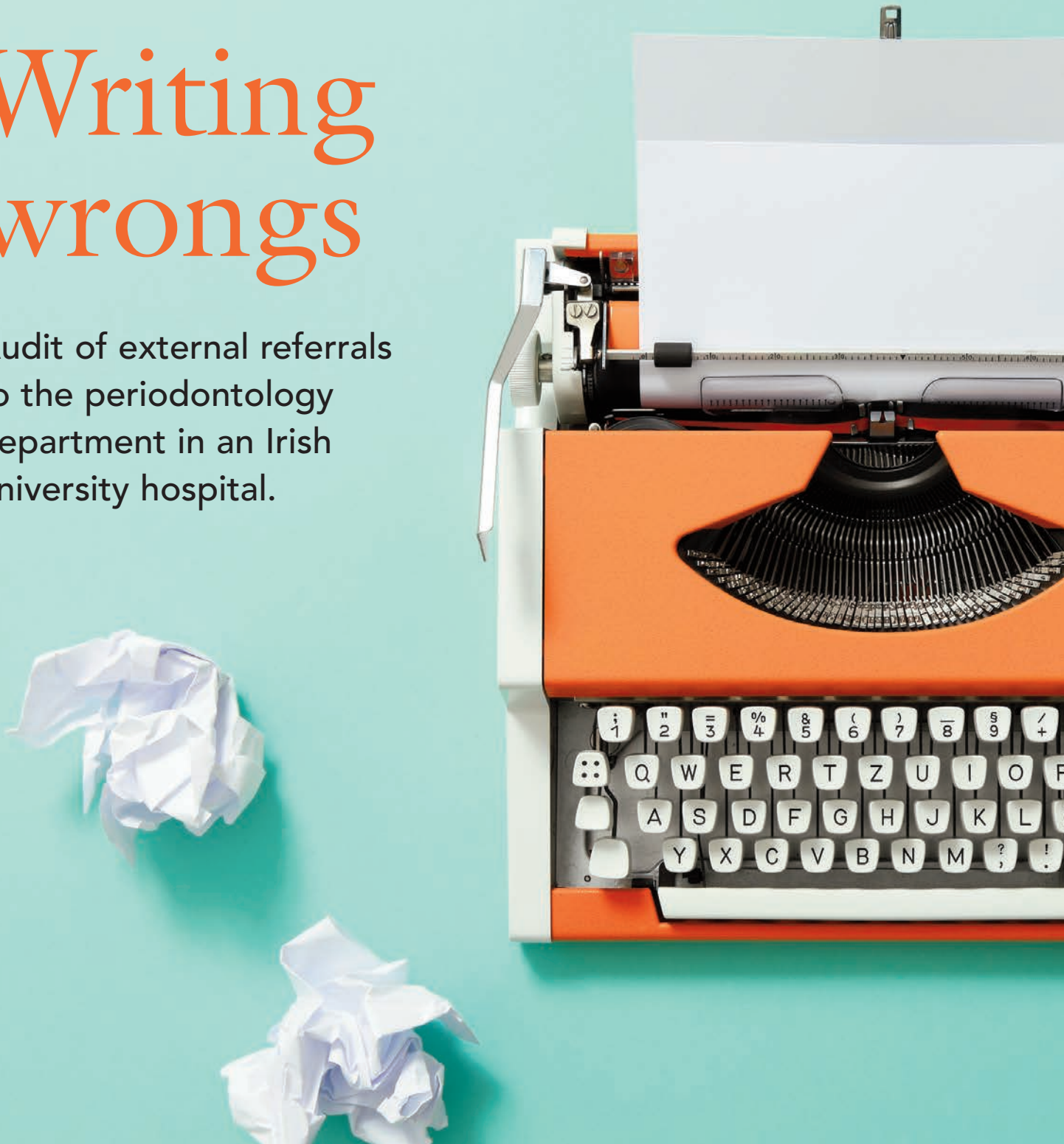
IDA
irish dental association

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

Volume 68 Number 4
August/September 2022

Writing wrongs

Audit of external referrals to the periodontology department in an Irish university hospital.



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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, Meliosa Fitzgibbon**

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.
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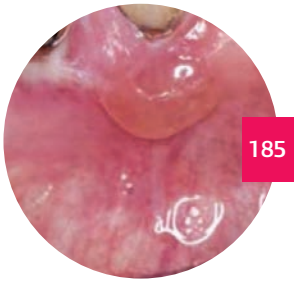

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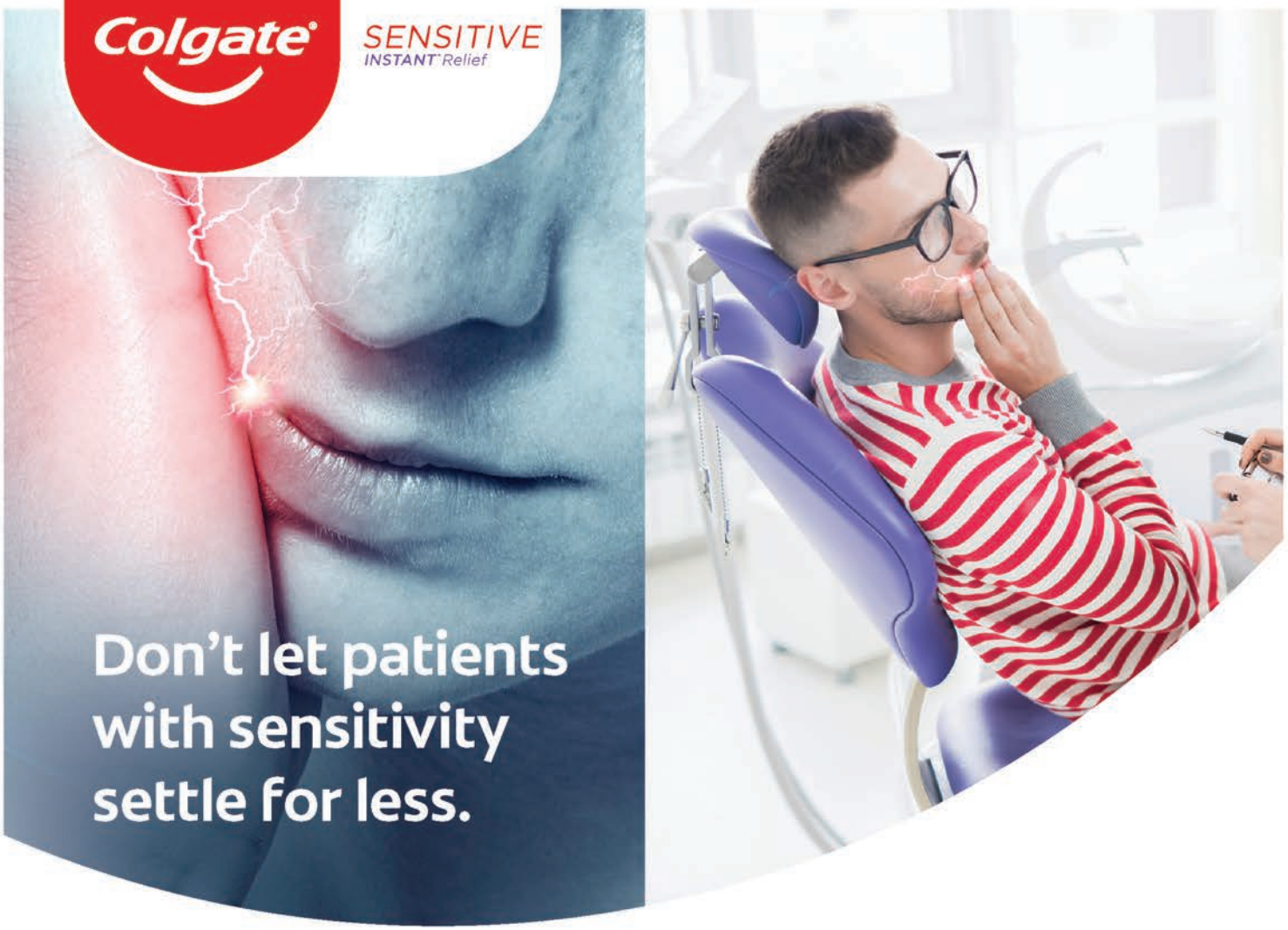

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‡vs baseline in an air blast test, $p<0.05$.
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References: 1. Nathoo S, Delgado E, Zhang YP, et al. Comparing the efficacy in providing instant relief of dentine hypersensitivity of a new toothpaste containing 8.0% arginine, calcium carbonate, and 1450 ppm fluoride relative to a benchmark desensitising toothpaste containing 2% potassium ion and 1450 ppm fluoride, and to a control toothpaste with 1450 ppm fluoride: a three-day clinical study in New Jersey, USA. *J Clin Dent*. 2009;20(Spec Iss):123 -130. **2.** Docimo R, Montesani L, Maturo P, et al. Comparing the Efficacy in Reducing Dentin Hypersensitivity of a New Toothpaste Containing 8.0% Arginine, Calcium Carbonate, and 1450 ppm Fluoride to a Commercial Sensitive Toothpaste Containing 2% Potassium Ion: An Eight-Week Clinical Study in Rome, Italy. *J Clin Dent*. 2009;20(Spec Iss):17- 22.

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EDITORIAL

Dr Cristiane da Mata
Honorary Editor

Influencing change

Dentists must engage and bring their ideas to the table to address the many challenges facing the profession.

In the last edition of the *Journal*, our President Dr Caroline Robins (who is interviewed in this edition), highlighted some ongoing issues that concern our profession at the moment, such as VAT charges and the shortage of dentists in Ireland. These problems are already or will soon be impacting on dental businesses directly, but we must not forget that they will ultimately be detrimental to the oral health of Irish people. The number of dentists in a country is just one among many factors that impact on the oral health of the population; other aspects related to dentists include the quality of their training, the technology and materials they use, and their engagement with oral health policies.

Those who pay the highest price for all of these issues currently affecting the dental profession are ultimately the patients, who face dental services that are more difficult to access, an increase in the cost of dental treatment, and a lack of dentists seeing public patients through schemes such as the Dental Treatment Services Scheme (the DTSS or medical card scheme).

Prof. Albert Leung, Dean of the Faculty of Dentistry at the Royal College of Surgeons in Ireland (RCSI) has written a powerful commentary in this edition, supporting the view of our President and discussing some new ways of addressing the shortage of dentists in Ireland. One problem is the small number of dentists qualifying from Irish dental schools yearly and Prof. Leung raises some important points about the need to expand the offers to dentistry courses and change the way we currently educate dentists. He finishes by stating: "The population in Ireland is growing and ageing, meaning demand for dental care will increase at a time when we are graduating fewer dentists than we need … Lack of access to dental care is a longstanding challenge and it's time for an urgent new solution".

Thinking globally, acting locally

All of these challenges that are faced, not only by the dental profession, but by oral health globally, make me reflect on the importance of engagement, to influence and promote local and global change. Dr Habib Benzian and colleagues wrote a very interesting commentary in the *Journal of the American Dental Association* recently (which I may remind you that IDA members have free access to), where he discusses the importance of thinking globally and acting locally, where oral health is concerned.[1] Oral health problems affect billions of people worldwide, and addressing unmet treatment needs globally seems like a very daunting task. Unmet needs, in the Irish context, will be exacerbated by the shortage of dental professionals. This is further complicated by global problems such as unhealthy diets, tobacco, and the sugar industry. This is a great example of local and global challenges acting together to exacerbate poor oral health in a population. As Dr Benzian suggests, both need global and local solutions, simultaneously.

Engagement is key to promote change, and dentistry is an isolating profession. We can influence change, and one way to do it is by gathering forces and bringing our opinions, knowledge and ideas to the table. I think that the Association and this *Journal* offer great platforms for this.

Centenary

Next year, the IDA will be celebrating 100 years of service to the dental profession in Ireland. It is an exceptional landmark, and there are certainly a lot of reasons to celebrate. In this edition of the *JIDA*, we present the centenary logo, and we are looking forward to Dr Eoin Kinsella's book on the history of the Association, which will be launched in early 2023. The *Journal* is also planning special features to celebrate this milestone and reflect on the past 100 years in Irish dentistry, so keep an eye out for those in future editions!

As 2023 also marks the centenary of the Northern Ireland Branch of the British Dental Association (BDA), one joint initiative that has arisen is the inclusion of content from Tristen Kelso, Director of BDA in Northern Ireland, in the *JIDA*. This commences in this edition where the President's Message from Dr Caroline Robins is replaced in all copies circulated in Northern Ireland with information from Tristen about their work. This is only possible through the goodwill and co-operation of all bodies involved, to whom we are most grateful.

JIDA submission system

I am delighted to announce that we will be moving to an online manuscript submission system from mid August. This means that authors will not have to email their articles to the Journal anymore, but will use the Scholastica platform to upload all of their submission documents. We anticipate huge benefits to everyone involved in the submission-review-publication cycle, and a faster review process. I would appreciate it if authors could give us their feedback on the new system as they use it, so that we can make sure it is as user friendly as possible.

Reference

1. **Benzian, H., Beltrán-Aguilar, E., Niederman, R.** Think global, act local: why global oral health matters: *The Journal of the American Dental Association* introduces a new commentary feature. *JAMA* 2022; 153 (7): 596-597.

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1. Araujo M W B et al. Meta-analysis of the effect of an essential-oil containing mouth rinse on gingivitis and plaque. JADA 2015; 146:610-622

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PRESIDENT'S NEWS

Dr Caroline Robins
IDA President

Time to meet and air our views

While there have been no developments on the serious issues affecting the profession, the IDA is planning a series of regional meetings to keep members informed, and gauge their views.

As the summer continues, we are unfortunately no closer to resolving the issues currently of concern to the profession. We are still awaiting a date for the commencement of talks on the Dental Treatment Services Scheme (DTSS), and on the PRSI scheme, and there has as yet been no resolution of the VAT issue. Meanwhile, the crises we face show no sign of abating.

The number of practitioners operating a DTSS contract continues to fall. The allocation of additional funding to the Scheme, while welcome, only serves to demonstrate that the Scheme itself is failing to a degree that cannot be solved by funding alone.

The staffing crisis is also continuing, with seemingly no end in sight. The IDA recently met with representatives from the Royal College of Surgeons in Ireland (RCSI) to discuss the issue and I welcome their commitment to finding solutions.

Without sufficient practitioners to meet patient need, and without an overhaul of the Scheme to reflect modern, preventive dentistry, its collapse is inevitable, with catastrophic consequences for patients.

The staffing crisis is also continuing, with seemingly no end in sight. The IDA recently met with representatives from the Royal College of Surgeons in Ireland (RCSI) to discuss the issue and I welcome their commitment to finding solutions. Dean of the RCSI's Faculty of Dentistry, Prof. Albert Leung, has written an article on the issue in this edition (see page 184), and I urge you to read it.

We want to hear from you

As we try to address these issues as a profession and an Association, we need you, our members to get involved and make your voice heard. The Association has organised a series of regional meetings for dentists in private practice, which will provide vital updates on all of these issues. Members will be briefed and consulted in regard to negotiations expected to commence shortly in regard to the DTSS and also the latest information on roll-out of the Smile agus Sláinte oral health policy, and the timetable for new dental legislation, which is expected to provide for mandatory CPD and dental practice inspections.

Details of the meetings are set out below:

Cork: Wednesday, September 13, Rochestown Park Hotel, 6.30pm
Limerick: Tuesday, September 14, Strand Hotel, 6.30pm
Sligo: Tuesday, September 27, Radisson Blu, Sligo, 6.30pm
Galway: Wednesday, September 28, Connacht Hotel, 6.30pm
Dublin: Thursday, September 29, Radison Blu, Golden Lane, Dublin 2, 6.30pm
Kilkenny: Tuesday, October 4, Hotel Kilkenny, 6.30pm
Portlaoise: Wednesday, October 12, Midlands Park Hotel, 6.30pm
Killarney: Friday, October 21, Hotel Europe, 4.00pm

I sincerely hope you will be able to join us at one of these meetings. We need to hear your views on all of these issues, to inform our approach as we enter talks that could have a huge impact on the future of dentistry.

In-person celebrations

I was honoured to make my first ever visit to the Cork School of Dentistry recently to present the IDA Award at the School's prizegiving ceremony and to address the graduating class. It was wonderful to see these events happening in person once again, and to reconnect with the Dean of the School, Prof. Christine McCreary. I share the disappointment and frustration of faculty and students however at the delays in starting work on the new Dental School. At this moment in time, as we call for an increase in student numbers in dentistry, it is more important than ever that this project should go ahead.

I am also grateful to my predecessor as President, Dr Clodagh McAllister, who represented the Association at the Dublin Dental School's prizegiving event.

IDA centenary

The build-up to the IDA centenary in 2023 has begun, with a range of events and initiatives at the planning stages. This is obviously a huge event in the profession's history, and is something exciting and positive to look forward to in the new year. Watch out for further information on centenary events, in the *Journal* and throughout all IDA communications. I look forward to meeting many of you at the celebrations.

Quiz

Submitted by Dr Denise MacCarthy.

1. New cases of head and neck cancer, including all sites, collectively accounted for what percentage of all cancer cases worldwide in 2018 (Bosetti *et al.*, 2020)?

- ☐ 20.5%
- ☐ 6.7%
- ☐ 3.8%
- ☐ 1.2%

2. In Ireland, what is the most common age group for head and neck cancer (NCRI, 2018)?

- ☐ 25-35 years of age
- ☐ 35-45 years of age
- ☐ 45-55 years of age
- ☐ 55+ years of age

3. What percentage of Irish 65+ year-old edentulous individuals "occasionally or never" visit a dentist (National Survey of Adult Dental Health, 2007)?

- ☐ 20-40%
- ☐ 40-60%
- ☐ 60-80%
- ☐ 80-100%

4. A survey on the first Mouth Cancer Awareness Day in Ireland (MacCarthy, D., *et al.*, *JIDA* 2012) revealed that 94% of respondents had never received any information about mouth head and neck cancer. What are the most common modifiable risk factors for mouth head and neck cancer?

