IDA irish dental association

JIDA

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IDA irish dental association
100 YEARS
1923 - 2023

The future of dentistry

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MANAGING EDITOR **Ann-Marie Hardiman** ann-marie@thinkmedia.ie
EDITORIAL **Colm Quinn** colm@thinkmedia.ie
Rebecca Pollard becky@thinkmedia.ie
ADVERTISING **Paul O'Grady** paul@thinkmedia.ie
Calum Petit calum@thinkmedia.ie
DESIGN/LAYOUT **Rebecca Bohan, Tony Byrne, Meliosa Fitzgibbon**

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Irish Dental Association Unit 2 Leopardstown Office Park, Sandyford, Dublin 18.
Tel: +353 1 295 0072 Fax: +353 1 295 0092 www.dentist.ie
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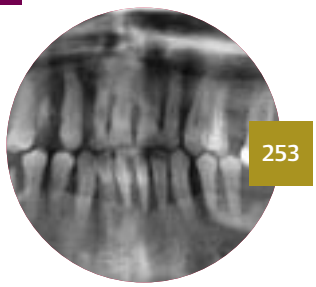

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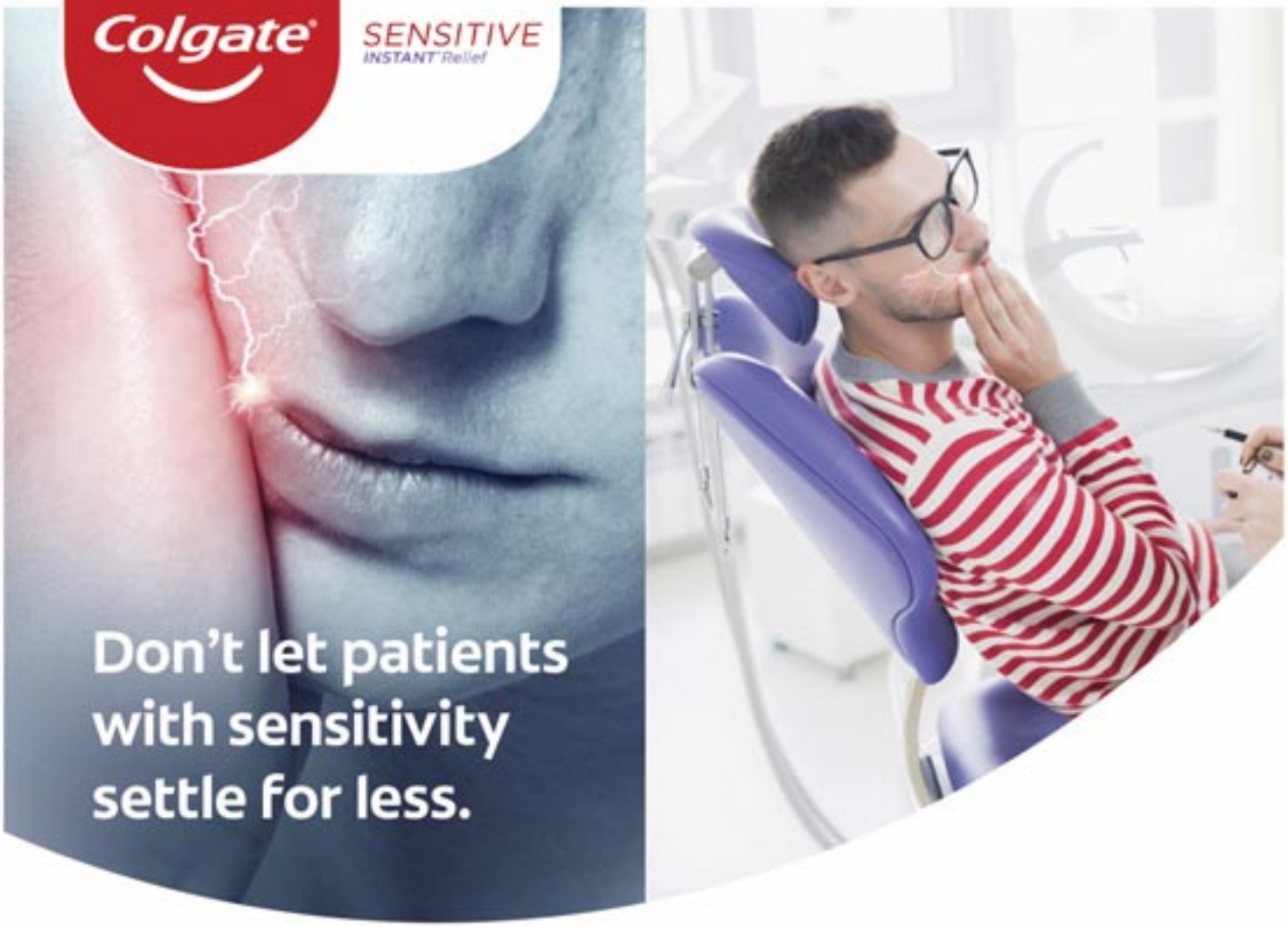

