on Swords main street. Full Invisalign training available. Modern practice with a new iTero scanner. Full- or part-time positions available. Contact practicemanager@oneilldentalcare.ie.

Dentist required for our Tuam practice. High earning opportunity, strong established book. Join our modern, fully equipped practice with state-of-the-art facilities. Flexible options. Supported by skilled and experienced staff. Email careers@dentalcareireland.ie.

Part-time dentist required for a friendly family practice in Swords. IDC registered and some experience needed. One to two days to start. Contact vmongey@hotmail.com.

We are looking for a part-time dentist, two to three days, to join our team, 30 minutes from Dublin. Private/PRSI. Computerised. OPG. Very busy practice. Contact kildarenorthdentist@gmail.com.

Part-time general dentist needed to join our team – experience required. We are a modern, busy private practice in the heart of Dublin City, that cover all aspects of dentistry. Invisalign and cosmetic experience required. Contact info@molesworthclinic.ie.

Experienced dentist for busy, modern, holistic practice near Dublin, preferably with view to partnership/ownership. Minimum two years' postgraduate experience. Enquiries/CV to holisticdental35@gmail.com.

Dentist required to work Saturdays in state-of-the-art, busy north east clinic. Apply to Dr Fee at mbcar06@gmail.com.

Looking for experienced general dental practitioner with an interest in orthodontics for South Dublin mixed dental practice. Fully computerised, excellent support staff. Contact mkshahani1@outlook.com.

New Graduates – Smiles Dental is looking for new graduate dentists to join our private, well-established, state-of-the-art practices in Dublin, Enniscorthy, Wexford and Limerick. Positions offer up to five days/week, established patient lists, great supportive environment. Contact joanne.bonfield@smiles.co.uk.

Three to four days a week in a modern friendly practice in Gorey. Great working conditions within a small friendly team. Fully computerised, scanner, OPG, sedation, Invisalign. Contact eleanor@ocdental.ie.

Full-time dentist required to join state-of-the-art digital practice. Very busy private book. Cosmetic, orthodontic, implantology, general – depending on candidate. Excellent support team, fully serviced lab on site. Strong earning potential. Email hr@3dental.ie.

Family Dental is seeking an experienced dentist for two to three days for our south Dublin dental practices in Terenure and Rathfarnham. We are fully computerised, private/PRSI only and equipped with OPG and ITero. Start in September. Please email laurasoshea@yahoo.co.uk for details.

Dentist required for busy practice in Blackrock, south Dublin. Established, fully private book. Modern, luxury, fully digital, OPG, iTero. Flexible options. Email alex@whitesmiledental.ie.

We are looking for a dentist to join our growing team. Two to four years of experience required, fluent English, Polish desirable. Full- or part-time. Email dentist.smithfield@gmail.com.

Dental Options Ireland is looking for a full-time dentist for our newly refurbished clinic in Dublin city centre. Amazing opportunity to build your skill in cosmetic dentistry as well as general. Invisalign training provided. Very supportive work environment. Email louise@clearbraces.ie.

Full-time or part-time dentist required for south Dublin practice. Fully digital, friendly staff. Start date September. Email sladecastledental@gmail.com.

Dental Options Ireland is looking for a part-time dentist for our state-of-the-art clinic in Clane, Co. Kildare. Amazing opportunity to build your skill in cosmetic and general dentistry. Invisalign training provided. Very supportive work environment. Emil louise@clearbraces.ie.

Dentist required for busy practice in north Dublin with excellent support staff. Full Invisalign training and ongoing training provided. Fully digital practice with modern iTero scanner. Looking for a dentist to grow with our practice. New graduates welcome! Contact practicemanager@oneilldentalcare.ie.

Dentist required to replace departing colleague in Co. Meath. Private and PRSI. Immediate start, flexi sessions to full-time. CVs to dunboyneorthodontics@gmail.com.

Experienced part-time dentist wanted for practice in Dublin 6. PRSI/private. Sessions available Tuesday, Wednesday and Thursday. Hours negotiable. Contact Chloe@clonskeaghdental.ie.