- ☐ Oral hygiene and diet
- ☐ Alcohol consumption and tobacco use
- ☐ Genetic history
- ☐ Bacterial and viral conditions

Answers on page 207

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DIARY OF EVENTS

IDA REGIONAL ROADSHOWS
Cork: Wednesday, September 13, 6.30pm
Rochestown Park Hotel, Cork
Limerick: Tuesday, September 14, 6.30pm
Strand Hotel, Limerick
Sligo: Tuesday, September 27, 6.30pm
Radisson Blu, Sligo
Galway: Wednesday, September 28, 6.30pm
Connacht Hotel, Galway
Dublin: Thursday, September 29, 6.30pm
Radison Blu, Golden Lane, Dublin 2

BIOCLEAR COURSE
Friday, September 30, Dublin
Dr Claire Burgess – SOLD OUT

BIOCLEAR COURSE
Saturday, October 1, Dublin
Dr Claire Burgess – SOLD OUT

IDA REGIONAL ROADSHOW
Kilkenny: Tuesday, October 4, 6.30pm
Hotel Kilkenny

HANDS-ON ENDODONTIC COURSE (FULL DAY)
Friday, October 7, Cork
Dr Bob Philpott

IDA REGIONAL ROADSHOW
Portlaoise: Wednesday, October 12, 6.30pm
Midlands Park Hotel

HSE DENTAL SURGEONS SEMINAR
Thursday and Friday, October 13-14
Midlands Hotel, Portlaoise

SOUTH EAST REGION ASM
Friday, October 14
Faithlegg House Hotel, Waterford*

KERRY BRANCH ASM, INCORPORATING THE IDA REGIONAL ROADSHOW
Friday, October 21, Hotel Europe, Killarney*
IDA Regional Roadshow: 4.00pm

SOUTHERN REGION ASM
Friday, November 25
Fota Island Resort, Cork*

***Full ASM programmes to follow.**

Colgate Caring Dental Awards 2022

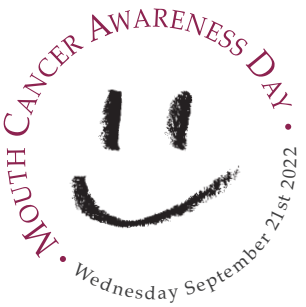
On Saturday, November 19, the InterContinental Hotel in Dublin is the place to be for the Colgate Caring Dental Awards 2022. Don't miss this spectacular event where we celebrate everything good and positive about the dental profession. Why not spoil your dental team members and treat them to a night in this stunning five-star venue?

Make sure to display the Colgate Awards posters in your practice and post the graphics sent from the IDA to all practices on your social media.

Put the date in your diary now – Saturday, November 19, InterContinental Hotel, Dublin.

See you all there!

Mouth Cancer Awareness Day 2022



The first Mouth Cancer Awareness Day took place in 2009 – so this year will be the 13th year of the campaign.

The Mouth Cancer Awareness Group is made up of representatives from the Cork and Dublin Dental Hospitals, the Irish Cancer Society, the Dental Health Foundation, the International Cancer Control Partnership (ICCP), and mouth cancer survivors. The group is a voluntary, unfunded, community-focused partnership of dental and healthcare professionals, mouth head and neck cancer survivors, and advocacy professionals.

After numerous successful awareness campaigns, the group has now decided to disband. The IDA has agreed to take up the baton and continue with building awareness of mouth cancer with members of the dental profession and the public through media and online campaigns. The website will continue to grow and we urge you to visit it and encourage your patients to visit it on www.mouthcancer.ie.

The IDA is committed to continuing with the patient stories on how mouth cancer has affected them and in encouraging the public to get checked if they are in doubt.

This year, Mouth Cancer Awareness Day will take place on Wednesday, September 21.

Centenary celebrations

As many dentists know, 2023 will mark the centenary of the first AGM of the Irish Dental Association and therefore also, given Irish history, the foundation of the Northern Ireland Branch of the British Dental Association (BDA).

A history of the Irish Dental Association is currently being written by historian Dr Eoin Kinsella, and it will be launched at the centenary Annual Conference of the Association in Kilkenny next May. The Conference itself is a central part of the celebration of the centenary and an exciting and varied programme is being planned. Over the course of the next 18-24 months, this *Journal* will also cover aspects of the history of dentistry on this island in the last 100 years. Watch out especially for features on dental education and women in dentistry. Arising from contact for the centenaries, one new initiative is that the President's Message in the *JIDA* is being replaced in the copies distributed in Northern Ireland with a message from the Director of the BDA in Northern Ireland, Tristen Kelso. This co-operation has been managed with great goodwill between all the parties involved. If anyone still has material that may be of interest for the history, Eoin can be contacted by email at eoinkinsella@gmail.com.

IDA irish dental association

100 YEARS

1923 - 2023

Historian and author Dr Eoin Kinsella can be contacted at eoinkinsella@gmail.com.

Spotlight on Irish dental research

The Irish Division of the International Association for Dental Research (IADR) will hold its annual meeting as part of the Pan-European IADR Oral Health Research Congress, which takes place in Marseille from September 15-17. The Irish Division will also sponsor a symposium during the meeting, where Irish researchers will discuss clinical and translational research in Ireland.

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Medical emergencies and medical emergencies for sedation

For those of you who have not done a medical emergencies/BLS course in recent years, the IDA will be running a number of courses. For those dental practices offering sedation, make sure you sign up for and complete an ILS course as scheduled below:

CORK

Friday,	September 30: BLS course,	Safe Hands
Saturday,	October 1: ILS course,	Safe Hands

DUBLIN

Friday,	October 21: ILS,	Safe Hands
Saturday,	October 22: BLS,	Safe Hands

GALWAY

Friday,	November 4: BLS,	Safe Hands
Saturday,	November 5: ILS,	Safe Hands

Education/CPD autumn programme

The CPD/education programme will recommence in early September. The IDA will continue with our webinars from September, and our first webinar will be in conjunction with Mouth Cancer Awareness Day on Wednesday, September 21. Webinars will then continue on the last Wednesday of the month at 8.00pm, and the majority of webinars will be available to watch afterwards from our CPD library.

HSE Dental Surgeons return to Portlaoise

The Annual HSE Dental Surgeons Seminar returns this year after a break of two years. We return to the Midlands Park Hotel, Portlaoise, on Thursday and Friday, October 13 and 14. This event is an ideal opportunity for those working in the HSE dental service to meet with colleagues and friends, and gain relevant CPD/education over the two days.

An excellent line-up of speakers has been arranged and we hope, after a two-year break, for a good turnout of those employed in the HSE dental service, including team members.

To book rooms in the hotel at €120 for a single room and €150 for a twin/double room, please call the hotel directly on 057-867 8588 quoting 'IDA seminar 2022'.

Capitalflow launches €200m dental fund

Capitalflow, the specialist business lender, has set aside €200m in funding specifically for the growth of its partner panel. According to the company, by providing access to fast, simple finance, it intends to enable dental equipment partners to generate more sales with strategic relationship management, exclusive and dedicated access to a team of experts, and an online portal.

Capitalflow was recently acquired by Dutch digital bank bunq, and the company states that its team has extensive experience providing tailored finance solutions to the dental industry. According to Capitalflow, it has financed items for a wide range of suppliers and dentists, such as:

- surgery/dental cabinetry;
- chairs and treatment centres;
- digital imaging systems;
- sterilisation/decontamination equipment;
- digital chairside dentistry;
- dental technology; and,
- 3D printers.

Stephen Byrne, Head of Distribution and Partnerships, said: "A key focus for us is the growth of our partner channel, particularly with reputable suppliers and manufacturers of dental equipment in Ireland. There are many benefits when partnering with Capitalflow – our instant quotes, quick decisioning, digital processing and contracts, plus our customer service is second to none".

Tommy a winner with *JIDA*

Amir Aghdaei (right), President and CEO of Envista, a global group of more than 30 brands with 12,000 employees worldwide, is photographed with well-known Kerr Regional Manager for Ireland, Tommy Maguire, in Hawaii in June. Kerr, Nobel Biocare, Ormco, Spark, Implant Direct, Orascoptic and Metrex are all part of the group. The photograph was taken at the Envista Winners' Circle meeting at the Four Seasons Resort, Ko Olina, Honolulu, which took place over five days in June. The event celebrates those who were the top 10% in sales from each of the operating companies. Myles Turley from Ormco also made the trip.

Coltene's team effort

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Coltene states that two of its products work better together than on their own. According to the company, SoloCem with One Coat 7 Universal is a good option for when maximum bonding strength is required. Alongside reliable adhesion, Coltene states that other benefits include easy handling and less stock to order. Another product that the company believes is a strong offering is the composite Brilliant Crios. The company states that it is an excellent shock absorber. Another advantage from Coltene's perspective is its mechanical properties, which the company states are excellent, making it suitable for bruxism patients and implant-supported crowns, as well as a wide range of other everyday indications such as inlays, onlays and veneers. Coltene also states that this reinforced composite for CAD/CAM fabrication is an adaptable material that is available in two sizes, 15 shades and three translucencies.

DCRS Annual Report published

Mary Culliton
Facilitator, Dental Complaints Resolution Service.

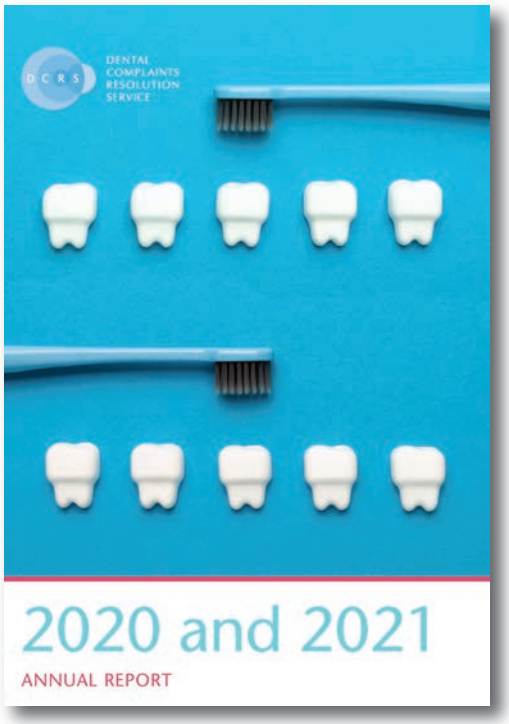

Table 1: Complaints and queries 2020.

Complaints and queries	January 2020-December 2020 (12 months)
Complaints received	154
Queries received	180
Total complaints/queries	334
New contacts per month (complaint/query)	30

Note: January 1-June 30 is estimated.

Table 2: Complaints and queries 2021.

Complaints and queries	January 2021-December 2021 (12 months)
Complaints received	163
Queries received	194
Total complaints/queries	357
New contacts per month (complaint/query)	30

The Dental Complaints Resolution Service (DCRS) launched its Annual Report at the start of August. The Report covers both 2020 and 2021, and is the first presented by new Facilitator Mary Culliton. The DCRS has continued its important role in dentistry in Ireland, providing an efficient resolution process for dentists and patients who find themselves in disagreement.

In her foreword to the Report, IDA President Dr Caroline Robins notes that the DCRS is ten years in operation this year, and that in that time "the Service has earned the praise of many other professions here in Ireland and among dental communities across the world.

In fact, we know of no other equivalent service, and are justly proud of the huge contribution the Service has made to bolstering confidence in dentistry, saving dentists and patients thousands of hours, which would otherwise have been spent seeking resolution in the courts or elsewhere".

Over the ten years the DCRS has been operational, the IDA estimates that it has received over 15,000 letters, calls and emails, handled over 1,000 complaints, and resolved more than 600 of those. The Dental Council and Dental Protection both continued their praise of the DCRS with statements of their own in the Report. In her Facilitator's report, Mary Culliton speaks about the things that she has learned in her first couple of years dealing with dental complaints. She says that the first thing patients want is to be heard, and that they deserve this even if they are not right in their complaint. Mary also says: "Equally, the dentist needs to be heard. Receiving a complaint can be frightening, particularly for an inexperienced dentist or indeed an experienced dentist for whom it is a first complaint. As Facilitator, I aim to be a source of help to both parties". In 2020, there were a total of 334 complaints/queries, which resulted in 154 accepted complaints **(Table 1)**. In 2021, there was a slight increase with 357 complaints/queries, and 163 accepted complaints **(Table** 2). For the first time, the Report includes two memoranda of service, one for patients and one for dentists, which explain what the DCRS does and how it works in both parties' circumstances.

To download/read the DCRS Annual Report, go to www.dentalcomplaints.ie or www.dentist.ie.

People person

IDA President Dr Caroline Robins speaks about finding her feet as a dentist from outside Ireland, and about some of the issues facing the profession.

When Dr Kieran O'Connor formally introduced new IDA President Dr Caroline Robins at this year's Annual Dinner in Galway, he gave part of the introduction in Maori, a gesture acknowledging Caroline's New Zealand heritage, and also the fact that she is the first non-Irish graduate to be President of the Association.

Originally from Ruapuna in Mid Canterbury, Caroline's decision to become a dentist sprang from her own childhood experiences, but not, perhaps, as one might expect: "I was probably every dentist's nightmare because I was terrified. My father's cousin, Peter Robins, was a dentist, and once I was older and a little bit calmer, he set about fixing all the issues. He put an anatomy book in my hand while he worked, and talked about what dentistry involved. He also talked about how it's a good career for a female from the point of view of family and things like that. He stirred an interest in me while I had a lot of work done".

It was a good fit: "I'm a people person, and I'm artistic, I'm creative – I like nothing more than making something look like a tooth again".

Caroline studied dentistry at Otago University, where the approach is slightly different to the Irish system, with a common entry first year where students of medicine, dentistry and pharmacy study together, and have the opportunity to take a range of subjects. She feels that the combination of her childhood experiences and this broad education gave her a great preparation for a career in dentistry: "I was lucky enough to do anthropology and psychology in my first year, which I really enjoyed. I love psychology. I often say that dentistry is one-tenth the mechanical and nine-tenths the person, and that's what I enjoy most about my job, my interactions with patients. I've also had a wisdom tooth out, I've had fillings, I've had injections. I have a degree of empathy with patients when they sit in the chair and have a fear, because I had it myself".

"I'm a people person, and I'm artistic, I'm creative – I like nothing more than making something look like a tooth again".

Down on the farm

Caroline lives on the family farm in Wicklow with her husband Anthony and daughters Ruby (15) and Sarah (12): "I'm from a farming background, born and bred. I love the countryside; I wouldn't want it any other way". When she is not walking the family's three golden retrievers around the farm, she loves to cook while listening to music, and enjoys a good crime novel. The whole family is involved in the local GAA club, where both of her daughters play football, and she and her husband coach. Now that the children are older, she plans to get back to playing golf with her husband, and hopefully to get the girls interested too!

After graduation in 1995, Caroline went to Australia, and spent three years working in Westmead Hospital in Sydney, where she says she got a terrific grounding in many areas of dentistry, from paediatrics and oral surgery, to caring for patients with oral cancer, and even forensics: "I used to spend a lot of time in the morgue doing identifications and I really loved that. I think if I had gone down the medical route, pathology is possibly what I would have done".

Like many of her fellow Antipodeans, Caroline planned to travel to the UK to work for a time, but meeting her future husband Anthony on a night out in Australia changed all of that, and she found herself travelling to Ireland in 1999: "I came for a look, and as I tell them, I'm still looking!"

"I used to spend a lot of time in the morgue doing identifications and I really loved that. I think if I had gone down the medical route, pathology is possibly what I would have done".

Early obstacles

Despite being a well-rounded general dentist with plenty of experience, Caroline quickly found that working in Ireland was not as straightforward as she'd expected, as her degree was not recognised here: "When I look back, it was farcical. You couldn't apply for a job without a panel number, but you couldn't get a panel number without the offer of a job".

Not to be deterred, Caroline arranged a meeting with the then registrar of the Dental Council, who alerted her to the fact that she could work in a hospital under the supervision of a consultant. This led her to Prof. Derry Shanley, then Dean of the Dublin Dental School, who offered her a position as a registrar. Over the next two years, she completed her fellowship exams at the RCSI, and eventually sat the statutory exam to be registered in Ireland. But this wasn't the end of her problems, as she now needed a work permit. She was fortunate enough to find work with Dr Brenda Barrett in Carlow, where she worked for 11 years before starting her own practice, Kiwi Dental, in 2012.

All of these experiences give Caroline particular insight into the plight of foreign-trained dentists seeking to work here, as well as non-Irish dentists who train here as international students, but then cannot stay to work: "Work permits aren't easy and you can see why principal dentists may shy away from them. It's an employee situation that is completely different to the traditional self-employed model and there's a lot more to take on as the employer. That said, I am extremely grateful to Brenda for taking me on and being prepared to do the mountains of paperwork required each year until I got married in 2006 and my residency status changed".

Perfect storm

Caroline's personal experience is particularly pertinent at the moment, as the profession deals with a major personnel crisis. It's something she wants to focus on in her year as IDA President, but she's all too aware that it's a complex problem with no easy solution: "There's no one single factor. It's like a perfect storm: feminisation of the profession, dentists working fewer hours generally, younger dentists not doing traditional dentistry. Then there's the difficulty getting registered, the fact that the statutory exam is only run once a year and there's only such a tiny number that can sit it each year, combined with current numbers graduating from dental schools".

As a general practitioner in a rural community, Caroline sees the impact of this crisis first hand: "The Dental Council says that there's never been so many dentists on the Register, but on the ground, no one can get dentists. It's a real worry. If I was to lose a dentist, I'm not sure what I'd do".

Finding other dental staff, particularly hygienists, is just as difficult, and the housing crisis and rising cost of living are adding to the problems. The knock-on effect, of course, is felt by patients, who are waiting longer for appointments, or finding that they can't get a dentist at all. Caroline feels it's also contributing to the number of dentists quitting the DTSS, as they consolidate their practices and adapt to working with the staff they have.

Whatever the answer, it will be multifaceted, and will involve all stakeholders working together. Caroline says she would welcome the opportunity to meet with the Dental Council, and other institutions are already joining the discussion. The IDA recently met with representatives of the RCSI's Faculty of Dentistry, where Dean Prof. Albert Leung is keen to look at issues such as increasing the number of places in dental schools (an opinion piece on the shortage of dentists by Prof. Leung is on p.184 of this edition). Other changes that might help would include changing the rules to allow non-Irish dentists who train here to work for a time after graduation, or implementing proposed changes to the scope of practice of auxiliary staff, but these involve regulatory and legislative change, which is notoriously slow, and in the meantime the crisis continues.

"Until we can have a chance to sit around the table and talk about a better model, the DTSS is still going to haemorrhage dentists".

Talks about talks

Increasing the number of dental graduates also takes additional funding, at a time when the profession is also lobbying for an overhaul of the medical card and PRSI schemes, and the health service in general is struggling to recover from the pandemic. The IDA is still waiting for an official start date

for talks on these issues, and Caroline is understandably frustrated at this. The recent allocation of additional funding for the DTSS was helpful, but doesn't address the fundamental issues: "It doesn't change the fact that we just don't have enough people offering the service and dentists are still leaving the scheme. It's reinforcing what we've always said: it's not about the money, it's about the system, and the system is still broken. Until we can have a chance to sit around the table and talk about a better model, it's still going to haemorrhage dentists".