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References: 1. Nathoo S, Delgado E, Zhang YP, et al. Comparing the efficacy in providing instant relief of dentine hypersensitivity of a new toothpaste containing 8.0% arginine, calcium carbonate, and 1450 ppm fluoride relative to a benchmark desensitising 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

Re-imagining the dental team

As we consider the future of the profession, is it time to think about new roles for members of the dental team?

After reviewing the history of dentistry and of the IDA in Ireland over the past 100 years, this edition brings a look into the future of the profession.

The shortage of dentists and dental team members, lack of political commitment to the country's oral health, and insufficient funding to provide treatment to those most in need are just some of the challenges that our profession faces into the future.

GV Black, the father of modern dentistry, once said: "The day will come, and maybe you will all live to see it, where we will practise preventive instead of reparative dentistry". Well, this day has not come yet; more than a hundred years after Black's famous quote, dentists still devote most of their time to treating rather than preventing dental disease, and untreated disease is still a major public health problem worldwide.

Considering that caries is 100% preventable, I wonder what we could do differently, in order to make Black's words a reality? Will there ever be a future when caries will be a rarity, as has happened to many diseases of the past?

A way forward

In reflecting on a way forward, I believe some answers to this question might be found in the roles and composition of the dental team.

Skill mix is a term used to describe the different combinations of workers in a team to deliver a service. We could further sub-divide it into two categories:

1. Role substitution: different members of the dental team undertaking tasks instead of a dentist.
2. Role supplementation: team members augmenting the activity of a dentist.[1]

I believe that both could play important roles in the future, if we intend to move from an interventionist to a prevention culture, and to decrease the current oral health inequalities.

This starts to make more sense when we reflect on how population needs are changing. Some socio-economic groups are presenting with very low treatment needs, while others, such as children of low socio-economic status, the elderly, people with disabilities and homeless individuals, to mention a few, still find themselves with high treatment needs and deprived of basic oral health services. The former could maybe be managed by other members of the dental team, under the supervision of a dentist, releasing the skills of this professional to treat more complex disease or patients with complicated medical histories.

This is already happening in many countries worldwide, and not only in dentistry but also in medicine, where nurses are undertaking more common and simple aspects of care as effectively as doctors.

"Rethinking the roles within the dental team could help to maximise all members' abilities and make preventive care more viable."

Maximising all abilities

In the dental team, hygienists and hygiene/therapists are considered the most appropriate members to deliver primary prevention, with studies showing that they are better than dentists for that purpose. Screening for disease is also a role that is well played by hygiene/therapists. Rethinking the roles within the dental team could help to maximise all members' abilities and make preventive care more viable.

Countries where role substitution has been implemented successfully include the Netherlands, Sweden, Finland, Denmark, Norway, Canada, and the USA. In these countries, hygienists have varying degrees of independence and scope of practice. In some of them, these professionals have been allowed to practise independently for more than 20 years (more than 40 in the case of Sweden). Close co-operation with a dentist is required though, and some tasks, such as prescription and interpretation of radiographs, and diagnosis and treatment of dental caries, are still undertaken by a dentist. In the UK, the legal framework changed in 2013 to allow patients to directly access hygienists/therapists. The scope of practice was also expanded, and now appropriately trained hygienists/therapists can, among other things, place direct restorations in children and adults.