Experienced dentist required for busy private practice in Portumna, Co. Galway. Fully digital, strong, established book, hygienist, excellent support staff. Excellent remuneration. Contact drrothwelldental@gmail.com.

Drogheda, Dublin, Enniscorthy and Limerick – Smiles Dental is looking for passionate dentists to join our private, well-established, state-of-the-art practices across Ireland. Positions offers up to five days per week, established lists, great earning potential, strong support teams. Contact joanne.bonfield@smiles.co.uk.

Experienced and enthusiastic dentist to join established private practice in Bromley, UK. Please send CV by email to office@buckleypractice.com.

Dentist required to join our team in Rathfarnham D14. General dentistry, PRSI/private. hygienist, digital practice. Contact Agata at agataziobron@gmail.com.

For busy modern practice close to Dublin, full- or part-time with huge earning potential. CV to drjohnmurphy@gmail.com.

Looking for an experienced dentist, start date September 2022. PRSI/private. Part-time surgeon work is also available with an immediate start. Contact: office.hundental@gmail.com.

Full- and part-time dentists required. Busy family practice in Donegal. Mostly private, some medical card. Friendly staff and patients. Full appointment book. Contact mvlavin@gmail.com.

Exciting opportunity to join one of Dublin's leading dental practices. Busy, well-established, state-of-the-art clinic in Ballsbridge. Four years' plus experience essential. CEREC, adult orthodontics and facial aesthetics. Apply with CV to office@pembrokedentist.ie.

Experienced dentist required to join award-winning team in Carlow Town. Full-time position in private clinic. Great multidisciplinary team with visiting specialists. Excellent backroom support. CEREC, in-house laboratory, fully digital, CBCT. Exceptional position. Please send CV to patientcare@pembrokedental.ie.

Galway. Dentist required to replace departing colleague in busy, modern, computerised practice with excellent support staff. Please email CV to loughreadentalassociate@gmail.com.

Dentist required for our south Dublin practice. Exciting opportunity to join our established, modern practice. Strong book with great earning potential and flexible options available. Supported by our skilled and friendly staff. Apply by email to careers@dentalcareireland.ie.

Part-time dentist required for busy, fully private practice in north Dublin. The dental practice is fully digital, with state-of-the-art equipment. Excellent remuneration and support staff. Contact northdublindentalassociate@gmail.com.

South Dublin award-winning practice looking for full-time general dentists. Excellent support team. Excellent salary, paid holidays, paid bank holidays plus bonus package. Fully digital with Trios4 plus 3D denture printing. Contact bevin@dentaltech.ie.

Dentist required for busy private Dublin 13 practice. Full book. Contact hygieneplacement@gmail.com.

We currently have exciting dentist opportunities available in Kilkenny and Carlow locations. Great earning potential with strong established books. Our modern practices are supported by skilled, friendly support staff. Flexible options available. Email your interest to careers@dentalcareireland.ie.

Dentist required for busy two-practice surgery in Tipperary. Initially three to four sessions but full-time within three months if required. All options considered. Friendly staff, relaxed atmosphere, excellent remuneration. Reply to dentalpost1@gmail.com.

Dentist required for busy private practice. New graduates welcome to apply. 50% remuneration. Strong, established book, private/PRSI only, Panara software, friendly supportive team. Potential partnership option. Email info@jessopstreetdentalpractice.ie.

Part/full-time dentist required in north Dublin practice. Immediate start possible. Must be IDC registered. To apply please email northdublinclinic1@gmail.com.

Looking for an enthusiastic general dentist for private practice in Ballsbridge, Dublin. Fully digital with OPG. Contact dentistdublin10@gmail.com.

Full/part-time dentist required. Long-established clinic in Sligo. Immediate start. Fully computerised practice, digital X-rays and good remuneration. Three years+ experience preferred but not essential. Modern practice, friendly atmosphere, excellent staff and hygienists. Contact geraldmjoconnor@gmail.com.

General dentist required in Co. Westmeath. Fully computerised, friendly practice with established book. Part-time, flexible days and possible full-time for right candidate. Contact midlandsdentalassociate@gmail.com.