She hopes that further talks will also help to rebuild the trust that has been lost between dentists and the Department/HSE in recent years. She feels strongly that only by understanding each other's point of view can progress be made, and says that a recent meeting with representatives from the Department felt like a positive step: "There was a good, open, frank discussion. We got a chance to have a conversation with each other and get some points across that perhaps neither side had fully appreciated".

She acknowledges that it won't be an easy road, but it's a necessary one: "We need to be able to sit down and try and iron out the issues, so we can all move together for the common goal, which is the oral health of the nation. The reality is, we're one of many, and we've all got our hands up trying to get attention, to get what is obviously important to us as a profession, and we feel that it should be important to the Department of Health. But we are one of many fields in health that need attention and are failing".

"I think as a professional body, in any profession, your association is your advocacy. If you lose your advocacy, you lose your voice".

Professional support

Having been a member of the Australian Dental Association, Caroline is a firm believer in getting involved in your professional organisation, so joined the IDA as soon as she came to Ireland. She got involved with the GP Committee when she set up her own practice as a way of meeting others in the same boat: "Dentistry can be lonely. I didn't have that [university] class back-up. You've got to make your own friends if you're on your own, you've got to go out and introduce yourself, so that's what I did. When I was setting up my practice, there was a lot of stuff I didn't know. What do you pay nurses and what do you look for? What materials and equipment should I buy and what's unnecessary? I came away from my first meeting feeling so relieved that I was normal, that my worries and concerns were everybody else's worries and concerns. I got so much information and help".

This progressed to involvement with the Board, and from there to her current role as President: "I really have enjoyed it so far. I've always been interested in politics and how things work. Everyone in IDA House has been so welcoming and they're all fantastic people".

Using your voice

Perhaps because of these experiences, Caroline also wants to use this year to get dentists talking face to face again. With so many issues and crises affecting the profession, from staff shortages and State contracts to VAT, it's never been more important to get dentists' views and input. Caroline feels that one of the many negative impacts of Covid-19 has been to limit communication in many instances to the virtual world: "I want to see people come back together as the profession and as people. I think we've become very isolated.

"Everyone has an opinion from the safety of a keyboard, but when you have a meeting and you ask people for ideas or what they think, nobody says anything. I want us to get back to actually having a decent, frank conversation about what is going on in our profession, which is a failing public health system where we can't meet the needs of our medical card patients. Everybody needs and has a right to basic decent oral health: pain free, disease free and clean. Maybe we need to look at how meetings are run, to get that conversation going. You don't have to agree with us. Whether you like us or don't, come and talk".

Her final comment is a cautionary one: "The New Zealand Medical Association, the NZMA, folded this year because not enough people were participating in it. I think as a professional body, in any profession, your association is your advocacy. If you lose your advocacy, you lose your voice".

Ireland's chronic shortage of dentists

Prof. Albert Leung, Dean of the Faculty of Dentistry at the Royal College of Surgeons in Ireland, noted Association President Dr Caroline Robins' comments on the shortage of dentists in Ireland in our last edition and says that this problem must be addressed urgently.

Maintaining a high standard of oral health is vital for the well-being and general health of our patients. For many, dental diseases are very unpleasant, symptomatic, demoralising and expensive to treat, yet most of these conditions can be avoided with timely access to high-quality dentistry and appropriate preventive dental care. As dental care professionals, we know that good dental healthcare provision is also essential for our general health because dentists can help with the early detection of a number of serious diseases and conditions. We also know that well-maintained hard and soft oral tissues inspire confidence for our patients. Access to dental care in Ireland and manpower in dentistry are two major challenges that go hand in hand. There is a major shortage of dentists practising in Ireland, and waiting lists for child and adult dental care are ever increasing. Furthermore, around 80% of medical card holders find it difficult to access dental care, and many dentists have turned away from the medical card scheme (DTSS), which has become non-viable. For many patients, this means that preventable conditions become irreversible, with adverse effects on their oral and general health and quality of life.

Addressing the shortage

We must immediately address the chronic shortage of dentists in Ireland. Ireland has 44 dentists for every 100,000 people. Germany and Italy each have almost double that number. France has 65 and the UK has 53. It is no wonder that Irish residents, particularly those with medical cards, find it hard to access the dental care they need and deserve.

Fundamentally, we are not graduating a sufficient number of dentists each year. Ireland educates fewer dentists per capita than most other OECD countries and we are not catching up. The availability of licensed dentists per capita in Ireland has not increased since 2005, while it has grown by approximately 20% in other OECD countries. The number of Irish-trained dentists entering the Dental Council of Ireland (DCI) register has been relatively static over the past 25 years, and many dentists on the register are not actually practising or are practising dentistry part-time.

As a consequence, the system has become increasingly reliant on overseas-trained dentists; 45% of dentists on the current register who qualified in the past 10 years were trained overseas. A reliance on overseas dentists exposes us to greater international competition for talent, greater risk if the international pipeline is reduced because of factors such as Brexit or Covid-19, and challenges in staffing practices, particularly in more deprived and rural communities. It can also contribute to a brain drain, which would negatively impact poorer countries, compounding health inequalities elsewhere.

At the same time, we know that we have lots of bright young people who would like a career in dentistry. Last year, over 460 students set dentistry as their first CAO preference. With about 60-65 places available nationally, only some of those with maximum possible Leaving Cert scores of 625 points received places. The challenge is a lack of domestic training places. We need a step change in the provision of dental education in Ireland – potentially by enabling more institutions to offer dentistry courses. The way we educate dentists must also change. There has been much development in recent years of primary care-based clinical training of dentists in community settings. More clinical training should take place close to where patients live. This way, dental students would experience a far more realistic and integrated approach to patient care. It would target the dental workforce to where the patients are, offering patient care and reducing waiting lists, while training dental professionals in a well-supported setting closely related to the clinical environment where they will go on to practise. It also has potential to enable the State to support an expansion in dentistry graduates at a lower cost. This approach has been adopted in other jurisdictions where they have seen an increase in the number of dentists opting to work in areas of greatest public need after they have qualified.

The population in Ireland is growing and ageing, meaning that demand for dental care will increase at a time when we are graduating fewer dentists than we need. The younger generation will continue to require quality preventive dental care despite an overall improvement in public dental health over the last few decades. Lack of access to dental care is a longstanding challenge and it's time for an urgent new solution.

Prof. Albert Leung,
Dean of the Faculty of Dentistry at the Royal College of Surgeons in Ireland.

Diagnosis and management of oral mucosal conditions commonly seen in the elderly population

Learning outcomes:

- recognise the older adult as a unique subset of patient;
- develop familiarity with the appearance and aetiology of various oral mucosal conditions that can present in the older adult; and,
- develop awareness of common treatment modalities for oral mucosal diseases.

Introduction

Ageing may be defined as the age-progressive decline in intrinsic physiological function. However, due to advances in medicine, the rate of mortality has reduced and the older population is ever increasing. Indeed, the proportion of the Irish population aged 65 and over is expected to double over the next 20 years from 11% in 2006 to 22% in 2041.[1] The older population is more likely to have a high burden of comorbidities and, as such, a higher incidence of oral disease, including oral mucosal diseases. The oral mucosa is subject to various age-related changes (**Table 1**). Although the oral mucosa is not subject to the same environmental threats as the skin, such as UV light and air pollution, it is exposed to a barrage of irritants throughout life. Masticatory trauma and resident microflora cause a constant influx of inflammatory and immune cells. Elastic changes may lead to a higher incidence of trauma and infection complicated by a poorer response of the immune system. The oral mucosa may also suffer the effect of polypharmacy, which is defined as the concurrent use of five or more medications. According to a report published by The Irish Longitudinal Study on Ageing (TILDA), one in three Irish adults over 65 report polypharmacy.[2]

Table 1: Reported age-related changes in the oral mucosa.

Decreased overall thickness
Flattening of epithelial cells
Decreased cell density
Decreased mitotic activity
Reduction in microvasculature
Less prominent rete ridges

The purpose of this article is to provide an overview of the common oral mucosal lesions seen in the older patient that may present to the general dental practitioner (GDP), and their management.

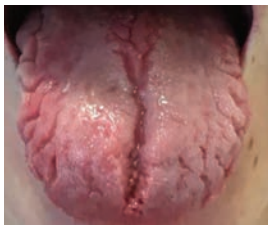

FIGURE 1: Fissured tongue.

Common oral mucosal findings in an elderly population

Many soft tissue variations may be seen during the intra-oral soft tissue examination of an elderly patient. Therefore, variations of normal should be easily recognised and diagnosed by the GDP. Examples of these include lingual varices, fissured tongue and atrophic tongue.[3]

Lingual varices

Lingual varices are dilated veins that may be seen on the ventral surface of the tongue.

Their pathogenesis may be related to changes in the connective tissue and/or weakening of the venous walls during the ageing process. There is an increased incidence of lingual varices in the older population, and a correlation with cardiovascular disease and smoking has also been noted.[4]

Fissured tongue

Fissured tongue is characterised on clinical examination by a central groove on the dorsal surface of the tongue, with multiple laterally extending, branching fissures (**Figure 1**). Its incidence increases markedly with age and it can be considered a variation of normal findings and a result of the ageing process.[5]

Fissured tongue is usually asymptomatic unless accompanied by inflammation, which may be caused by low-grade bacterial infection or trapped food debris. Atrophy of the filiform papillae on the dorsal surface of the tongue can result in pain, soreness, or a burning sensation of the tongue.

Oral mucosal diseases

Oral mucosal diseases are more common among the elderly. Three common oral mucosal conditions associated with the older population are: salivary gland hypofunction and/or xerostomia; oral lichen planus (OLP); and, the vesiculobullous conditions.

Oral cancer is not a common malignancy seen in the elderly; however, it is more common in this age group than in the younger population.

Dr Orla McPhillips
Senior House Officer Oral Medicine/Oral Surgery
Cork University Dental School and Hospital

Dr Barry Patton
Senior House Officer Oral Medicine/Oral Surgery
Cork University Dental School and Hospital

Dr Richeal Ní Ríordáin
Consultant/Senior Lecturer in Oral Medicine
Cork University Dental School and Hospital

Corresponding author: Dr Orla McPhillips E: OMcPhillips@ucc.ie

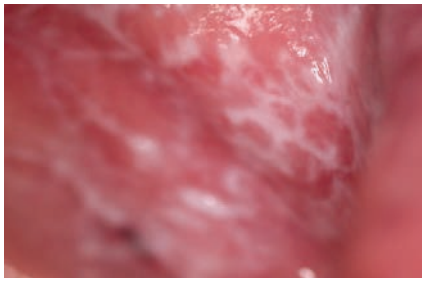

FIGURE 2: Reticular pattern of oral lichen planus.

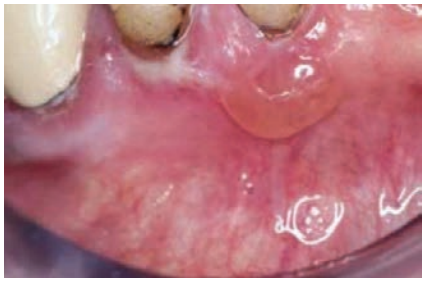

FIGURE 3: Mucous membrane pemphigoid.

Salivary gland hypofunction

Saliva has many functions, including:

- maintaining a moist oral mucosa that is less susceptible to abrasion;
- clearance of micro-organisms, desquamated epithelial cells, leucocytes and food debris; and,
- acting as a buffer to protect the oral, pharyngeal and oesophageal mucosae from ingested or regurgitated acid.

Salivary gland hypofunction or hyposalivation is an objective reduction in whole salivary flow rates (unstimulated rate of <0.1ml/min).[6] Xerostomia is defined as the subjective complaint of dry mouth. Both conditions are common among the elderly and may be related to the use of xerogenic drugs, including (but not limited to): anticoagulants; antidepressants; antihypertensives; antiretrovirals; hypoglycaemics; levothyroxine; and, non-steroidal anti-inflammatory drugs. The impact of dry mouth on the oral mucosa includes the development of smooth surface caries, ill-fitting dentures, and soreness associated with denture wear. Patients can also have difficulty with speech and swallow, and are more prone to candida infection.[5]

Management: Salivary gland hypofunction may be managed through salivary substitutes containing carboxymethylcellulose, mucin or xanthan gum. There is also evidence for the use of parasympathomimetic agents such as pilocarpine to stimulate salivary flow.[7]

Oral lichen planus

OLP is a common, chronic, autoimmune disease associated with cell-mediated immunological dysfunction.[8] It affects 0.5-2% of the adult population and has a female predisposition. It is generally diagnosed in the sixth decade and the disease process may continue for life. Therefore, patients presenting with OLP will often be elderly. It can present with a range of clinical appearances, including: a lacy white pattern (**Figure 2**); erythema; erosions; ulcerations; plaques; desquamative gingivitis; and, blistering of the oral mucosa.

The cause of OLP is unclear and it can present with a range of symptoms ranging from asymptomatic to severe soreness, with impact on oral health-related quality of life (OHRQoL). Although controversial, according to a recent meta-analysis, OLP has a reported malignant transformation rate of 1.14%.[9] As such, regular screening for dysplastic changes in the oral tissue is crucial in the management of patients with oral lichen planus.

Management: Mild cases may be treated with 5mg prednisolone soluble tablets, dissolved in water and used as a mouthwash, up to six times daily. Patients should be instructed to hold the mouthwash in contact with the tissues for 5-10 minutes at a time.

Vesiculobullous diseases

Due to immune system alterations in older age, and the accumulation of autoantibodies, older patients are more susceptible to immunobullous conditions. These diseases are listed in **Table 2**.

Table 2: Immunobullous diseases.

Pemphigus: – pemphigus vulgaris – pemphigus foliaceous – IgA pemphigus – drug-induced pemphigus – paraneoplastic pemphigus
Pemphigoid: – bullous pemphigoid – mucous membrane pemphigoid – linear IgA disease – drug-induced pemphigoid
Epidermolysis bullosa acquisita
Dermatitis herpetiformis

Pemphigus is a rare, chronic, potentially life-threatening autoimmune vesiculobullous disorder. The average age of presentation is reported to be 71 years but it can affect all age groups.[10] There are three clinical subtypes of pemphigus vulgaris (PV):

- mucosal-dominant type – mucosal lesions with minimal skin involvement;
- mucocutaneous type – extensive skin blisters and erosions in addition to mucosal involvement; and,
- cutaneous type with skin lesions only.

PV is an autoimmune disease in which autoantibodies are produced against desmoglein-1 or 3 (two of the desmosomes that hold epithelial cells together). Oral lesions typically present as shallow vesicles and bullae. Ruptured vesicles may form irregular erosions on the mucosa.

Mucous membrane pemphigoid (MMP) is a chronic, autoimmune, sub-epithelial blistering disorder (**Figure 3**). Possible affected sites include: the oral mucosa; the ocular mucosa; the laryngeal mucosa; the tracheal mucosa; and, the anogenital mucosa. It typically occurs in the elderly with a mean age of onset of 60-80 years.

Like PV and OLP, MMP persists into old age. Clinical appearance differs from that of PV as the roof of the blister is formed by intact, full-thickness epithelium. Therefore, vesicles and blisters are more resilient and may be seen on clinical examination before they burst. If these break down, they leave shallow ulcers with ragged margins. Diagnosis involves a perilesional biopsy and immunofluorescence.

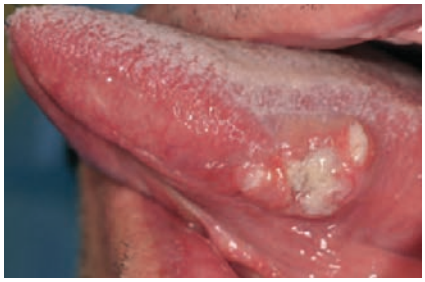

FIGURE 4: Oral squamous cell carcinoma.

Management: First-line therapy involves corticosteroids paired with an adjuvant immunosuppressant (e.g., azathioprine) to induce remission of the disease, followed by a tapered reduction of the corticosteroids and continuation of the steroid-sparing immunosuppressant therapy. The use of corticosteroids establishes disease control more rapidly than steroid-sparing agents; however, these have a more important role in maintenance therapy.[11]

Oral cancer

Cancer of the oral cavity and pharynx is now the seventh most prevalent cancer globally.[12] These cancers are strongly associated with smoking and excessive alcohol consumption. A 30-year study on survival rates reported mean age of diagnosis to be 62 years. Overall survival rate at five years was reported to be 64.4%. Early diagnosis is key to improving survival rates and improving quality of life for survivors. A thorough oral cancer screening should be completed for all patients. Oral cancer is commonly managed by surgical excision with or without reconstruction with a local or free flap. Patients may also receive postoperative radiation therapy. **Figure 4** illustrates a squamous cell carcinoma of the tongue.

These patients require careful management by their GDP in conjunction with the oncology and surgical team to restore function and minimise risk of postoperative complications such as osteoradionecrosis of the jaw. This includes a thorough pre-operative dental assessment along with stringent oral hygiene instruction. The identification and treatment of any dental disease should be completed prior to surgery. Patients may also suffer unpleasant side effects of radiation therapy such as mucositis, trismus and xerostomia.[13]

Denture-related conditions

According to the 2011 TILDA report on oral health in older adults, 18% of Irish adults over the age of 54 have no natural teeth remaining, and this figure increases to 40% over the age of 75.2 Some 17% of the population wear complete dentures, and these people are predisposed to denture-related oral mucosal lesions. These may be acute or chronic reactions to microbial colonisation of the denture base or the denture base material itself, or may be caused by mechanical injury caused by the denture. Angular cheilitis, denture stomatitis and traumatic ulcers are the more common oral mucosal lesions seen in denture-wearing patients.

Angular cheilitis

Angular cheilitis is an infection at the commissure of the lips, which is typically caused by the leakage of saliva at the angles of the mouth. Reduction in vertical dimension caused by edentulism and ill-fitting dentures can cause inappropriate support of the corners of the mouth, which commonly harbour *Candida albicans*, *Streptococcus aureus*, and *Streptococci*.[14]

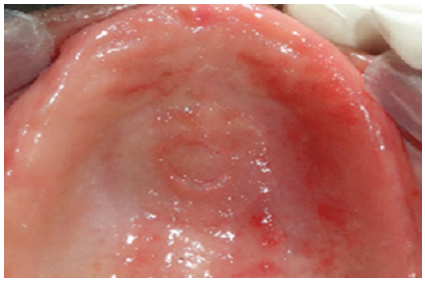

FIGURE 5: Denture stomatitis.