Redesigning the roles of the dental team and establishing appropriate training pathways will require a better understanding of the population's oral health needs. It will also require an open-minded approach, where professionals work together and support each other, but also have proper training and remuneration. A future not only to dream of, but to start considering and planning.

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Dr Eamon Croke
IDA President

Expecting the unexpected

The autumn has brought some new developments and new topics to consider, but in terms of Government inaction on dentistry and oral health, it seems that nothing changes.

We are all quite fond of making and listening to predictions. Success rates are generally low, unsurprisingly, as even Nostradamus warned about a nil return as "everything is made up of so many unique particulars that cannot be foreseen". Generally, that is undoubtedly true but certain events seem predictable, in the sense that they are expected or are habitual. For example, we can predict events that herald the end of summer. First is the return to education, with college on the heels of the start of school. One can expect discussions on the weather. The end of the holidays also brings back a vitality to the political and media arenas. Commonly, this is all fairly predictable.

So it was with the end of summer for the Association. It was all a bit predictable. Well, yes and no.

Embracing important topics

Certainly, our autumn CPD programme kicked off again in September, but the live webinar on menopause was probably a starting topic very few expected. Yet, as the presenter, Loretta Dignam of The Menopause Hub, pointed out in the course of her thought-provoking presentation, the menopause has the capacity to touch all our lives and, definitely, the very being of women who may suffer for up to half of their lives with postmenopausal health issues. And yet, too many are slow to talk about 'the change'. As dentists, we are slow to talk about any personal health matter, even though we may share many of them. A hope that I share with many in the Association is that we, as a profession and all genders, will become comfortable in speaking openly about health and issues that touch us. The Association has started on a journey of education and support in self-care, in addition to our promotion of the Practitioner Health Matters Programme.

The weather? A predictable Irish summer you might say? Well, yes and no.

Southern Europe burned and we were washed out. All the high-level declarations over the summer have made it clear that long-predicted climate changes are racing down the tracks at us if not already actually with us and out of control. The mantra is that we must act now. Everyone has a role to play. Sustainability is now part of the Association's programme. The role that dentistry must take in the sustainability debate is being explored by the Association's Quality and Patient Safety Committee. Of great importance is the Management Committee's decision to examine its role and responsibilities under environmental, social and governance (ESG) metrics, enabling it to evaluate its social and environmental impact. What we know, as members of the Council of European Dentists, is that the Association is well placed to show leadership on ways forward, not only at home but also within the EU. Who would have predicted this in 1973?

Coming out fighting

Dentistry and the issues that matter to the profession in Ireland have received a lot of media coverage in the past years. Unpredictably, a lot of the coverage has been positive or understanding. Then you get the unforeseen but unsurprising stories like September's *RTÉ Investigates* report, 'Revealed: Convicted, unknown and unregulated 'dentists''. Surprised that illegal practice exists in Ireland? Utterly predictable I would say after 10 years on the Dental Council. The Dental Council and the Association have highlighted the absence of dental practice regulation as a risk to patients for nearly two decades. The Dental Council, in its 'Submission Regarding Legislative Change in Dental Regulation' to the Department of Health, in 2021, mused that at present, "the State seems to offer a better protection to animals in a veterinary practice than it does to human patients in a dental practice". The Department's response in pointing out that five separate State and regulatory agencies can inspect dental practices (there are at least six) is misleading and evasive in context.

To get a sense of the previously unspoken frustration that exists for those who have worked, over many years, on behalf of all dental patients, I recommend the Letter to the Editor, which was originally published in *The Irish Examiner* on September 13, 2023, and which is republished in this *Journal* (page 230). Written by experienced, dedicated fellow Dental Council members – Drs Holohan, Murphy and Farrelly – it speaks for itself.