Experienced dentist required for modern private practice in Skerries/north Dublin. Part-time, friendly staff, fully computerised, digital X-rays/OPG, great opportunity to join our team. Contact yoursmile2612@gmail.com.

Dentist required for busy Cork City practice. Established, fully private book, fully digital, flexible options. Must have experience/interest in fixed braces/Invisalign. Email alex@whitesmiledental.ie.

Dentist required for new practice in Cabra, Dublin 7. Fully private. Modern, luxury, fully digital. Flexible options. Excellent opportunity to build long term book. Email: alex@whitesmiledental.ie.

Enniscorthy – Smiles Dental is looking for a passionate dentist to join our state-of-the-art, well-established, fully private practice in Enniscorthy, Co. Wexford. Position offers five days per week, established patient book, excellent earning potential plus up-front bonus. Contact joanne.bonfield@smiles.co.uk.

Dublin, Enniscorthy, Galway, Athlone, Drogheda, Dun Laoghaire – Smiles Dental is looking for passionate dentists to join our private, well-established, state-of-the-art practices across Ireland. Positions offer up to five days per week, established lists, great earning potential. Contact joanne.bonfield@smiles.co.uk.

Part time dentist required two days per week. Immediate start, increasing to four- to five-day week from November to cover maternity leave. Very busy private practice. Fully computerised, digital X-rays, hygienist and excellent support staff. Experience essential. Contact dentaljobmayo@gmail.com.

West Cork. We are looking for a general dentist to join us, long term or short term, to work between one and three days per week. Contact barryod1968@gmail.com.

Malahide Dental Care is looking for an experienced dentist to join our team. Private/PRSI, full book, four to five days per week. Lovely patients and staff – Malahide centre. An interest in sedation is a bonus. Email cirociao4@gmail.com.

Dentist required for busy south Dublin, Blackrock practice. Established fully private book. Modern, luxury, fully digital, OPG, iTero. Flexible options. Free parking. CV to alex@whitesmiledental.ie.

Part-time dentist required for busy, modern practice with extensive support staff. Excellent earning potential for a well-motivated candidate. Contact colinpatricklynam@hotmail.com.

Full-time experienced dentist to join busy, modern computerised practice in Bray. Private, OPG, Exact, hygienist, free parking. Possibly ownership/partnership option. CV please to drjohnmurphy@gmail.com.

Locums

Part-time locum dentist for two to three months with immediate start in busy practice in Bray. 50% remuneration. Please send CV to jonathandentalfisher@outlook.com or call Michelle on 01-286 2137 for further information.

Locum dentist required for six-month maternity leave, commencing mid-November 2021, in north Dublin City practice. Busy book, digital X-rays, OPG, Trios scanner and friendly staff. Full-time but part-time considered. Contact duggandentalpractice@gmail.com.

Locum dentist – guaranteed day rate – Smiles Dental is looking for a locum dentist to join our well-established practice in Drogheda, Co. Louth. Position offers guaranteed day rate, up to five days per week, well-managed appointment book and experienced support team. Contact joanne.bonfield@smiles.co.uk.

Independent, established, fully computerised practice, digital x-Rays/OPG and good remuneration. Three years+ experience for locum dentist with view to part/full-time position, in a relaxed, bright and spacious environment. Friendly atmosphere, with excellent staff and two hygienists. Contact castlemilldental@gmail.com.

Experienced locum dentist required for busy, modern Killaloe practice, Co. Clare. Immediate start, four days/week with view to part/full-time position, in a relaxed and friendly atmosphere with excellent staff. Email CV to Joe@networksolutions.ie or call 087-233 3053.

Locum dentist required. Busy modern practice in seaside location. Blackrock, Co. Louth. Immediate start, five days/week with view to part/full-time position. Excellent staff. Digital X-rays. Fully computerised. OPG. No GMS. Email tomdentist@yahoo.com, or call Tom on 086-851 2493.

Specialists/limited practice

Implant surgeon – Smiles Dental is looking for an implant surgeon to join our well-established practices in Dublin and Dun Laoghaire – weekly basis. Practices offer full support team and great referral base. Must be able to provide an implant portfolio. Contact joanne.bonfield@smiles.co.uk.