Management: Elimination of causative factors in conjunction with a topical antifungal usually leads to resolution.

Denture stomatitis

Denture stomatitis is defined as an inflammatory process of the oral mucosa that underlies a removable denture (**Figure 5**). It is commonly associated with candida infection, trauma to mucosa, poor denture hygiene, and denture wear at night.[15] The ability of candida species to adhere to the porous acrylic material contributes to the incidence of denture-related candidiasis.[16] Continuous wear of the denture may also prevent the self-cleansing action of saliva on the oral mucosa. Diagnosis is based on the clinical picture of a sharply demarcated erythema restricted to the area covered by the denture, and can be confirmed by a finding of candida hyphae in a mucosal smear from the inflamed mucosa.

Management: Topical application of an antifungal such as miconazole gel to the fitting surface of the denture is recommended. For more widespread infection patients can be prescribed Nystatin oral suspension (1ml – 400,000-600,000 units) to be dropped on the tongue and retained in the mouth for as long as possible four times daily for four weeks. Systemic therapy may be indicated in severe cases. Patients should also be counselled on denture hygiene and reduction in denture wear at night.

Orofacial pain

Two common orofacial pain conditions affecting the elderly are burning mouth syndrome (BMS) and trigeminal neuralgia (TN).

Burning mouth syndrome

BMS is characterised by a burning sensation of the oral mucosa in the absence of any clinically apparent mucosal alterations. It is most common among middle-aged and older women, occurring with a predilection for the female sex of 5:1.[17] Patients may also complain of dysgeusia and xerostomia. BMS can be commonly associated with stressful life events, anxiety or depression. There is also evidence for a neurogenic cause.[18]

Management: BMS is commonly managed through psychological methods such as cognitive behavioural therapy (CBT), or pharmacological means such as a selective serotonin reuptake inhibitor (SSRI) or tricyclic antidepressant (TCA), or a combination of both.

Trigeminal neuralgia

The International Association for the Study of Pain (IASP) defines TN as a sudden, unilateral, severe, brief, stabbing, recurrent episode of pain in the

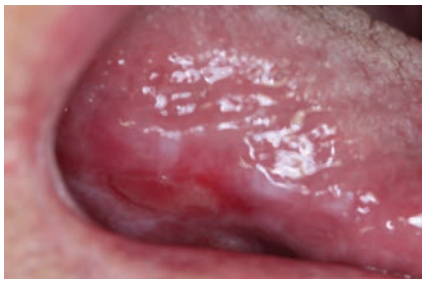

FIGURE 6: Lichen planus-related ulcer.

distribution of one or more branches of the trigeminal nerve.[19] It may be categorised as Type I, Type II and Secondary TN. In Type I, symptoms are of 'classical' TN – short sharp paroxysms of pain that may be brought on by touch, toothbrushing, or shaving. Type I may be further subdivided into 'idiopathic', in which no microvascular compression is demonstrated on investigation, or 'classical', in which microvascular compression is proven. Type II presents as a continuous low level of pain superimposed by bursts of severe pain. Secondary TN occurs as a result of a neurological disease and is not caused by microvascular compression of the trigeminal nerve.[20]

Management: **The first line of treatment is medical management with the use of anti-convulsant medications such as carbamazepine or oxcarbazepine. Second-line treatment options include transcutaneous, percutaneous, radiotherapy and open surgical management. Patients suffering from secondary TN should undergo treatment for the primary source of pathology.**

Case report

A 71-year-old lady attended the Oral Medicine Department in Cork University Dental Hospital. She was referred by her dentist regarding fiery red appearance of her gingivae, and painful ulceration and white patches on the buccal mucosae and lateral borders of the tongue. She had soreness while eating spicy foods and during toothbrushing.

Medical history included hypertension, type II diabetes mellitus, osteoarthritis, and gastro-oesophageal reflux disorder. Medications included bisoprolol, aspirin, and pantoprozole.

On examination, her attached gingivae had a full-thickness erythematous appearance and her buccal mucosae were erythematous with white macules and striations superimposing. She had an ulcer on the lateral border of her tongue that measured 9x4mm (**Figure 6**).

An incisional biopsy was taken and sent to histology. A diagnosis of OLP was made and the patient was treated with topical prednisolone mouthwash.

A one-month review showed improved appearance of the erythematous tissues and complete healing of the ulcer.

Conclusion

The GDP should be aware of the normal physiological signs of ageing tissues in the older dental patient.

They should also be aware of conditions that warrant appropriate referral for further investigation and monitoring.

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IDA irish dental association

Volume 68 Number 4
August/September 2022

MEMBERS' NEWS

IDA pre-Budget submission 2023

The IDA's pre-Budget submission aims to communicate to Government how to ensure dental healthcare to all in the country during a time of high inflation.

Due to the cost of living crisis, the Government will be presenting Budget 2023 in September, one month earlier than usual. The IDA recently put forward its pre-Budget submission on how the Government could ensure access to dental care in inflationary times. After years of underinvestment and outdated policy, access to essential services and dental care is now in crisis and requires urgent intervention through a series of measures in Budget 2023. The IDA knows that

4. Amend the critical skills list for non-European Economic Area (EEA) visa applicants to include dental nurses, and to reform work permit rules for non-EEA citizens seeking work as dental nurses (currently prohibited) or as dentists (permitted only where the dentist works as an employee with a single employer – most private dentists are self-employed and many work in more than one practice).

Patients can claim relief for non-routine dental care carried out by a registered practitioner. Up until 2009, the rate for this relief was 40%, but this was cut to 20% and has not been amended since. This means higher costs for patients and inevitably leads to reduced access. The IDA believes that reform and expansion of the Med 2 scheme can significantly alleviate the difficulties faced by patients in accessing dental care. The IDA put to options Government to improve the scheme:

- expanding the range of treatments for which relief could be claimed at the standard rate, such as dentures;
- allowing marginal rate relief for some or all dental treatments; and,
- allowing marginal rate relief subject to a ceiling for some or all dental treatments, including dentures.

These recommendations come off the back of a survey of IDA members, which ascertained what the profession believes would be most effective at improving access to care. The survey received over 200 responses, with 86% of those surveyed believing reform of the Scheme would improve access to dental care. Conversely, if the Scheme sees no reform, 21% of dentists predict practice

4. Amend the critical skills list for non-EEA visa applicants

Dentists and dental nurses should be included on the critical skills list for non-EEA visa applicants. Dental nurses are currently not on the list and dentists only in limited circumstances. We believe both professions should be added to the critical skills list for work permits.

The IDA sought to have dental nurses included on the critical skills list in 2018 but this application was unsuccessful. Since then, recruitment challenges have only become more acute. In fact, dental nursing was added to the list of ineligible occupations for work permits, which means that non-EEA dental nurses can no longer get a work permit to work in Ireland.

This is in contrast to medical nurses, who have long been named on the critical skills list for non-EEA visa applicants. We are calling for the decision to place dental nursing on the ineligible occupation list to be urgently reversed in order to enable non-EEA dental nurses to take up these vital roles within dental practices.

5. Investment in the HSE public dental service

The HSE public dental service has been chronically underresourced for years

Registration pathway for refugee dentists

A new registration pathway has been established to assist refugee dentists who wish to practise in Ireland.

Mandatory sick pay

Mandatory sick pay legislation will be enacted imminently.

The Sick Leave Bill 2022 was passed by both Houses of the Oireachtas in July

Review contracts/policies

Complications: recognising, managing and preventing them

In recent years, dental practice has become increasingly challenging. Patient expectations have never been higher, both in terms of clinical outcomes and service levels.

Meeting patient expectations often requires far more than simply providing work of good quality. Patients nowadays see themselves as consumers and often believe that they are buying a commodity—which, if it doesn't meet their expectations, means they are entitled to a refund.

They take for granted things like building a rapport, trust, anxiety management and pain control – elements that can, in fact, be the most difficult of all to manage, and for which there is no fee. Recognising that complications will occur is a crucial part of being in practice these days. You may have excellent clinical skills but will need other skills if you are to be able to deal with challenging patients and tricky situations, and sort them out effectively and efficiently.

Recognising risky situations

Distractions are a key cause of misunderstandings and mistakes. These might start off as small errors and later lead to much more serious complications. Every day we have to manage external distractions — phone calls, broken equipment, new staff members — but more insidious and dangerous are the internal distractions, the ones that cause us to respond emotionally.

These are the things that keep us awake at night – death, disease, debt, divorce, depression, drink/drug addictions. If these things are going on in our lives, we will struggle to focus and concentrate fully during the day and become vulnerable to slips, lapses and errors. When under these pressures, we will also be less tolerant of our patients and staff and they may affect our ability to respond to difficult situations in a calm, thoughtful and measured way. Of course, these things may also be going on in your patients' lives, and if so, they too are likely to be less resilient, more impatient and anxious, and more likely to complain if the treatment or service doesn't meet their expectations.

Communication skills are vital in trying to build a relationship of rapport and trust early on. A 2017 study carried out by the Medical Protection Society showed that patients place a very high value on communication skills, and are less likely to complain if they feel an effort has been made to communicate with them. We know from 30 years of research that poor communication leads to dissatisfaction for patients and is one of the main drivers behind patient complaints.

Clinical skills are extremely important but if you want to experience high levels of satisfaction among your patients, you need to be able to communicate with each one effectively. This is important when things are going well — but even more so when complications arise. Tailoring your communication style to match each patient's needs requires time and effort, but it is time extremely well spent. Consider it an investment in the success of the treatment plan going forwards. Should a complication arise, it is likely you will be better able to navigate and negotiate this with the patient if you have already built a solid foundation of good communication.

Nuala Carney
Dentolegal Consultant at Dental Protection

After the complication occurs

When a complication or adverse incident arises, it is crucial that you respond appropriately and proactively. It is important to explain to the patient what has occurred, apologise for any inconvenience or discomfort, and make sure that they are kept comfortable and safe. Pain management in the aftermath of an adverse event is critical and is often an element of the allegations made at a later stage, as is the need to be referred to an appropriate specialist at the earliest opportunity. You should make sure that you make a detailed record of everything that occurred, paying particular attention to any discussions that were had with the patient.

Remember that these records might not be looked at until three/four years later, or sometimes even 10, and may be vital in establishing your defence. Make sure not to abandon the patient. If something untoward has occurred, keeping in touch to ensure they are being looked after and are comfortable is very important. Finally seeking independent objective advice and support as soon as possible can often make the difference between resolving the matter early on or allowing it to fester and escalate.

Every practice must have a complaints protocol. This is a Dental Council ethical and professional obligation. This should be provided to the patient as soon as they raise a complaint. Having a member of staff who is trained in handling complaints is essential. Your patient needs an early acknowledgment of the issue they have raised, usually within three days – and then a commitment to provide them with a full response once you have had time to review the matter carefully. Please make sure to give yourself plenty of time in your protocol to do this, and err on the side of three to four weeks. You can always respond more quickly but it is very awkward to have to keep asking for more time. Our team at Dental Protection are experienced in writing explanation and apology letters and we are more than happy to assist you with this. Having an independent, objective view often makes the response a little more balanced and palatable to a frustrated patient, and facilitates an earlier resolution acceptable to both sides.

Preventing complications

In his book Blink, Malcolm Gladwell discusses what he calls 'thin slicing'– essentially where patients make judgements based on small amounts of crucial information that they deem to be very important. Research shows that for patients, tone of voice and an ability to listen are extremely important, and that clinicians who are perceived to be good at these things receive less complaints and claims than those who are not.

So paying attention to these two key aspects in the early stages of building a relationship and making the treatment plan, as well as when dealing with a challenging situation or adverse event, is likely to serve great dividends.

Managing complex people in challenging circumstances is what we do all day long. It is inevitable that at times wires may become crossed, mistakes will happen, and complications will occur. Being aware of times when these things are more likely to happen, and also recognising that there are key skills you can utilise to respond to tricky situations, can often make the difference between early effective resolution and stressful, protracted disagreements.

If in any doubt, don't hesitate to contact your dental defence organisation. Dental Protection members benefit from ongoing learning and development opportunities, including CPD workshops offered periodically throughout the year, to help you avoid claims or complaints.

Canine ramps

A canine ramp is a useful technique when a patient has a flattened canine and the teeth that are involved in lateral excursion are weakened with large restorations or have undergone endodontic treatment.

As we age, physiological or pathological tooth wear can alter our occlusion from canine-guided (or 'canine-protected') lateral excursion, to group function. Group function itself is not problematic, but the burden of lateral excursion can be damaging to compromised teeth. For example, an upper premolar with a large mesio-occluso-distal (MOD) amalgam restoration is particularly prone to cusp fracture if a weakened cusp becomes involved in lateral excursion. It may be desirable to restore the patient to canine-guided lateral excursion to protect heavily restored teeth. A minimally invasive option is the canine ramp.

When should I consider creating a canine ramp?

During your routine examination you may note that a patient has a flattened canine, which is similar in length to the neighbouring lateral incisor and first premolar (**Figure 1**). A flattened canine in itself does not always indicate that treatment is needed. If the wear is physiological (i.e., in keeping with the patient's age) and the other teeth involved in lateral excursion are unrestored, it is unlikely that operative treatment is warranted. In this case, monitoring with appropriate clinical records is sufficient.

However, if the teeth that are involved in lateral excursion are weakened with large restorations or have undergone endodontic treatment, group function may be undesirable and may increase the risk of tooth or cusp fracture.

You may also consider creating a canine ramp if you are planning a restoration and do not wish to involve the restoration in dynamic tooth movements (e.g., a resin-bonded bridge pontic or a post-retained crown).

How do I create a canine ramp?

1. You will need articulating paper of two different colours. Using one colour, mark up the patient's intercuspal position (ICP) (or static) contact points (**Figure 2**). These should appear as point contacts or spots.
2. Use the other colour to mark their contacts in lateral excursion (dynamic contacts). These should appear as lines from the ICP contact moving towards the cusp tips or incisal edge (**Figure 3**).

Dr Martina Hayes
Senior Lecturer in Restorative Dentistry, Cork University Dental School and Hospital

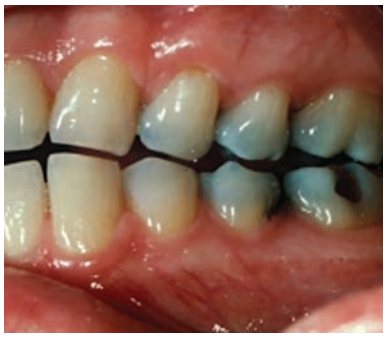

FIGURE 1: Note the flattened canine, which is similar in length to the lateral incisor and the first premolar. Also note the grey appearance of the premolars due to large amalgam restorations indicating thin buccal cusps.

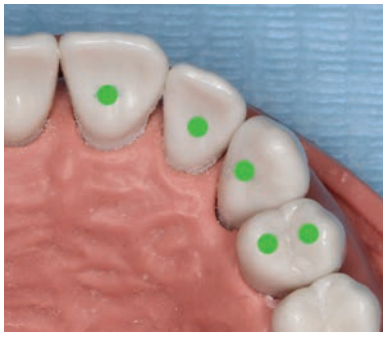

FIGURE 2: Intercuspal position (ICP) contacts.

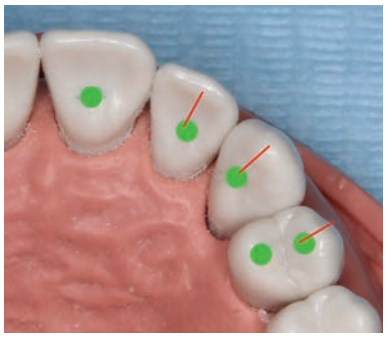

FIGURE 3: Contacts in lateral excursion.

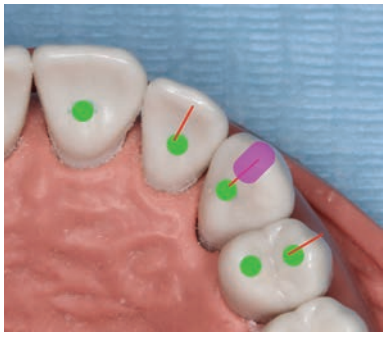

FIGURE 4: Graphic showing the area to apply the composite. Note you should avoid the ICP contact.

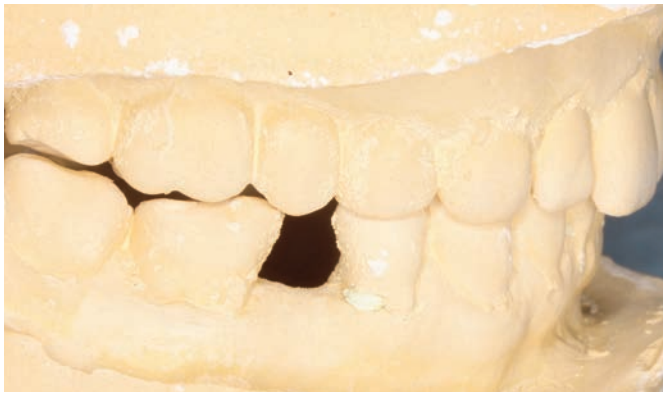

FIGURE 5: Articulated study models demonstrating the ICP.

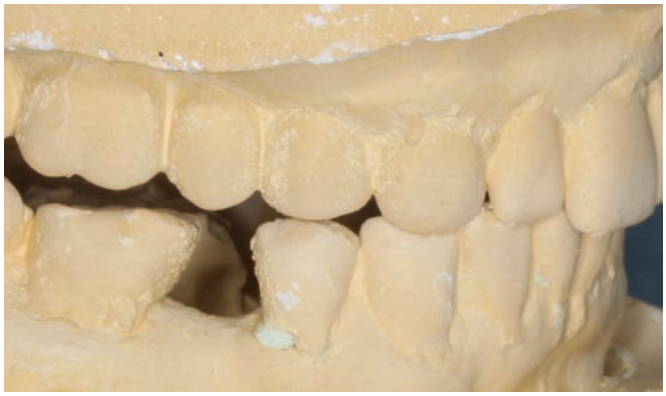

FIGURE 6: Teeth involved in lateral excursion.