Is the continued refusal by the Minister and senior Department officials to legislate for a new Dental Act in the face of the evidence now farcical? Well, yes. Will we stop campaigning on this issue? Hell, no.

You can take that as a surefire prediction.

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ADVOCACY AND CAMPAIGNS UPDATE

Fintan Hourihan
IDA CEO

Past time for change

Dentists' frustration at the lack of meaningful dialogue with or commitment from Government is mounting, and the IDA is reflecting this in its representation of members.

The publicity around the vote of no confidence in the Garda Commissioner recently was remarkable. For 99% of gardaí to vote no confidence in their boss, within a hierarchical, disciplined force, reflects huge disquiet over working conditions for the 14,000 gardaí.

At our AGM last year, a vote of no confidence in the Minister for Health and his officials was passed unanimously. The reasons for that are easy to see for dentists. Therefore, it was regrettable that the Minister withdrew from attending our centenary conference at 24 hours' notice a week later. Of course, he may have felt upset, but surely this was an opportunity to recognise that there is a problem and to make a fresh start? In fact, he had admitted to the Association just weeks before that dentistry had been ignored by his Department over many years.

Self-employed dentists are denied the opportunity to engage in protests that are available to employees and, in fact, face the threat of legal sanction if they engage in collective action. In the absence of alternative means of registering protest, a vote of no confidence seems the only other means available.

No sense of urgency

The failure to address the need to publish new dental legislation to improve patient safety, combat unregistered dentistry, and enable recognition of dental specialties (for which legislation is not required), proper systems of mandatory CPD supervision, etc., is further evidence of neglect by the State. We had thought that media exposés in the past 12 months demonstrating the limited powers of the Dental Council to intervene to protect patients would force a change of pace. Again, promises are made, but where is the action? Will it really take a dental fatality to force the necessary urgency?

Our discussions with the Department of Social Protection on the PRSI dental scheme (DTBS) have faced different problems. When a fees review is delayed for the best part of four years and is again frustrated by legal impediments, it is time to cry halt. We have recently warned the Department of Social Protection, and will be bringing this message directly to Minister Humphreys, that we will withdraw from direct negotiations with the Department unless there is a sea-change in its approach. We have alternative means to represent our members in contract negotiations and are prepared to adopt a new strategy with the Department if necessary. Our primary duty is to represent our members, and both of our Group Committees – representing general practitioners and public dental surgeons, respectively – have renewed their commitment to exhausting every means to do that within the legal parameters we operate as a trade union for self-employed contract holders and employees.

"Will it really take a dental fatality to force the necessary urgency?"

Meaningful engagement needed

More importantly, the decision-makers need to realise that oral health reforms can only succeed if the State engages meaningfully with the Association and respects the role we discharge on behalf of our members. Surely, lessons must have been learned by the Department of Health, which tried some years ago to circumvent the Irish Medical Organisation (IMO) in rolling out an extension of free medical care, only to realise that doctors would not support reforms that had not been discussed fully with their representative body. Cue change of approach by the Department of Health and a marked turnaround in the pace of reforms. Of course we recognise that the dynamic is very different between medicine and dentistry in general practice. Medical doctors' incomes are very much linked to publicly funded schemes, in marked contrast to dentists, where independent practice prevails, as dentists prefer.

Our public service members are entitled to ask if they are being forced to engage in industrial action for the first time to stop the rot and to end the dismantling of public dental care for children and special care adults. Ballots for industrial action are commonplace in the rest of the health service and seem the only way to force the State to address issues of concern to doctors, nurses and other healthcare workers. I look forward to engaging with our members at the IDA's HSE Group seminar in Portlaoise and to agree a new campaign approach.

Listening to dental associates

Finally, it is important to recognise that the interests and ambitions of dentists are changing, and in many ways this has been brought into sharper focus over the course of the pandemic. More dentists are opting to work as an associate dentist by choice and have no interest in becoming a practice owner. More are looking at salaried employment. In recognition of these changes, the GP Committee has said that the Association should look at new ways to engage dental associates. We need to listen to our members and see what we can offer in these rapidly changing times. More news on that shortly.