Perio and endo – Smiles Dental is looking for passionate periodontists and endodontists to join our well-established, state-of-the-art practices across Ireland, including Dublin. Positions offer established referral bases, great earning potential and strong support teams. Contact joanne.bonfield@smiles.co.uk.

Orthodontist required to cover maternity leave from November to February. Preferably four days per week for 12 weeks. Mainly at Sligo practice, with one day at satellite clinic. Modern surgery, friendly professional team with two orthodontic therapists. Excellent daily rate, accommodation/travel subsidy. Email jenny.westcoastortho@gmail.com.

Multidisciplinary practice seeks orthodontist to help part to full time with busy orthodontic list. Excellent local and county reputation. Caring and friendly staff. Comprehensive range of orthodontic treatment services offered. OPG, lateral Ceph, CBCT and intraoral scanning available. Email siomurr@hotmail.com.

Weekly sessions available in oral surgery, ortho, endo, at multi-surgery clinic in North East. Contact Bernie at mbcar06@gmail.com.

Orthodontist required three days per week to work alongside principal orthodontist, two therapists, two hygienists, two associate dentists and part-time surgeon. Excellent opportunity. Future progression available. Contact orthosull@gmail.com.

Endodontist wanted to join busy practice. Bright, modern, well-equipped five-surgery clinic. Microscope provided, CBCT, sedation, etc. Go to www.kingdomclinic.ie or contact tomas.allen@kingdomclinic.ie.

We are a family dental practice in Celbridge and are looking for an orthodontist to replace a retiring colleague with a very busy book. Two days per month, days negotiable. CVs to info@oreillysdentalpractice.ie.

Orthodontist required urgently, Oranmore, Co. Galway. Locum orthodontist required with possible opportunity for future progression. Immediate start in a well-established busy practice. Salary negotiable. Please contact 087-215 1815, or email reception@annehahessy.ie.

Orthodontists – Smiles Dental is looking for passionate orthodontists to join our well-established, state-of-the-art practices across Ireland, including Dublin. Positions offer established referral bases, great earning potential, strong support teams, monthly or weekly days available. Contact joanne.bonfield@smiles.co.uk.

Orthodontist required for busy family practice in Blackrock, Co. Dublin. One to two days per week. Newly renovated, modern practice. CV to reception@booterstowndental.ie.

Clinical supervisors

DDUH is seeking to recruit clinical supervisors for the following divisions: paediatric; A&E/oral surgery; Restorative; and, periodontology. Further information: https://dublin-dental-university-hospital.hirehive.com/job/82716/clinical-supervisor-part-time.

Dental nurses/receptionists/managers

Fantastic opportunity for a candidate with exceptional business management skills to lead our dynamic friendly team based in Dublin 18. Role includes all aspects of practice management such as administration, financial, staff management, chairside assisting and reception, as required. Contact eddiegoggins@gmail.com.

Dental nurse required for part-time position in a very busy practice, north Co. Dublin. Contact Ngough@me.com.

Dental nurse required for modern specialist practice in Limerick. Part-time initially with a view to becoming full-time. Please email application to richard@castletroyortho.ie.

Looking for an experienced dental nurse to join our Maynooth team. Experience using EXACT. Candidate must be a team player with a positive attitude and used to working to a high standard in a busy clinical environment. Contact enquiries@boynedental.ie.

Exciting opportunity for qualified dental nurse to join established orthodontic practice on a full-time basis. Modern surgery, friendly, professional team, excellent conditions. Mainly at our Sligo clinic with one day in Ballina. Email CV to jenny.westcoastortho@gmail.com.

Nurse required for maternity leave in busy Cork City practice. Six-month full-time placement from September/October. The role will be assisting an orthodontist. Flexible hours. Possible full/part-time post placement. CV to alexgthomas1234@icloud.com

Qualified dental nurse required for Naas-based orthodontic practice. We are seeking a warm, friendly person with good communication and computer skills. Email application to info@braces.ie.

Nurse required for maternity leave in busy Cork City practice. Six-month full-time placement from September/October. The role will be assisting an orthodontist. Flexible hours. Possible full/part-time post placement. CV to alexgthomas1234@icloud.com.