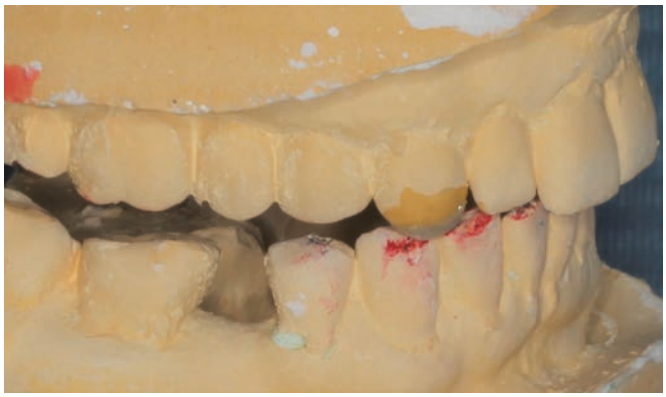

FIGURE 7: Postoperative lateral excursion showing first premolar clearly discluded.

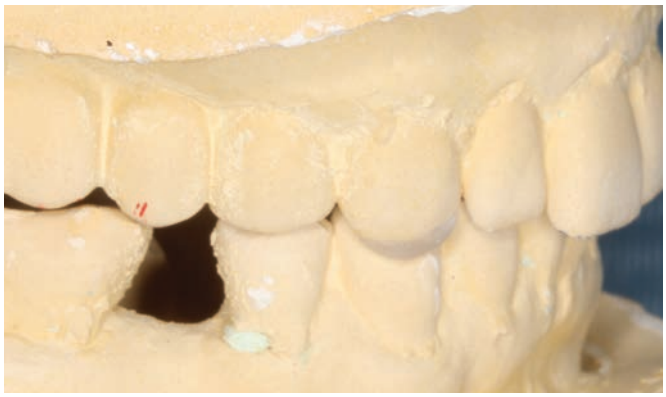

FIGURE 8: Intercuspal contacts unchanged by the addition to the canine.

3. Etch and apply your bonding system to the palatal surface of the canine. Place composite on the dynamic contact (i.e., the line), taking care not to place composite on the ICP contact (**Figure 4**).
4. Clean the original marks from the articulating paper and mark the ICP contacts again. These should appear unchanged and the patient should not notice a difference when they are asked to bite together. However, when you now mark up the patient's lateral excursion, only the canine should appear in occlusion.

Sample case

Figure 5 shows articulated study models for a patient mounted in the ICP. The patient's first premolar has been root canal treated, has a post-retained core, and is a bridge abutment for a fixed-moveable bridge. **Figure 6** shows that lateral excursion is guided by the lateral incisor, the canine, and the first premolar. In this case, it would be preferable to remove the first premolar from lateral excursion as it is a heavily restored, compromised tooth. The ICP contacts are first recorded using red articulating paper and then lateral excursive movements are recorded with blue articulating paper. Wax is added to the blue area but not the red, so the patient's ICP is unaltered. The resulting canine ramp now clearly removes the first premolar from lateral excursion (**Figure 7**), but the ICP remains unaltered (**Figure 8**).

Risks and benefits of the procedure

Your patient should be informed that this is a minimal procedure, which involves adding resin composite, and no tooth tissue is removed. However, over time this may wear down or debond and the patient may not become aware, as their ICP is unaltered.

Lateral excursive contacts should be examined at future routine dental examinations to determine if the procedure needs to be repeated. The canine tooth should be periodontally sound, as excessive lateral force on a periodontally compromised tooth could result in secondary occlusal trauma. Addition of composite to form a canine ramp will make the palatal aspect of the tooth feel bulkier to the patient initially, and it may restore the canine to its original 'pointy' appearance.

For aesthetic reasons, it may be desirable to add composite to the contralateral canine to preserve symmetry.

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An audit of external referrals to the periodontology department in an Irish university dental hospital

Précis

An audit indicated that referral letters submitted to the periodontology department of a university dental hospital frequently failed to provide sufficient information. Clinicians utilising the bespoke referral proforma letter achieved a markedly higher standard of referral.

Abstract

Statement of problem: Concerns were raised that referrals to the Dublin Dental University Hospital (DDUH) periodontology department often lacked sufficient information for triaging.

Purpose of the study: To investigate the quality of external referrals to the DDUH periodontology department, as well as identifying how frequently the current referral proforma letter was used, and if proforma use was associated with a higher quality of referral.

Materials and methods: Data was collected by retrospectively auditing 150 external referrals to the DDUH periodontology department at representative intervals over a 12-month period (2019/2020). Referrals were assessed to investigate if they included 22 information points as requested by our local standard (referral proforma letter). Data was input into a Microsoft Excel spreadsheet and analysed. Ten periodontal referral proforma from similar dental institutes across Ireland and the UK were also compared to our proforma to investigate if our institution requests a similar level of information to peer institutions.

Results: Referral analysis indicated that clinicians provided on average 12.9 out of 22 (59%) items of required information in their referral correspondence. Referrers utilised the appropriate referral proforma in 28% of cases. Use of this proforma was associated with a better standard of referral (17.9 out of 22 required information items provided [80%]) when compared with non-proforma referrals (11.2 out of 22 required information items provided [51%]). Analysis of other institutions' proformas highlighted that the DDUH requests referring practitioners to include more information than equivalent peer institutions.

Conclusion: Periodontal referral letters to the DDUH frequently fail to include sufficient information. Practitioners seldom utilise the divisional referral proforma, although its use is associated with improved referral quality. Simplification of the existing referral proforma and dissemination of referral guidelines to practitioners is recommended moving forward.

Journal of the Irish Dental Association August/September 2022; 68 (4): 198-203

Introduction

Referral letters are an essential means of communicating clinical information between healthcare professionals. High-quality referral letters provide a means of efficient triaging to provide appropriate patient care.[1-8] Previous studies have highlighted that referral letters to specialist care settings frequently omit items of key information.[1-11]

Part of the challenge for referring practitioners may be the lack of universally adopted guidelines indicating what a referral letter should contain. General recommendations on referral practices have been highlighted in the dental literature for many years,[12] and are included in general dental texts,[13,14] but these are not uniformly and consistently utilised by professionals. The challenge extends across clinical disciplines; a previous review of referral letters

Dr Conor O'Meara
BDS NUI MFDS PGCert-HPE
Executive Registrar,
Dublin Dental University Hospital

Dr Henry F. Duncan
BDS (Glas) FDS RCS (Edin) MClin Dent (Lond) MRD RCS (Edin) PhD
Lecturer and Consultant in Endodontics, Dublin Dental University Hospital

Dr Peter Harrison
BDentSc MFD DChDent,
Lecturer and Consultant in Periodontology
Dublin Dental University Hospital

Corresponding author: Dr Peter Harrison E: peter.harrison@dental.tcd.ie

to an oral medicine department in the UK highlighted that fewer than half contained a list of problems or a provisional diagnosis.[15] The Scottish Dental Clinical Effectiveness Programme (SDCEP) has provided clinical guidelines on the management of periodontal diseases in primary dental care, which include suggestions on what a periodontal referral letter should contain.[16] The British Society of Periodontology (BSP) has also published helpful guidelines on periodontal patient referrals,[17] although these focus principally on case and complexity features that may be relevant in making referral decisions rather than the content of referral communications themselves.

Dublin Dental University Hospital (DDUH) accepts patient referrals for educational purposes, with the majority of care being provided in undergraduate student clinics. The school has an obligation to balance the number and complexity of referrals accepted against its teaching and research requirements. Triaging referrals in respect of their complexity and urgency can prove difficult if appropriate information is not supplied.

The use of proforma letters/forms has been shown to improve the standard and quality of referrals in dentistry[2,6,8] but, despite this, they are often not utilised by the referring practitioner.[4,6] A previous audit of referrals to the Department of Oral and Maxillofacial Surgery at the DDUH concluded that, in general, referral letters required modification and did not provide required information to the receiving clinician.[1] These authors suggested a template for use in future referrals. The Division of Restorative Dentistry and Periodontology in the DDUH developed a proforma letter several years ago to assist practitioners referring patients for restorative and periodontal assessment or treatment. Proformas are hosted on the hospital website under the 'For Health Professionals' tab. Summary acceptance criteria and editable Word document versions of the proformas are provided (www.dentalhospital.ie/clinical-services).

Consultants triaging periodontology referrals noted that the proforma was not uniformly used and recounted multiple anecdotal episodes where significant relevant medical or treatment factors missing from referral letters were noted at time of initial assessment. Consequently, an audit was proposed to assess the quality and completeness of referrals to the periodontology department to identify any possible areas where the referral pathway could be improved for referring clinicians.

Aims

The aims of the audit were:

1. To assess the quality of external referrals to the DDUH periodontology department.
2. To identify how frequently the current referral proforma was used.
3. To establish if proforma use was associated with a higher quality of referral information.

Method

The standard of the audit was determined using the existing DDUH referral proforma for the Division of Restorative Dentistry and Periodontology to define the required information. This referral proforma requests 22 unique information points including patient details, referring practitioner details, and medical, dental and problem-specific content (**Figure 1**).

A pilot audit of 20 referral letters was undertaken to assess the data collection parameters. This was reviewed and minor adjustments made to these parameters. Thereafter, 150 external referrals to the DDUH periodontology department were assessed. Referrals were sampled at four-monthly intervals

Referral to Division of Restorative Dentistry and Periodontology

Date of Referral: _____

Referring clinician (qualification, address, telephone number)	
Patient Name Address Mobile phone number Date of Birth	
Reason for referral / patient complaint	
Preliminary Diagnosis	Periodontal Screening Record: ____/____/____ / / / Plaque Score: % Bleeding Score: % Comment:
Previous treatment provided & response	
Your treatment plan (RPD, FPD, implant)	
Relevant medical history	
Relevant social history (occupation, motivation, smoker/non smoker)	
Relevant family history	
Indicate suitable level of care	Undergraduate Postgraduate Consultant
Level of urgency of treatment	
Enclose copy of relevant radiographs	Yes No Radiographs will be copied and returned

FIGURE 1: Existing DDUH proforma.

(August 2019, January 2020, and May 2020) to provide a broad sample. Referrals were assessed individually from the start of the relevant month, with only internal referrals being excluded. Fifty consecutive external referrals were obtained from each of the selected months.

Individual information items did not need to be comprehensively completed to be classified as being provided. Where the referring practitioner placed a dash next to a required item on the proforma, it was inferred that the practitioner had determined there was no applicable information to add. Such items were classified as a completed response. If a required item was left blank with no comment, it was classified as incomplete.

Supplemental information was also gathered from the referrals to identify possible areas of improvement to the current referral pathway. This information included:

- type of referral (if not on proforma);
- financial reason for referral (if stated);
- type of radiograph enclosed (if any);
- age of patient at time of referral;
- location of referring practice; and,
- other miscellaneous information.

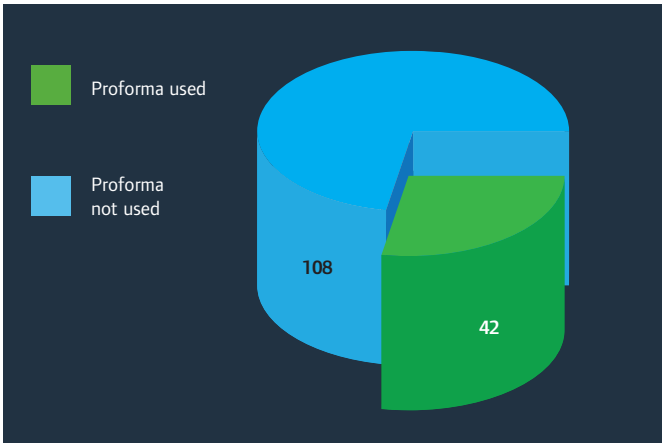

FIGURE 2(a): Frequency of appropriate proforma use.

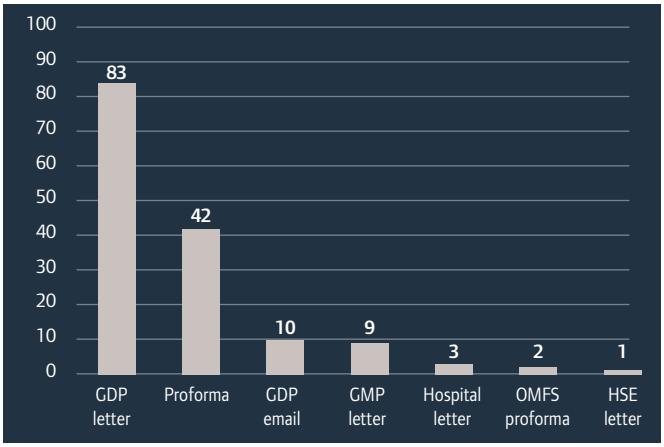

FIGURE 2(b): Type of external referral form utilised.

This information was gathered and inserted into a Microsoft Excel spreadsheet for analysis.

Finally, the current divisional proforma was compared to proforma referral forms used by 10 peer dental hospitals/NHS Trusts across Ireland and the UK to investigate if a similar level of detail is being sought from referring clinicians elsewhere. These proformas were accessed via hospital websites or direct correspondence, and were assessed for the 22 information points requested by the DDUH.

Results

Of the 150 external referrals assessed, 42 utilised the appropriate DDUH proforma. A wide variety of other types of referral was evident, with the most common being a handwritten letter on headed paper (n=83) (**Figure 2**). The referrals were analysed according to the 22 information points requested by the existing proforma (**Figure 3**). Referrals were initially assessed as an entire group (i.e., proforma and non-proforma referrals; n=150). When the entire cohort was assessed collectively it was demonstrated that the referrals contained an average of 59.2% of the required information items. Only three of the 150 referrals (2%) addressed all of the 22 information points. The most commonly omitted information was bleeding score (16.7% provided), plaque score (16% provided), and family history (14.7% provided).

Referrals were then grouped based on whether or not they used a proforma. When the non-proforma referrals (n=108) were assessed, it was discovered that they contained an average of 51.2% of the required information. The most commonly omitted information was bleeding score (3.7% provided), family history (2.8% provided, and plaque score (1.9% provided). No referral provided all of the required information.

When the proforma referrals (n=42) were assessed, an average of 79.9% of the required information was provided. The most commonly omitted information in such cases was bleeding score (50% provided), family history (46.2% provided), and referrer's qualification (41.5% provided). Three of the 42 proforma referrals (7.1%) were fully completed.

The majority (n=112) of the referrals were from the Dublin area, with the Dublin 6 area accounting for the highest number of referrals by locality (n=16). As expected, the neighbouring counties accounted for the majority of referrals outside Dublin, with Kildare (n=10) accounting for the most referrals outside Dublin. Three referrals did not contain the address of the referrer and one referral was from overseas (London, UK) (**Figure 4**).

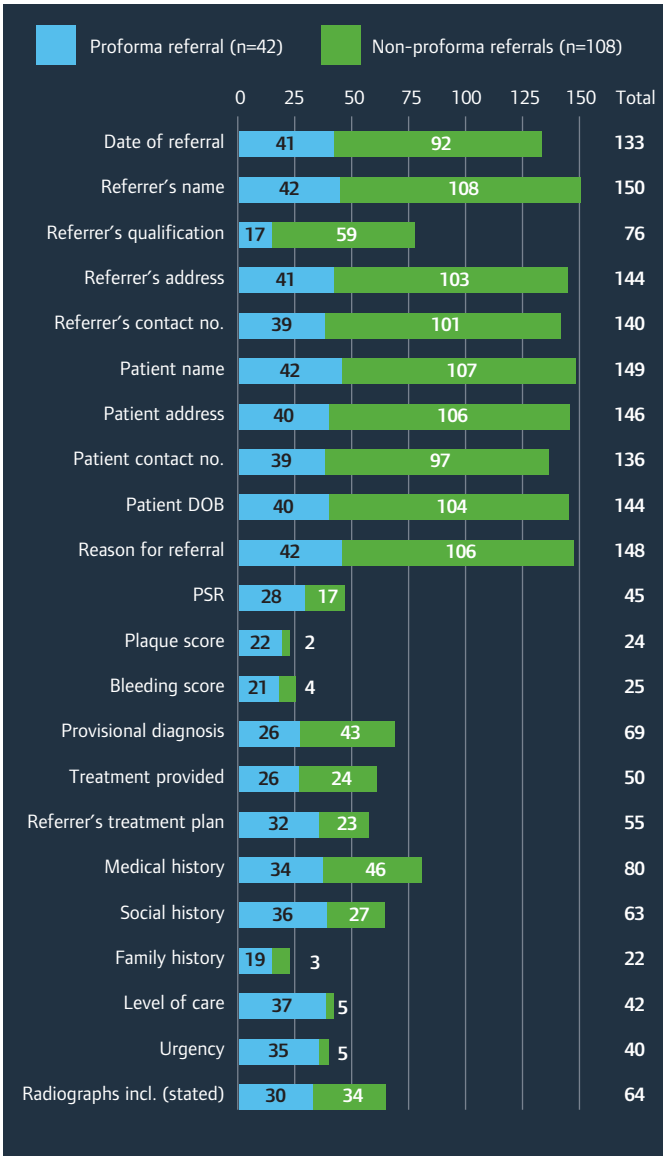

FIGURE 3: Referral analysis.

FIGURE 4(a): Dublin referral locations.

FIGURE 4(b): National referral locations.

The mean age of patients at time of referral to the service was 47 years (range 14-90 years). Six referrals failed to detail the patient's date of birth.

The current divisional proforma was compared to proforma referral forms used by 10 peer dental hospitals/NHS Trusts across Ireland and the UK (**Figure 5**); these included a mixture of periodontal, restorative department or hospital-wide proforma forms for referring practitioners. This comparison revealed that the DDUH is among a minority of institutions requesting certain information items, including referrer's qualification, plaque score and bleeding score. Seven of the 10 dental hospitals requested details of patient's general medical practitioner (GMP); this information item is not currently included on the DDUH proforma.

Discussion

The findings of this audit are consistent with the previously published literature on the topic.[1-10] Referral letters frequently failed to include expected information items with only three fully completed referrals (i.e., all 22 information points) identified, all of which utilised the referral proforma. The use of a standardised proforma serves to guide clinicians on items to include in their referral and has been shown to improve referral. This is reinforced in the current audit with proforma referrals on average providing an increased mean level of information compared non-proforma letters (79.9% vs 51.2% of items, respectively). However, despite the availability of the referral proforma on the DDUH website, fewer than one-third (28%) of referring practitioners utilised it for their referral.

A common finding in previous studies is the lack of medical history details being supplied by referrers,[1,2,9,10] and this feature was also evident in this

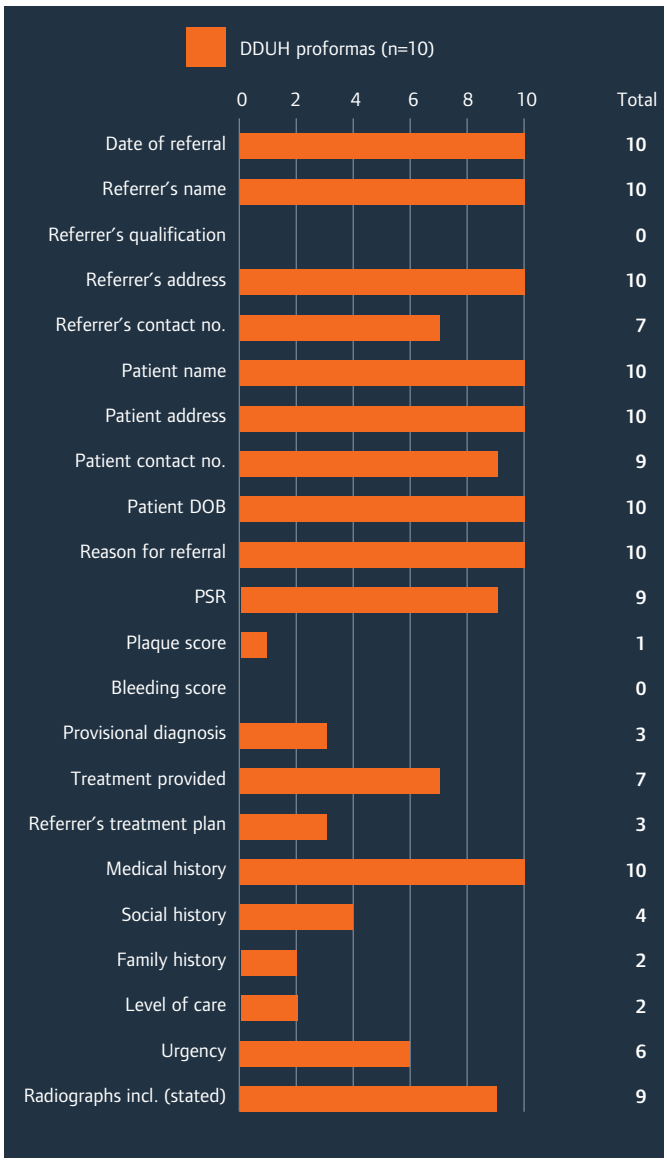

FIGURE 5: Comparison of DDUH proforma requested information against proformas from other dental institutions.

audit, wherein slightly over half (53%) of referrals included some comment on the patient's medical history. Detailed knowledge of a patient's medical condition is paramount when providing any dental care.[11]

Fewer than one-third of referrals included radiographs. Radiographic assessment is an important component in establishing individual patient diagnoses in practice,[18] and every effort should be made by the referring dentist to include any relevant previous radiographs in the referral in order to minimise patient exposure to radiation and conserve clinical resources.

A comparison of the DDUH proforma with those from 10 peer dental hospitals/NHS Trusts revealed that the DDUH is among a minority of institutions requesting referrer's qualification, and details of patient plaque and bleeding scores. However, while the DDUH does not currently request details of the patient's medical practitioner, seven of the 10 peer institutions request this information. Since it has been suggested that including GMP details in referrals is good practice,[1,2,10] this should be considered in future iterations of the DDUH referral proforma.

It must be recognised that patient opinions, practitioner-related factors and non-disease factors such as socioeconomic status and proximity to specialist services may affect the decisions of practitioners and patients regarding periodontal referral.[19,20] One-fifth of the patient referral letters to the periodontology department were referred from a county outside of Dublin. It can be inferred from this that a percentage of patients are travelling a significant distance to receive care at the DDUH. Since more detailed referral letters will allow more accurate triaging, this would in turn decrease the number of patients who are not accepted for care following their assessment appointment, which may be particularly important for patients who may have mobility issues or have to travel greater distances.

The practice of clinical audit represents a valuable opportunity to evaluate institutional practices and establish areas for possible service improvement. The findings of this audit have implications for clinicians and educators, and a number of measures can be recommended. In the short term, a divisional review of the existing proforma is in progress. Items of information such as plaque score or bleeding score – which are not requested by peer institutions – may be modified or removed; a comment on overall patient compliance with oral hygiene may be a simpler alternative. Staff may also wish to request GMP details on the proforma. At an institutional level, drafting referral criteria and circulating them to referring dentists has been shown to improve referral quality in restorative dentistry[8] and periodontology.[10] In the medium term, the authors strongly recommend that the DDUH provide guidance to referring general dental practitioners on both the information required by individual departments and to periodically highlight the availability of its referral proforma. Shaffie and Cheng[2] demonstrated a marked increase in referral quality following distribution of guidance letters to their most common referring general dental practices.

In the longer term, implementation of a mandatory online referral proforma system should be considered. This could be tailored to require referrers to complete all information before the referral is accepted for triage, as suggested by Björkeborn *et al*.[21] This would expedite the referral pathway and offer reduced environmental impact but would have additional implications for management of personal data. Re-audit following implementation of the appropriate changes will be indicated to evaluate their effect, as well as completing the audit cycle (**Figure 6**).

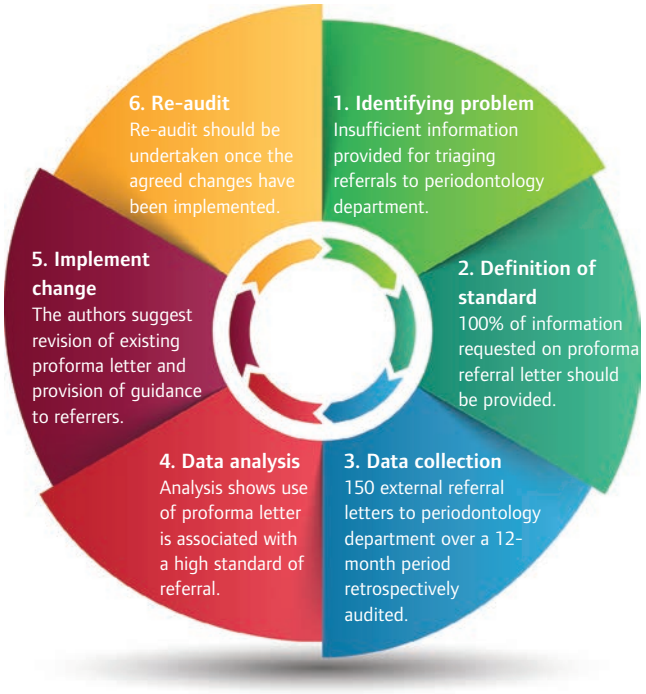

FIGURE 6: Audit cycle.

Conclusion

Many current referrals to the DDUH periodontology department are incomplete. Use of the current departmental referral proforma was associated with a marked increase in referral quality. A reduction in the number of information items requested from the referrer and the provision of education to referrers may enhance compliance with proforma use in the future.

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CPD questions

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

IDA irish dental association CPD

1. Why is it important to include any available radiographs when submitting a periodontal referral?

- ○ A: Facilitate making a diagnosis
- ○ B: Minimise need for further radiation exposure of the patient
- ○ C: Conserve clinical resources
- ○ D: All of the above

2. Overall, the most commonly omitted information seen in this audit was:

- ○ A: Bleeding score
- ○ B: Family history
- ○ C: Referrer's qualification
- ○ D: Medical history

3. The most common referral type seen in this audit was:

- ○ A: Referral proforma form
- ○ B: Handwritten letter
- ○ C: Email
- ○ D: Hospital referrals

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Costello Award abstracts

Students from Cork University Dental School and Hospital and the Dublin Dental University Hospital presented the following two abstracts at the IDA ASM 2022 for consideration for the Costello Award.

Cork University Dental School and Hospital

Should patients on long-term systemic steroid medication receive supplementary glucocorticoids or 'steroid cover' when undergoing certain dental treatments?

Ivanisevic, O., Smeenk, G., Brady, P.

Background: Glucocorticoids are a popular class of drug prescribed for a variety of autoimmune and inflammatory diseases. Long-term glucocorticoid therapy can result in adrenal gland atrophy, leading to an inadequate release of endogenous adrenocortical hormones in response to stress, and may progress to a potentially life-threatening adrenal crisis. Despite the rarity of adrenal crises, there are documented incidences precipitated by dental treatment. Pre-operative steroid cover is recommended to prevent adrenal crisis; however, most guidelines proposed are found within the contexts of medical literature. There lacks a metric for categorising what is considered a stressful enough procedure to warrant supplementation of steroids in dentistry.

Aim: to investigate the relative need for prophylactic glucocorticoid supplementation prior to dental treatments in patients on long-term glucocorticoid treatment.

Methods: The PubMed, Cochrane Library and Web of Science databases were searched for literature published between 2000 and 2022. Randomised controlled trials, systematic reviews, meta-analyses, cohort studies and cross-sectional studies were included, while *in-vitro* studies were excluded. From 940 sources identified, 20 were included in the review after screening.

Results: Based on the current literature, patients on long-term glucocorticoid medication do not require routine steroid cover for restorative dental procedures under local anaesthesia.
Generally, patients taking low-dose long-term glucocorticoids (less than 7.5mg prednisolone/day) should not require steroid cover with minor surgical procedures under local anaesthetic. However, patients taking higher-dose long-term glucocorticoids should double their dose the day of minor surgical procedures under local anaesthetic. It is suggested that for minor surgical procedures under general anaesthetic, a 100mg intramuscular dose of hydrocortisone should be supplemented in addition to their regular daily dose. Finally, patients undergoing major surgery under general anaesthetic require a pre-operative 100mg bolus dose of hydrocortisone followed by 50mg every eight hours for 48 hours after the procedure.

Conclusion: Dentists may take comfort in knowing that patients on long-term glucocorticoids do not require pre-procedural management for routine dental work under local anaesthetic. Dentists should still be wary of the signs of adrenal crisis and consult the patient's prescribing physician about any concerns prior to commencing treatment.

Dublin Dental University Hospital

Environmental sustainability policies in healthcare: a global qualitative review of policy content and production

Price, C., Ademaj, D.

Background: Climate change is an increasing threat to humanity. The healthcare sector produces more than 4% of global carbon emissions. So far, little work has been done to increase the environmental sustainability of healthcare delivery. When action has been taken, it has been mostly aspirational in nature and inconsistent in its approach and goals.

Aim: To determine if, when and where environmental scans of environmental sustainability policies have been published. To investigate the types and content of published sustainability policies, the likelihood of successful policy implementation, and their applicability to improving sustainability in Irish dentistry.

Methods: Two research databases were searched (Medline and Scopus) for previously published scans. A Google search of grey literature from 59 English-speaking countries and key organisations was performed to identify policy documents and included policies underwent thematic analysis.

Results: No previously published environmental scans were found in the databases. A total of 106 policy documents were identified. Several key sustainability themes were identified including: travel; building standards; waste prevention; staff awareness; and, changing models of care. Most of the policies were produced by State organisations or regulatory groups in developed countries.

Conclusion: The approach in high-income countries to developing and implementing environmental sustainability frameworks has been piecemeal and inconsistent. Where success has occurred, it has been driven by legislation or by altering financial incentives. Policy design should be guided by centres of global expertise with increased emphasis on disease prevention.

Topical fluoride effectiveness in high-caries-risk adults

Jurasic, M.M., Gibson, G., Orner, M.B., Wehler, C.J., Jones, J.A., Cabral, H.J.

Abstract

This retrospective analysis of longitudinal data was developed to determine which types, combinations, and intensities of topical fluorides more effectively prevent new caries-related restorations and extractions in high-caries-risk adults. We included data from October 1, 2008, through June 30, 2018, from the electronic dental and medical records and pharmacy database of the US Department of Veterans Affairs. Veterans who were eligible for continuing and comprehensive care, met the criteria of high caries risk (received two or more caries-related restorations within a 365-day period), and had three years of follow-up, were included. Multivariable logistic regression models estimated the odds of caries-related treatment during the one-year observation period, controlling for age, gender, race and ethnicity, illness burden (Selim comorbidity index), use of prescription medications, attendance at dental prophylaxis appointments, number of caries-related restorations during the index year, and time between first and last caries-related restoration during the index year. The study sample included 68,757 veterans, who were primarily male (91.5%), white (73.6%), had a mean age of 59.2 ± 13.5 years, and had significant medical comorbidity as measured by the Selim index (3.7 ± 2.4 physical and 1.3 ± 1.2 mental diagnoses). They had 10.8 ± 6.3 prescription VA drug classes, took 0.6 ± 0.8 strong anticholinergic medications, and had 3.9 ± 2.6 teeth restored due to caries during the index year. Adjusted multivariable logistic regression models showed that veterans who received a varnish or gel/rinse fluoride intervention versus no fluoride had approximately 29% decreased odds of receiving caries-related treatment during the observation period (gel/rinse adjusted odds ratio [AOR] = 0.72; 95% confidence interval [CI], 0.67-0.76; varnish AOR = 0.71; 95% CI, 0.67-0.75). The receipt of a varnish and gel/rinse did not demonstrate statistically better odds than each intervention alone (AOR = 0.69; 95% CI, 0.64-0.75). A dose-response effect was observed. Two-plus applications of varnish versus none (AOR = 0.73; 95% CI, 0.69-0.77) and two-plus applications of gel/rinse versus none (AOR = 0.71; 95% CI, 0.67-0.75) were more effective than one application of either modality versus none.

Journal of Dental Research 2022; 101 (8): 898-904.

Quiz answers

Questions on page 172

1.

New cases of head and neck cancer, including all sites, collectively accounted for what percentage of all cancer cases worldwide in 2018 (Bosetti *et al.*, 2020)?

Correct answer: 3.8%

2.

In Ireland, what is the most common age group for head and neck cancer (NCRI, 2018)?

Correct answer: 55+ years of age

3.

What percentage of Irish 65+ year-old edentulous individuals "occasionally or never" visit a dentist (National Survey of Adult Dental Health, 2007)?

Correct answer: 80-100%

4.

A survey on the first Mouth Cancer Awareness Day in Ireland (MacCarthy, D., *et al.*, *JIDA* 2012) revealed that 94% of respondents had never received any information about mouth head and neck cancer. What are the most common modifiable risk factors for mouth head and neck cancer?

Correct answer: Alcohol consumption and tobacco use

ABSTRACTS

Cancer vaccines: building a bridge over troubled waters.

Sellars, M.C., Wu, C.J., Fritsch, E.F.

Abstract

Cancer vaccines aim to direct the immune system to eradicate cancer cells. Here we review the essential immunologic concepts underpinning natural immunity and highlight the multiple unique challenges faced by vaccines targeting cancer. Recent technological advances in mass spectrometry, neo-antigen prediction, genetically and pharmacologically engineered mouse models, and single-cell omics have revealed new biology, which can help to bridge this divide. We particularly focus on translationally relevant aspects, such as antigen selection and delivery, and the monitoring of human post-vaccination responses, and encourage more aggressive exploration of novel approaches.

Cell 2022; 8: S0092-8674(22)00787-5. Epub ahead of print. PMID: 35835100.

Chronic exercise preserves lean muscle mass in masters athletes

Wroblewski, A.P., Amati, F., Smiley, M.A., Goodpaster, B., Wright, V.

Abstract

Ageing is commonly associated with a loss of muscle mass and strength, resulting in falls, functional decline, and the subjective feeling of weakness. Exercise modulates the morbidities of muscle ageing. Most studies, however, have examined muscle loss changes in sedentary ageing adults. This leaves the question of whether the changes that are commonly associated with muscle ageing reflect the true physiology of muscle ageing, or whether they reflect disuse atrophy. This study evaluated whether high levels of chronic exercise prevent the loss of lean muscle mass and strength experienced in sedentary ageing adults. A cross-section of 40 high-level recreational athletes ("masters athletes") who were aged 40 to 81 years and trained four to five times per week underwent tests of health/activity, body composition, quadriceps peak torque (PT), and magnetic resonance imaging (MRI) of bilateral quadriceps. Mid-thigh muscle area, quadriceps area (QA), subcutaneous adipose tissue, and intramuscular adipose tissue were quantified in MRI using medical image processing, analysis, and visualisation software. One-way analysis of variance was used to examine age group differences. Relationships were evaluated using Spearman correlations. Mid-thigh muscle area (P = 0.31) and lean mass (P = 0.15) did not increase with age and were significantly related to retention of mid-thigh muscle area (P < 0.0001). This occurred despite an increase in total body fat percentage (P = 0.003) with age. Mid-thigh muscle area (P = 0.12), QA (P = 0.17), and quadriceps PT did not decline with age. Specific strength (strength per QA) did not decline significantly with age (P = 0.06). As muscle area increased, PT increased significantly (P = 0.008). There was not a significant relationship between intramuscular adipose tissue (P = 0.71) or lean mass (P = 0.4) and PT. This study contradicts the common observation that muscle mass and strength decline as a function of aging alone. Instead, these declines may signal the effect of chronic disuse rather than muscle ageing. Evaluation of masters athletes removes disuse as a confounding variable in the study of lower-extremity function and loss of lean muscle mass. This maintenance of muscle mass and strength may decrease or eliminate the falls, functional decline, and loss of independence that are commonly seen in ageing adults.

The Physician and Sportsmedicine 2011; 39 (3): 172-178.

Effectiveness of a chairside acrylic adjustment cabinet in reducing dental acrylic debris and aerosols

Srivastava, A., Andersen, M.R., Alshehri, A.M., Lara, B., Bashiri, R., Li, G., et al.

Abstract

Purpose: Chairside prosthesis adjustment procedures generate contaminated acrylic particle debris that include visible splatter (particles >50μm), as well as invisible aerosols (<50μm). The purpose of this study was to evaluate the effectiveness of a chairside acrylic adjustment cabinet (CAAC) in reducing airborne aerosol particles (<10μm) and visible acrylic debris, time required for airborne aerosols to return to baseline levels after an acrylic adjustment procedure, and the effect on operatory turnover time.

Materials and methods: A total of 40 acrylic adjustment procedures were carried out in a simulated setting with (experiment) and without (control) a CAAC. Standardised acrylic samples of self-polymerised, and heat-polymerised polymethylmethacrylate resins, Triad and Fastray custom tray materials were evaluated. Airborne aerosol measurements were done using a handheld laser particle counter for absolute particle counts of sizes 0.3, 0.5, 1.0, 2.5, 5.0, and 10.0μm before, during, and immediately after adjustment, and 10 minutes post adjustment. Spread of aerosols was assessed at three distinct locations within the dental operatory specific to the provider, the patient, and the caregiver/guest. Visible acrylic debris and operatory turnover time were evaluated immediately post adjustments by a blinded investigator. Repeated measures ANOVA was used to estimate group effect, time effect and interaction between group and time for air particle analysis. Independent sample T-tests were used for group differences between operatory turnover time, and time for aerosols to return to baseline. Chi-square test was used for visible surface analysis.