Dental nurse required for busy orthodontic practice. Candidate must be friendly, a good communicator and motivated. Immediate start. CV to admin@clonmelorthodontist.ie.

Part-time nurse needed for busy, modern practice with friendly team atmosphere: Swords Dental. Good remuneration for the right candidate, experience essential. Please email CVs to colinpatricklynam@hotmail.com.

Experienced staff member required to join established dental practice. Preferably dental nurse with reception experience. Receptionists encouraged to apply. Hours 7.15am-5.15pm, four days. Please send CV to reception@beaumontdental.ie.

Exciting and rare opportunity for a part-time dental nurse to join a multi-award-winning practice, based in Co. Meath. Fully computerised with Exact, digital radiographs and experienced, friendly, dynamic team. Previous dental nursing experience essential. Contact meathdentists@gmail.com.

Part-time dental nurse/receptionist for busy orthodontic practice in Midleton. Good remuneration for the right candidate. Experience preferred. Immediate start. Contact midletonortho7@gmail.com.

Experienced part/full-time dental nurse required for a busy practice in Arklow. Candidate must be friendly, a good communicator and motivated. Immediate start required. Please send CV to annedental@hotmail.co.uk.

Caring dental nurse required for Kilkenny City practice (ideally qualified). Lovely working environment in a small friendly team. Approximately 30 hours per week (negotiable). Computer and administrative skills desirable. Contact dan@kilkennyendodontics.com.

Dental nurse required for a busy practice in Co. Galway, 30 minutes from city. Must be friendly, a good communicator and motivated. Four to five days a week. Contact Drraypower@gmail.com.

Part time dental nurse required for busy practice in Ongar Village, D15. Flexible hours, generous remuneration, friendly staff. Please send CV to ongar.dental@gmail.com or call 01-640 2733 for further info.

Hygienists

Hygienist position available. Gorey, Co. Wexford. One to three days. Salaried. Busy mixed practice. Immediate start available. Qualified support staff and assistant available chairside if needed. Reply to adecdental365@gmail.com.

Enthusiastic hygienist required at Swords Dental. Saturday sessions from 9.00am-3.00pm available each week with more midweek sessions on a flexible basis. Well-established patient list with 45-minute appointments. Please send CVs to colinpatricklynam@hotmail.com.

Hygienist required. Friendly, busy and long-established practice in Letterkenny, Co. Donegal. Well-established book in a modern digital practice. Full- and part-time positions available. Excellent terms and conditions. Please email your CV to errigaldental@gmail.com.

Hygienist sought to join busy, computerised, four-surgery private practice. Join our friendly team on a salaried basis in the fabulous town of Dungarvan. Contact serenagrange@gmail.com.

Eyre Square Dental seeks a hygienist to replace departing colleague. Excellent terms for the right candidate. Full-time, part-time or locum considered. Please email paula@eyresquaredental.ie for more information.

Enthusiastic, caring hygienist required for one full day per week (Tuesday) in west Dublin. Experience preferred but not essential. Apply with CV to chapelizod.dental@gmail.com.

Mayo. Hygienist required for one to two days per week in our modern, busy, well-equipped and established practice in Castlebar, Co. Mayo. Contact Shane cadden on 094-902 5281 or castlebardentalclinic@gmail.com.

Part-time dental hygienist required one day per week in Longford Town. Please send CV to annedental@hotmail.co.uk or contact on 086-398 8981.

Part-time dental hygienist required for one or two days per week in Wicklow Town. Please email CV to wicklowdentist@hotmail.com.

Experienced dental hygienist required Tuesdays. Practice already has three hygienists. Excellent support. Must have a good manner with patients. Forward CV if interested to carmel@corabbeydentalclinic.ie.

Dublin south west. Hygienist required. Very busy, high-profile practice with excellent footfall. Can work any combination of days per month. Modern, friendly clinic. Large potential to grow the service. Good remuneration. Contact niall@innovativedental.com.

Ardara Dental – award-winning, state-of-the-art practice is looking for hygienist. Maternity cover with possibly of a full-time position following. Full support, Biolase laser, very friendly and dedicated team. WhatsApp 074-954 1933 or email richard@ardaradental.com.