Results: In the control group, total aerosol particle counts increased from 6,542.7 ± 162.6 particles at baseline to 598,378.7 ± 586,363.2 and 367,569.9 ± 432,220.8 particles during and immediately post adjustment, respectively. Adjustments made in the experiment group led to significantly reduced aerosol counts during (97,738.9 ± 97,866.5) and immediately post adjustment (19,786.5 ± 14,004.9; F = 17.8, p = 0.006). Similar trends were noted for the patient and guest positions. Time for aerosol particles to return to baseline was significantly lower in the experiment group (20.56 ± 14.5 minutes) compared to the control group (37.9 ± 31.96 minutes; p = 0.03). Visible acrylic debris analysis showed a significant decrease of 78% in the experiment group (p < 0.001). No significant differences were noted in operatory turnover time between the two groups (p = 0.61).

Conclusions: Acrylic adjustment procedures generated aerosols of particle sizes less than 10μm and were measured in significant quantities throughout the dental operatory for up to 115 minutes. Chairside acrylic adjustment cabinets significantly decreased airborne aerosols, visible acrylic particle debris, and reduced the time for airborne aerosols to return to baseline levels.

Journal of Prosthodontics 2022; 31 (6): 488-495.

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Full-time dental associate required in Wicklow Town to cover maternity leave. Commencing September for six months. Excellent support staff, private and PRSI only. Contact wicklowdentist@hotmail.com.

Full-time dental associate required for busy dental clinic in Dublin 12 to replace colleague returned to postgrad training. Modern, computerised surgery, OPG and Cerec. Basic endo and prostho experience required. 50/50 split. Contact info@cleardentalcare.ie.

Part-time associate position two to three days/week in a busy, modern two-surgery practice in Co. Laois serving a large area. Competitive remuneration for the right candidate. Good support, intra-oral scanner, OPG, computerised. Private, PRSI. Contact neil@orthodental.ie.

Enthusiastic associate required two to three days a week with scope to increase in Kilkenny City. New graduates welcome. Modern, dynamic, fully digital, computerised, friendly, independent practice with OPG, rotary endo, hygienist, Invisalign, facial aesthetics. Excellent terms, support, earning potential. Contact dentistkilk22@gmail.com.

Dublin 4 (Ballsbridge). Opportunity to earn up to 45% of patient fees. Monday/Wednesday/Friday sessions available. Come and join our team at Ailesbury Dental Practice – www.dublindentist.ie. CVs to owensroger@hotmail.com.

Dental associate required for a busy dental practice in Dublin 5. Flexible hours. Please send CV to northcitydental@gmail.com.

Associate wanted for modern, private practice 40 minutes north of Galway City. Would suit an enthusiastic young dentist looking to broaden skills. Mentorship support provided. Contact obeirne1@hotmail.com.

Full-time associate required. July start in Limerick City. Expanding modern clinic from an established practice. Hygienist, implant, restorative, orthodontic and general dentistry. Mentorship from clinicians with 15-35 years' experience. Very competitive percentage-based remuneration. Two years' experience required. Contact info@murphydentalcare.ie.

Enthusiastic associate required for progressive Douglas practice. Supportive principal and excellent ancillary staff. Successful candidate must be committed to continued professional development and enjoy working as part of a team. CVs please to sjjcurtin@gmail.com.

DSD seeking associate dentist to join our modern and vibrant team of 50+ people. CBCT, intra-oral scanners, specialist dentistry. Candidate must have two+ years of experience and genuine passion for dentistry. Excellent remuneration. Nine chairs. Fully private. Contact jobs@damestreetdental.ie.

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

Dental associate required in north Dublin for weekend work. Fully private practice, digital scanner, digital radiographs, excellent support staff. Excellent remuneration. 15 minutes' drive from city centre. CV to dublindentistjob@gmail.com.

Dental associate required two days/week for busy practice in east Cork. 9-5. On-site lab. Five-chair practice. Three hygienists. OPG. Excellent support. Private practice. Contact carmel@corabbeydentalclinic.ie.

Established family practice seeks part-time dental associate (three days/week), Co. Kildare. PRSI and private. Excellent support staff, accessible location, computerised, modern. Contact kilcockdental@gmail.com.

Part-time associates required in Bray (two to three days) and Ongar, D15 (two to three days). Alternatively, full-time associate working both practices. Very busy, 50% remuneration, excellent staff. Please send CV to Jonathandentalfisher@outlook.com or call 087-055 2625 for further info.

Enthusiastic associate required four to five days a week in a three-surgery clinic that is planning to expand further. Modern practice with a warm, friendly staff. Fully digital and computerised. Rotary endodontics, Invisalign, facial aesthetics. Excellent terms, support. Email willrymer@expressionsclinic.com.

Associate required for well-established, modern practice close to Galway City.

Classified advertisements are accepted via the IDA website – www.dentist.ie – only, and must be pre-paid. The deadline for receipt of advertisements for inclusion in the next edition is **Friday, September 16, 2022.** Classified ads placed in the *Journal* are also published on 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.

Excellent support staff and mentoring principal. New graduates welcome. Excellent opportunity for a well-motivated and caring dentist. Four-day working week for an ideal work/life balance. Email cathalmangan70@gmail.com.

Friendly associate dentist required two to three days a week in a city centre clinic. To take over a full book from a departing colleague. We provide orthodontics and family dentistry. Welcoming, private-only practice with a great patient pool. Email hello@plazahealth.ie.

Two full-time dental associate positions available in Dublin City Centre near Stephen's Green at Camden Dental Clinic. These are existing, busy roles that would suit new or experienced graduates. Computerised and modern with excellent support staff. Email dublincitydentistry@gmail.com.

Dublin 4. Experienced associate with long-term view required. Replacing departing colleague. Three to four days. Private, modern practice. Expect €11-12k/month. Hygienist service. CV and portfolio. Email owensroger@hotmail.com.

Dental associate required to replace departing colleague with full book in practice established over 30 years ago. Fully digitised, modern equipment, full time. Email sysakroman@gmail.com.

Full-time general associate required to replace a departing colleague. Private practice with implants, endo, ortho, CBCT, 3D printing, etc. Mentoring component offered. Ideally two years'+ experience, but not essential given the right candidate. Email careers@deansgrangedental.ie.

Co. Meath. Exciting opportunity to join our growing multidisciplinary team of dentists, hygienists and specialists. Established patient list. Locum or permanent position available, excellent support team. Easy commute from Dundalk, Drogheda, Newry, Cavan. Accommodation available. CV in strictest confidence. Email associatedental12@gmail.com.

Wexford Town. Part-time associate. Modern clinic with full book and excellent support team. Relaxed and friendly working environment. Email ailbhelouisemurphy@gmail.com.

Full-time dental associate required for fully private and busy north Dublin dental practice. Digital scanner, digital radiographs and excellent support staff. Excellent remuneration. 10 minutes' drive from city centre. Contact northdublindentalassociate@gmail.com.

Dental associate position available in a busy Mallow practice, 30 minutes from Cork City. Fully computerised with good support staff. Contact mallowdentist@gmail.com.

OC Dental, Gorey, north Wexford, an hour from the M50, is a modern busy, friendly practice looking for an associate two to four days weekly. Private/PRSI. RA, IV, facial aesthetics, hygienist. OPG, Invisalign providers. Visiting implantologist. Great team! Contact eleanor@ocdental.ie.

Associate required to replace emigrating associate with strong established book in our Maynooth clinic. An interest in prosthodontics and digital workflow desirable. Knowledge of facial aesthetics is advantageous. Team player with excellent customer service required. Please email CV to john@dentalhouse.ie.

Associate dentist required in a busy, private dental practice in Tralee, Co. Kerry. Two to three days per week. Apply with CV to info@flynnsdentalcare.ie.

Friendly associate dentist required two to three days per week for well-established practice in north Dublin. High earning opportunity. Email CV to Dublinsmilecenter@gmail.com.

Associate required to replace emigrating associate with strong established book in our modern clinic in Cavan town. Apply by CV to churchstdental@gmail.com.

Part/full-time associate position in busy, modern, four-surgery practice in Carlow. Excellent remuneration, immediate start, IOX, OPG, CBCT. Email: info@dentalsuite.ie.

Galway City. Associate required to replace departing colleague. Lovely working environment, competitive remuneration, busy practice, hours flexible for right candidate. Contact dentalpositiongalway@gmail.com.

Enthusiastic associate required two to four days a week with scope to increase in Kilkenny. New graduates welcome. Modern, dynamic, fully digital, computerised, friendly practice with OPG, rotary endo, hygienist, facial aesthetics, Invisalign. Excellent terms, support, earning potential. Email dentistkilk22@gmail.com.

Bowe Dental Clinic: associate dentists required in busy, private practice in Limerick. Full-and part-time positions with immediate start. Competitive remuneration. Established patient lists, OPG, CBCT, 3Shape 3D, fully digital. Experienced support team, friendly atmosphere, and excellent earning potential. Contact eamonn@bowedentalclinic.ie.

Full/part-time associate required to replace departing colleague. Busy, multi-surgery, private practice. Computerised, digital X-rays, intra-oral scanner. Friendly support staff. Mentoring available for new grad. Good remuneration. Sunny south east! Email info@rogersdental.ie.

South Co. Dublin. Associate wanted for two to three days with potential to expand in busy, fully digital, computerised practice. Hygienist, Invisalign, great back-up, lovely working environment. Contact dentalassoc993@gmail.com.

Dental associate required September 7-28, 2022 inclusive, Monday-Wednesday. General practice in D24 close to M50. Please forward CV/letter to Wendy at wmunroe@eircom.net.

Dr Paul O'Boyle seeks associate dentist for full-time temporary position (maternity leave) November to April. Great opportunity for future permanent roles. Details at https://1drv.ms/p/s!Au2G9pTl1owEvSl11YyoliXaGsYt?e=L8XSBS or email poboyleriverside@gmail.com.

Dentists

Portobello Dental Clinic is looking for a full-time dentist (minimum three years' experience) to replace a departing colleague. Focus is on high-quality general dentistry, with visiting orthodontic, endodontic and oral surgery practitioners. Primescan and iTero. Email helen@portobellodental.com.

Full/part-time dentist required for a busy practice in Arklow, Co. Wicklow. Practice is fully computerised. Highly supportive team. Excellent earning potential. Average earnings of 14k/month. Email CV to annedental@hotmail.co.uk or call 086-398 8981.

Dentist to take over a full patient book. Modern clinic, pleasant environment, strong and helpful support team. We are long established with computerised system, scanner, OPG, etc., and with tremendous earning potential. Please email your CV to office@centraldentalclinic.ie.

DentalSuite Carlow is looking for experienced dentist. Mainly private/PRSI/GMS. Excellent earning potential. Full- or part-time available. Email info@dentalsuite.ie.

Dental Care Ireland – opportunities for graduate dentists across our network of practices. Supported by our experienced, friendly clinical teams. Established, modern practices, opportunities to work in supportive and collegiate environments, broad variety of treatments. Contact careers@dentalcareireland.ie.

Dentist required for busy, modern, private practice in north Dublin. State-of-the-art equipment with digital scanner and radiographs. Position suits an enthusiastic associate who wishes to develop with a supportive team. Excellent earning potential. Hygienist support available. Contact dublindentistjob@gmail.com.

Dentist required to take over full book, part/full-time. Modern surgeries, excellent staff. Implants, rotary endo, intraoral scanner, facial aesthetics and general dentistry. Contact info@castleislanddental.ie.

Informal enquiries: Dr Siobhan Doherty, principal dental surgeon, Tel: 087-662 4795, Email: siobhan.doherty1@hse.ie; Dr Catriona Roe, Tel: 086-380 5367, Email: Catriona.roe@hse.ie. Closing date: 12 noon, Thursday, June 16, 2022. www.hse.ie/eng/jobs

Dentist required for our busy, modern practice in Cavan town. Immediate start and full book. Supported by experienced and friendly team. Apply by CV to churchstdental@gmail.com.

We invite an experienced dentist to join our team. Progressive, private, non-corporate two-surgery practice in Drogheda. One to two days/week. Well-equipped. Recent substantial investment in technology upgrades. All digital workflow. Excellent supportive staff. Email CV to angelamkearney@gmail.com.

Full-time dentist required for Wicklow practice only 30 minutes south of Dublin. Support and mentoring available for new graduates. Private and PRSI patients only with 50% remuneration. Contact gardencountydental@gmail.com.

Dentist required to take over full book part-full-time for long-established, computerised dental practice in Co. Kildare. Private/PRSI with hygienist. Preferable basic endo. Immediate start. Please email CV to loretodentalsurgery@gmail.com.

New graduate dentists – Smiles Dental is hiring! We have exciting opportunities available for newly qualified dentists looking for their first practice role. We can offer well-established lists, full- or part-time, and great earning potential! Contact sophie.collier@bupadentalcare.co.uk.

General dentist, Limerick – Smiles Dental is looking for an enthusiastic dentist to join our well-established, high-earning practice in Limerick. We can offer full or part time, a well-managed, busy diary, and great practice staff support. Contact sophie.collier@bupadentalcare.co.uk.

General dentists – Smiles Dental is looking for dentists across Ireland to join its fully private, well-equipped practices. We have opportunities across various locations, offers up to five days per week, established patient book, high earnings! Contact sophie.collier@bupadentalcare.co.uk.

Are you a newly qualified dentist looking for their first practice role? We are based in

Dublin 13, approximately 15 minutes from the city centre and offer private lists, full- or part-time hours, mentoring and great earning potential! CV to dublindentistjob@gmail.com.

Full-time dentist required for a busy Limerick City practice starting January/February 2023. Please send CVs to karendentalsurgery@gmail.com.

Dental Care Ireland Meath – we have a new high-earning opportunity, offering a strong, established book within our modern computerised practice now available. Fully supported by our friendly and skilled team. This is due to exciting company growth. Contact careers@dentalcareireland.ie.

Dentist required for busy D9/D11 practice. Two days per week. Well remunerated. Flexible working hours. Computerised, long-established family practice. Email CV to dublin11dental@gmail.com.

Dentist position available part time to take over full book from departing colleague. Days flexible. No medical card. Hygienist service. Digital and computerised. Recently renovated surgery. Full support staff. Gorey, Co. Wexford. Can offer employee or self-employed. Email info@thebridgedentalsurgery.ie.

Long-established, busy, digitalised practice in Dublin 22 looking for a full-time, committed dentist to join our team. Email CV to practicemanager221@gmail.com.

Naas, Co. Kildare. Full- or part-time associate required to replace departing colleague. Fully digitised, CBCT, Cerec, microscope. Replies (with CV) to james@theclinicnaas.ie.

Part-time dentist needed in fully private, modern clinic in Clane, 40 minutes from Dublin city centre. Invisalign full training provided. Excellent support staff. Email louise@clearbraces.ie.

Amazing opportunity available for a full-time general dentist, orthodontist two days and an oral surgeon one to two days a week to join our team. The practice is extremely busy in the heart of Limerick City. Fully computerised and digital practice. Email nikki@3dental.ie.

Co. Meath. Locum or long-term opportunity to take over a strong, well-established list from departing colleague. Position available July. Great location: 55 minutes from Dublin, 80 minutes from Belfast, 40 minutes from Newry. Accommodation can be provided. High demand for cosmetic dentistry, prosthodontics, Invisalign, bonding. Email associatedental12@gmail.com.

Part/full-time dentist required for fully private, busy, friendly practice in Limerick. Computerised, digital X-rays, etc. Excellent supportive staff. Excellent remuneration, Ideally three years'+ experience. Email CV to wallacedentalclinic@gmail.com.

We require general dental practitioners to join our growing clinics in Limerick, Roscrea and Blackrock. Please express your interest to our HR department by contacting alison.stubbins@shieldsdentalclinic.ie.

Shields Dental and Implant Clinics in Roscrea and Limerick are looking for a general dentist with Invisalign experience to join our expanding team. Please express your interest to our HR department by contacting alison.stubbins@shieldsdentalclinic.ie.

If you are looking for an exciting career change where no two days are the same, please contact us here at The Fresh Breath Clinic at tfbc16@gmail.com.

Looking for an enthusiastic, experienced (three+ years) dentist to join our team. Ideally three to four days per week. Very busy, established book and lovely team. Reply with CV to cirociao4@gmail.com.

Full-time dentist required for busy dental office in Swords. Fully digitised practice. Invisalign training available. Ongoing support from principal dentist. New graduates welcome. Currently two dentists at practice. Contact practicemanager@oneilldentalcare.ie.

Dentist required for our busy, fully private practice in Sligo. State-of-the-art equipment with full digitalisation. Position suits enthusiastic associate who wishes to develop within a progressive team. Excellent remuneration. Immediate start. Full/part-time. Contact hello@winestreetdental.com.

Cork City. Dentist needed to join our busy and long-established practice. Full- or part-time available. Also, locum dentist required. Please email gwalsh3000@gmail.com.

Locums

Locum required two days per week for the weeks starting July 11 and July 18 in north Co. Dublin practice. Please phone 086-821 8898.

General dentist required for maternity locum, three days per week, start August 2022. Busy, modern, family practice with excellent support. Private/PRSI. North Co. Dublin. Email pdsvacancy@gmail.com.

Locum required for three months (July-September 2022) in beautiful Co. Clare. Four days per week, excellent remuneration and generous travel/accommodation allowance in a busy, modern multi-surgery practice in Ennis. Excellent staff, great support. Contact gbrowne.ennis@gmail.com.

Co. Meath. Locum or long-term opportunity to take over a strong, well-established list from departing colleague. Position available July. Great location: 55 minutes from Dublin, 80 minutes from Belfast, 40 minutes from Newry. Accommodation can be provided. High demand for cosmetic dentistry, prosthodontics, Invisalign, bonding. Email associatedental12@gmail.com.

Part-time locum required for July and first week in August in Ongar village. Two-and-a-half days per week available. 50% remuneration. Busy practice, excellent staff. Please send CV to ongar.dental@gmail.com or call 087-055 2625 for further info.

Independent, established, fully computerised practice, digital X-rays/OPG and good remuneration. Two years'+ experience, for locum dentist with view to part/full-time position, in a relaxed, bright, spacious environment. Friendly atmosphere, with excellent staff and two hygienists. Contact reception@castlemilldental.ie.

Dr Paul O'Boyle seeks associate dentist for full-time temporary position (maternity leave) November to April. Great opportunity for future permanent roles. Details at https://1drv.ms/p/s!Au2G9pTl1owEvSl11YyoliXaGsYt?e=L8XSBS or email poboyleriverside@gmail.com.