Exciting opportunity to join one of Dublin's leading dental practices. Full-time dental hygienist required for maternity cover starting November. Apply with CV to office@pembrokedentist.ie.

Hygienist required two days per week. Based in Kildare. Immediate start to replace existing hygienist who is relocating to Kerry. Position well remunerated and very friendly work environment. Contact apply@fairgreendental.ie.

Hygienist position available. Full-time. West Donegal. Computerised modern practice. Friendly staff and patients. Contact mvlavin@gmail.com.

Full/part-time hygienist required for our busy dental clinic in Dublin 12. Fully computerised with a dynamic team and excellent support. Please email CV to info@cleardentalcare.ie.

Full time hygienist opportunity in our fabulous Grange practice, Donaghmede. Would consider part-time hours also. Immediate start available! Apply today! Contact recruitment@smartdentalcare.co.uk.

We are looking for a part-time experienced dental hygienist for two to three days per week to join us at our well-established private dental clinic in Terenure, as well as provide hygiene treatments to our nursing home customers. Contact bevin@dentaltech.ie.

Dental hygienist required in Cork two days per week (Monday, Wednesday). Experience with dental implants would be a benefit. Please apply with CV to airportdental@hotmail.com.

A permanent position has arisen for an experienced dental hygienist to join our team, three days per week, commencing November 2021. Full hygiene book at busy general practice. Please submit CV to angelamkearney@gmail.com for consideration.

Multi-award-winning practice in Co. Meath is looking for hygienist maternity cover (with possible position following), commencing at the end of 2021. Nursing support available from a dedicated, friendly and experienced team. Fully computerised with Exact. Contact dentaljobireland1@gmail.com.

Laboratory technicians

Qualified dental lab technician required. Full-time or part-time at our Sligo clinic. We're looking for a friendly, professional and motivated individual with a positive attitude. Immediate start, modern surgery/lab, with excellent conditions. Contact practice.westcoastortho@gmail.com.

PRACTICES FOR SALE/TO LET

A busy family practice for sale in south Dublin. Mixed, two chairs, OPG, Software of Excellence. Contact Newdublindentist@gmail.com.

Co. Galway. Two-surgery practice, well-established leasehold, low rent. Good modern equipment, computerised. Suit part-time practitioner as no other practice in the town. Potential for major speedy growth. Priced to sell. Contact niall@innovativedental.com.

Long-established, modern practice close to Dublin and M50, free parking. Mentoring and reasonable rent. Enquiries to holisticdental35@gmail.com.

The oldest and busiest ex-pat practice in the south of Spain for sale due to retirement. Three modern surgeries, hygienist. Fantastic location five minutes from beach, 25 minutes from airport. Sale including freehold property. €650,000. Email: alblan@mac.com.

Dublin south/west. Large potential rental premises available in a very busy shopping centre. Three serviced surgeries, planning permission in place. Medical practice and very busy pharmacy next door. Ample free parking directly outside. Reasonable rent, flexible options. Contact surgeriesavailable@yahoo.ie.

Busy private/PRSI practice for sale/to let in Co. Galway. Two surgeries. Fully digital. Long-established book. Contact drrothwelldental@gmail.com.

Cork. Well-established, ground floor, three-surgery practice for sale with OPG, sterilisation, staff and more. Front and rear access with free parking to rear. Situated on main street of large town. Priced to sell. Call Steven on 086-068 1242 or email steven@medaccount.ie.

Cork suburb. 1,500sq ft, superb location, parking, two-surgery practice. Computerised, sterilisation room. Principal retiring but can help with transition. Flexible terms. Email magwaclinic@gmail.com.

Urban village, Dublin. Two surgeries, fully private, long established. Strong passing trade. Leasehold/freehold. Strong new patient numbers. Excellent hygienist service/support staff. Room to expand space/services. Easy parking. Excellent profits. Principal available, transition period. Contact niall@innovativedental.com.

Unique opportunity to acquire a thriving general practice in south Tipperary town centre location. Three surgical rooms. Ideal for someone looking for the right work/life balance in outdoor activity region. Owner retiring. Freehold/leasehold negotiable. Contact seirldent@gmail.com.