Locum dental hygienist required for four to five months' maternity cover for state-of-the-art dental practice in Dublin 4. Extremely busy, established book. Highly competitive salary. Commencement date mid June 2022. Contact office@pembrokedentist.ie.

Locum hygienist required. Immediate start with view to ongoing position. Excellent remuneration – €55 per hour. Fantastic team and facilities. Contact begleycaitriona@yahoo.ie.

Specialists/limited practice

Part-time orthodontist required for a busy dental practice in Dublin 5. Flexible hours. Please send CV to northcitydental@gmail.com.

Part-time orthodontist required for very busy, fully private dental practice in Dublin 13, approximately 15 minutes from city centre. Flexible hours. Please send CV to dublindentistjob@gmail.com.

Part-time oral surgeon required to join existing team. Busy list. Ultra-modern clinic. Two days per week. Great remuneration. www.kingdomclinic.ie. Email tomas.allen@kingdomclinic.ie.

Specialist or dentist with special interest? Want to join an ultra-modern specialist clinic? Contact us today. www.kingdomclinic.ie. Email tomas.allen@kingdomclinic.ie.

Part-time orthodontist required to join a private practice to replace a departing orthodontist. Initially one day a week with an ample opportunity to increase. Intra-oral scanner, OPG, CBCT, on-site lab. Experienced orthodontic nurse. Email careers@deansgrangedental.ie.

Amazing opportunity available for a full-time general dentist, orthodontist two days and an oral surgeon one to two days a week to join our team. The practice is extremely busy in the heart of Limerick City. Fully computerised and digital practice. Email nikki@3dental.ie.

Part-time orthodontist required for new, modern dental clinic on the main street in Naas, part of a dental group. Contact info@dentalsuite.ie.

Shields Dental & Implant Clinic now has openings for the following positions: paediatric dentist, periodontist, orthodontist, prosthodontist, implant clinician and oral surgeon. Please express your interest to the HR department by contacting alison.stubbins@shieldsdentalclinic.ie.

Rare opportunity for specialists/dentists in limited practice (endo/perio/oral surgery/other) to join soon-to-open referral practice in Wilton, Cork. Part time. As associate, or even expense sharing partnership a possibility! Contact corkcitydental2022@gmail.com.

Orthodontist required to join our busy, modern group of private practices based in Kildare, Westmeath, Meath and Offaly. Full-time position available. Intra-oral scanner, OPG, CBCT, on-site lab. Experienced orthodontic nursing team. Great earning potential. Contact deirdre@thejamesclinic.com.

Dental nurses/receptionists/managers

Full-time dental nurse position available on the Tuam Road in Galway City. Modern, well-equipped general practice with a relaxed, friendly work environment. Monday to Friday. Please email CV to reception@kierandavittdental.ie.

Qualified dental nurse for vacancy in busy, friendly dental practice off M50 with free parking. We are a modern, computerised, digital practice. Excellent working atmosphere with emphasis on a team-based approach. Very competitive remuneration for the right candidate. Contact info@woodstowndental.ie.

Practice manager, Dublin 7. Team leader, staff management, recruitment, develop policies and procedures, regulatory work, reception/admin, infection control, accountability (nursing experience preferred), stock control. Email onemanorplace@gmail.com to apply, for more information or informal enquiries.

We are looking for an enthusiastic, well-organised nurse who can adapt to a fast-

paced environment within our specialist clinic. You must have experience as a nurse and in particular implants and periodontal treatment would be advantageous. Email periosolutions16@gmail.com.

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

Full-time dental nurse wanted for busy Cork City orthodontic practice. Experience in orthodontics an advantage but not essential. Modern practice utilising the latest techniques and technology, and a friendly, team-based atmosphere. Very competitive remuneration for the right candidate. Contact Info@corkclinicorthodontics.com.

Qualified dental nurse for full-time role on paediatric team in Citygate Specialist Dental Clinic and The Bon Secours Hospital, Cork. Passion for working with children essential. Reply with full CV noting dental nursing qualification to paediatric@citygatedental.ie.

Hygienists

Locum dental hygienist required for four to five months' maternity cover for state-of-the-art dental practice in Dublin 4. Extremely busy, established book. Highly competitive salary. Commencement date mid June 2022. Contact office@pembrokedentist.ie.

Full-time dental hygienist required for busy, well-established practice in west Dublin. Full book and very supportive team. Apply to mckeon.mcaleese@gmail.com.

Locum hygienist required. Immediate start with view to ongoing position. Excellent remuneration – €55 per hour. Fantastic team and facilities. Contact begleycaitriona@yahoo.ie.

Hygienist position, Bride Place Dental, Wexford Town. One to two days per week. Excellent terms, full book, friendly and supportive team. Contact ailbhelouisemurphy@gmail.com.

We are looking for a hygienist one to two days per week to join our long-established Maynooth clinic. Great opportunities for the right candidate to join our team. Excellent rates available. Contact john@dentalhouse.ie.

Dental hygienist required for busy, private dental practice in north Dublin. One to two days a week. 15 minutes' drive from city centre. Excellent remuneration. CV to dublindentistjob@gmail.com.

Part-time hygienist position available immediately for experienced/new grad, Co. Wexford, to cover maternity leave and possible further arrangement. Superb digital practice, Cavitron and full book. Mentoring available from experienced colleague. Full-time can be arranged with another practice. Call 086-858 6673 (evenings) or email quirkedental@gmail.com.

Dental hygienist required to join Dublin city centre practice. Great opportunity, great remuneration and amazing team. Monday, Tuesday, Thursday, Friday. Please contact Dr Clair at ddsurgery32@gmail.com.

Part-time hygienist required in Cork City. Excellent support staff, hours flexible. Email info@shandondental.ie.

Part-time hygienist required in very busy clinic in Carlow Town. Excellent pay, support staff, hours flexible. Email info@dentalsuite.ie.

Dental hygienist required to join very busy, modern practice in Westmeath. Great opportunity. One to two days per week. Fully digitised practice. Email sysakroman@gmail.com.

Dental Care Ireland has great high earning opportunities for hygienists within our established, modern practices. Strong books on offer with flexible part- or full-time options. Our locations are throughout Ireland. Please email us to find out more, at careers@dentalcareireland.ie.

Full- and part-time dental hygienist roles available. Private practice. Full book. Florida probe, air polisher. Excellent support staff. Mentoring component offered. No late evenings or weekend work. Email careers@deansgrangedental.ie.

Exciting opportunity to join multidisciplinary team in a busy, modern, private practice in Dublin 22. Full- and part-time dental hygienist roles available. Cavitron, Prophyflex. Great remuneration and benefits including maternity leave. Training and education fully supported. Contact vicky@3dental.ie.

Hygienist required for a busy, private dental practice in Tralee, Co. Kerry, to cover maternity leave from October to April (inclusive). One to two days a week. Apply with CV to info@flynnsdentalcare.ie.

Busy two-chair practice at Rathgar seeks registered hygienist 8-12 hours a week. Modern, friendly, fully computerised. Flexible timing, good earning potential. Contact ildiko@rathgardental.ie.

Bowe Dental Clinic: hygienist required for busy private dental practice in Limerick for full- or part-time position. Great remuneration and benefits. Excellent support team. Established patient list. Free parking. No late evenings. Fully digitised practice. Contact eamonn@bowedentalclinic.ie.

Hygiene position available in Rogers Dental, New Ross, to replace departing colleague commencing end of August. New surgery, Cavitron and Woodpecker scalers, great support team, established hygiene book, good remuneration, flexible hours. Days available: Wednesday and Friday. Contact info@rogersdental.ie.

Part-time hygienist required two to three days/week for established independent city centre clinic. Modern surgeries, Cavitron, Prophyjet, nurses perform sterilisation. 30/60-minute appointments, no weekends/late evenings. Competitive remuneration. Please apply with CV to info@murphydentalcare.ie.

Dental hygienist required to join a team of enthusiastic and supportive clinicians in a modern, high-tech dental practice. This role is salary based and is a full-time position. Contact deirdrecusack@gmail.com.

PRACTICES FOR SALE /TO LET

Cork City. Well-established practice, integral part of community. High footfall. Contemporary/turnkey. Three surgeries with potential to expand. Separate decontamination area. Digitalised/computerised. Realistically priced. High new patient numbers. Excellent profits. Large ability to grow. Contact niall@innovativedental.com.

Waterford City (Ireland's best place to live!). Long-established three-surgery practice in city centre location. OPG room, computerised. Excellent opportunity. Contact Steven@medaccount.ie.

Busy south Dublin orthodontic practice for sale. Premises not included. Current sole orthodontist winding down 2023. Prosperous, affluent area, loyal patient base, strong new patient demand, adults and especially teenagers. Transferrable brand name. For more information, contact orthopracticedublin@gmail.com.

South Dublin. Long-established, two-surgery, fully private practice. Prestigious location, primary care centre. Reasonably low overheads. Plentiful parking on site. Good new patient numbers. Top-class equipment. Active hygienist. Huge potential. Principal available for transition. Contact niall@innovativedental.com.

Long-established two-surgery practice for sale in the heart of mediaeval Kilkenny City. For enquiries, email dentalpractice3.1415@gmail.com.

South Tipperary. Very busy, long-established, well-equipped three-surgery practice. Decontamination, OPG in place. Excellent location, strong footfall. Freehold/leasehold options. Very good figures/profit. Long-term associate in place. Priced to sell – principal retiring. Contact niall@innovativedental.com.

Busy Cork City Dental Unit located within a Medical Centre. Turn Key. Huge patient base. Fantastic potential. E-mail: managingdirector@mdclinic.ie.

Co. Meath. Very busy, two-surgery, well-equipped, modern turnkey practice. Digitalised/computerised. Excellent location in high-profile medical centre, knowledgeable supportive staff. High new patient numbers. Excellent figures. Principal available for transition. Email niall@innovativedental.com.

Two-surgery, long-established, south Dublin practice for sale. Very busy, high turnover, free parking, well located. Leasehold or freehold, principal can facilitate transition. Contact fiachloir86@gmail.com.

Ski morning, beach afternoon. Long-established English international practice south of France. Close to Valbonne. Currently working three to four days a week. Owner does not do implants so huge potential. Retirement sale. Email drhempleman@yahoo.co.uk.

PRACTICES WANTED

Orthodontist with an interest in buying a practice, or in an associate position with potential for transition to ownership over the next four/five years. Dublin area is ideal but interested if good opportunity countrywide. Available to start late 2022. Contact orthodontisttransfer@gmail.com.

EQUIPMENT WANTED

OPG that can be digitalised. Intra-oral scanner in good working order. All contacts considered. Transport can be organised. Contact niall@innovativedental.com.

A day and career to remember

Dr Denise MacCarthy spoke about Mouth Cancer Awareness Day, her career, and her involvement with Mouth Head and Neck Cancer Awareness Ireland.

Would you like to give me some background about your career?

I graduated from UCC in 1977 and worked as a GDP in the UK and subsequently in an Australian outback town. This was great experience, which included work with the "flying dentist" and voluntary work with the Aboriginal Medical Service.

The 1980s were an exciting time. My hospital experience included Cork University Dental School and Hospital (CUDSH), The London Hospital and Dublin Dental University Hospital (DDUH) with Prof. Derry Shanley. Collaborating with the IDA/Irish Society of Periodontology, we encouraged regular periodontal examinations in general dental practice countrywide. We also supported legislation for the legalisation of dental hygienists in Ireland.

I was appointed Senior Lecturer-Consultant in Periodontology and Restorative Dentistry, and held the position from 1991-2019, with responsibility for dental undergraduate education (periodontology) and patient care. Dental undergraduate curriculum development was central to our work.

I established the first dental hygiene programme in Ireland in 1991, working alongside Karin Nylund on this project, and was Director until 2006. As President of the Irish Division of the International Association for Dental Research (IADR) in 2003, we published a 'History of the First 21 Years of IADR', recognising research collaboration between the three dental schools and the public dental service.

The first dedicated clinic for oral/dental care of mouth, head and neck cancer (MHNC) patients in Ireland was established in 1997.

Tell me about Mouth Head and Neck Cancer Awareness Ireland?

Mouth Head and Neck Cancer Awareness Ireland (MHNCAI) was founded in 2009 as a voluntary organisation to raise awareness of the risk factors, signs and symptoms, and to promote early detection of MHNC. Groups and national organisations integrally involved in the development of MHNCAI were MHNC survivors, the DDUH, CUDSH, the Irish Cancer Society (ICS), the Dental Health Foundation (DHF), the IDA, and the National Cancer Control Programme (NCCP). As well as developing educational material, a website (www.mouthcancer.ie), and engaging with the EU (IDA/Dr Conor McAlister), MHNCAI reached out to rural communities, marginalised and deprived communities, the young and the elderly.

In 2019, the NCCP funded a new consultant post to continue the service I had provided for MHNC patients in the DDUH since 1997 – this work is ongoing with Dr Osama Omer. In 2019, Dr Peter Harrison took over my consultant role in periodontal patient care and undergraduate education. I'm grateful to the DDUH for its enduring support and also colleagues in radiation oncology, especially Profs June Nunn and Leo Stassen, and Prof. Donal Hollywood (St Lukes). I want to recognise the many MHNC survivors whose generous and unstinting support of the MHNCAI Group made its significant achievements possible since 2009. I was chairperson of MHNCAI for a number of years, and want to acknowledge the other previous chairpersons: Dr Lia Mills, author and MHNC survivor; Dr Eleanor O'Sullivan, CUDSH; Etain Kett, DHF; and, Kevin O'Hagan, ICS.

What is being planned for Mouth Cancer Awareness Day 2022?

Following a recent strategic review, Mouth Cancer Awareness Day (MCAD) will now be run annually by the IDA in collaboration with the Irish Cancer Prevention Network (ICPN). Plans for MCAD 2022 are in the capable hands of IDA COO Elaine Hughes, who was instrumental in organising countrywide MCAD check-ups in general dental practice from 2011-2016.

What are the issues you would like to see the IDA focus on?

Establishing strong links was important for the MHNCAI Group. Our successful submission to the National Cancer Strategy 2017-26 recognised, for the first time, oral/dental care as essential for the MHNC patient. I hope the IDA will continue fostering links between dental care professionals, and medical and associated healthcare professionals. I would also like to see the IDA and dental schools leading a positive approach to the mental and physical health of dental care professionals.

How would you like to see the profession progress into the future?

I agree with Ronan King's aspirations for the IDA, encouraging graduates to bring their ideas, enthusiasm and aspirations for the future of the profession.

What do you like to do in your spare time?

Spending time with my husband Brendan Glass, daughter Hannah and son Henry, who recently had a beautiful daughter with Nora. I enjoy hill walking, water sports, sketching, history, and gardening since retirement.

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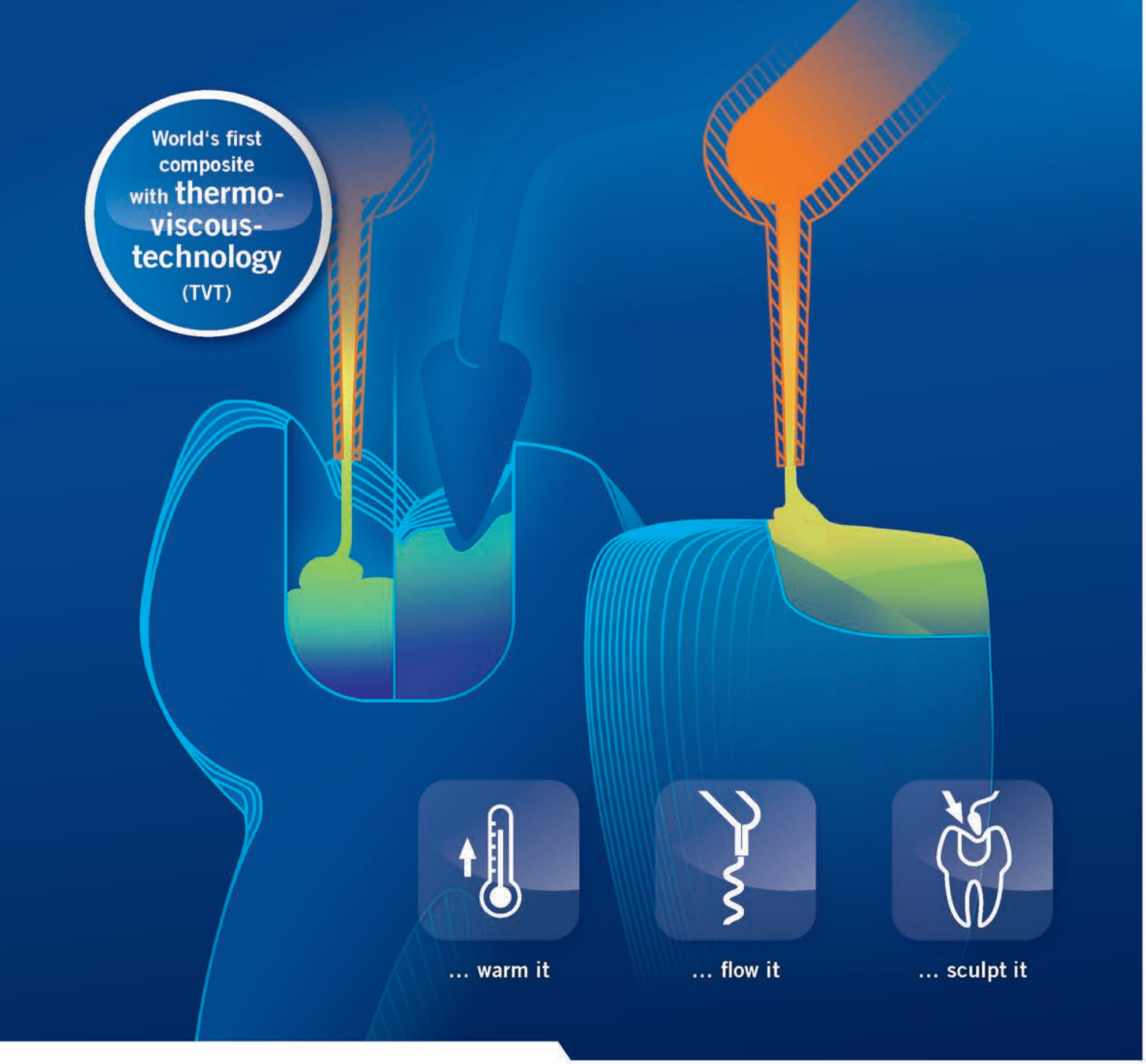

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