Dental Protection

Our team talks your lañguâgé

Protection with local understanding

Our expanding Irish team enables us to provide:

- Home-grown dentolegal experts on the ground – we don't work with third-party companies
- Over 100 years of experience and care in Ireland
- Local knowledge backed by global expertise
- Investment for your future protection needs with an expanding team of localised dentolegal experts

Protection that puts you first

dentalprotection.org/ireland

210813237608/21

Editorial direction

As Dr Ciara Scott prepares to step down from her role as Honorary Editor of the *Journal of the Irish Dental Association*, she speaks about the *Journal*'s important role in providing information and education to dentists and wider society.

What is your professional background?

I qualified in Bristol, and completed my specialist orthodontic training in Dublin in 2005. Since then, I've practised in the HSE, I've been a supervisor in the Dublin Dental University Hospital, I've been an examiner with the Royal College of Surgeons in Ireland, and I also work in the Blackrock Clinic.

How did you first get involved in the IDA?

I'm a member of the Orthodontic Society of Ireland, and I was Orthodontic Rep on the IDA Council for a couple of years. That was really interesting and gave me a real insight into the IDA. I served on the Editorial Board of the *Journal of the Irish Dental Association (JIDA)* for a number of years, and was appointed Honorary Editor in 2018.

What led you to take on the role of Honorary Editor of the *JIDA*?

I applied for it because I'd really enjoyed my involvement on the Editorial Board. I was mindful that I came into the role with a different skillset from Prof. Stassen, the previous Editor. He was an academic, and I'm primarily a clinician, but I wanted to bring that as a strength, while learning more about the academic process and the publishing process. We have a culture of contribution, where everyone on the Editorial Board brings different strengths – our academics, our practitioners, our publishers, and our colleagues in IDA House, and I've really valued that support and collaboration. I was also attracted to the challenge, to doing something different that I could bring my clinical knowledge to. And having that networking with the publishers, the sponsors, the authors and peer reviewers, the Editorial Board and our readers – that's something I've really enjoyed about it.

Why do you think the *JIDA* is important for the IDA and for Irish dentistry?

In one sense, we are an academic journal, and we do have a peer review process. But in another sense, it's about providing quality content that our readers value, in a way that's accessible. Most of our readers work primarily in general practice, so I have focused on how we can edit, commission and create content that's appealing and valuable to them. The GDPs on the Editorial Board have played a key role in this.

Another of my goals was to provide a forum for PhD scholars and researchers in Ireland to share their work with other dentists and lead Irish dentists to their primary research papers. Good quality research should be accessible and I think the *JIDA* is the right forum for experts and academics in Ireland, and internationally, to share their knowledge and experience with the rest of us.

One of the things the pandemic has shown is that there is a real appetite for good information, and the understanding that there are such things as trusted sources. I think it's really important for us in our profession not to underestimate patients' and professionals' appetite for real science and quality information, and look for new ways to ensure that the *JIDA* continues to be a trusted resource for the profession.

What would you say to anyone who is considering applying for the position of Honorary Editor?

I would say go for it. I really enjoyed it. It has been a great learning curve; I felt very supported by Prof. Stassen when he handed over, and by the publishers, by Fintan, Liz and the IDA team, and by Siobhan and the Editorial Board. I also did a number of courses to improve my skills and connected with other journal editors. You don't start a new role with all the skills, but when you've got good people around you, and you're open to learning, then you can really enjoy it. I wanted to bring my own values and strengths to the role and I think a new editor will do the same, to move the *Journal* on to the next stage.

Ciara has literally travelled the globe, from sailing around the world to taking part in expeditions in Ghana, the Arctic and Antarctica, and has completed a number of cycling challenges. While the Covid-19 restrictions have halted travel and other activities, she says she has found a new appreciation of staying home, and completed a postgraduate diploma at the RCSI Centre for Positive Health during the last year.

Southern Cross Dental

A Modern Dental Europe Company

New MEDIT *i*700

€17,900

FREE 1-1 ONLINE DEMONSTRATIONS

To find our more contact us on :
ireland@scdlab.ie