In the meantime, if you are not a member then I would ask you to join the representative body for your profession. Dentists are stronger together and in the face of rapid change and State indifference, the need for a strong representative body has never been greater.

Dear Editor,

As former members of the Dental Council we were very upset to learn from the RTÉ *Prime Time* programme (September 7) that the Dental Council finds itself not being in a position to act effectively against the alleged illegal practice of dentistry, and other allegations regarding an alleged sex offender practising in Ireland and matters involving faceless companies delivering dental services. It appears that the public may now find itself unprotected because of perceived limitations in the 1985 Dentists Act, the legislation underpinning the role of the Dental Council in the protection of the public and the regulation of dental practice and the dental profession in Ireland.

It is clear from the programme that the majority of blame for this lies in delays at Department of Health level in formulating new legislation to replace the outdated and inadequate 1985 Act.

We, through our experiences as members of the Dental Council, can bear witness to continual foot-dragging and prevarication by the Department of Health in bringing forward this legislation for more than 18 years. In our time on Council we were involved in such initiatives as a workshop on possible new legislation (February 2010), meeting the Minister and his officials (November 2010), making a submission to the Department of Health on possible new legislation (November 2011), contributing to an extensive (and expensive) Department of Health consultative process on planned new dental legislation (2013), meeting with Departmental drafting personnel (June 2015), and making an extensive submission on the matter to a hearing of the Joint Committee on Health and Children (October 2015). We are also aware that, since our time on the Dental Council, another significant submission on the matter was sent to the Department. In all, since 2005, the Dental Council has made five submissions to the Department about new legislation. In spite of all of this activity, nothing has happened and no new legislation has been introduced.

Now the matter is the subject of a television investigation. Is this what's needed to get any action from a Department, which, when it comes to matters pertaining to oral health is, in our view, uninterested, unprofessional, lacking in patient focus, obstructive and paralysed by a need for self-protection, and which has 'sat on its hands' throughout the terms of various Ministers for Health, including the current Taoiseach? In addition, we have a public dental service that is now third rate in structure and delivery. We are steadily regressing when it comes to oral health services. There are no national, cohesive models for publicly funded primary care or secondary care services to the citizens of this country. One's ability to pay for treatment or geographic location have become almost the only criteria for access. This farce is currently being overseen by a Minister who, when he was Opposition Spokesman for Health, was critical of the current National Oral Health Strategy and supported calls for it to be rewritten. Now he champions the same policy, which was five years being drawn up, has not yet been implemented, and has very little support from within the dental profession, which was largely ignored when the Policy was being written. He also voted against a recent bill making continuing professional dental education mandatory for all registrants. You couldn't make this up!

Now we are at the inevitable stage where patients are possibly being harmed. Will it take a catastrophic adverse event to get some action from within a dysfunctional Department of Health on long overdue new legislation, which would give patients the protection they now incorrectly assume is there? It is long past time for action. For goodness' sake, get on with it!

Martin Holohan
President, Dental Council, 2005-2010

Barney Murphy
Vice-President, Dental Council, 2005-2015

Terry Farrelly
Chair, Fitness to Practice, 2005-2015

This letter was previously published in the Irish Examiner *on September 13, 2023.*

New research on HIV stigma

Findings from a report entitled 'HIV-related Stigma in Healthcare Settings in Ireland' state that 40% of healthcare workers say they would worry, at least a little, about drawing blood from a person living with HIV.

The research was led by Dr Elena Vaughan at the Health Promotion Research Centre in the University of Galway, in collaboration with HIV Ireland, with funding provided by the Irish Research Council.

The findings from the report were produced following a joint national survey and interviews with both healthcare workers and people living with HIV. More than 400 people took part in the research, including 298 healthcare workers and 89 people living with HIV.

Of the 89 people living with HIV, 24% reported being told to come back later, made to wait, or put last in a queue when attending appointments. More than half (54%) reported avoiding healthcare because of worry regarding how they would be treated.

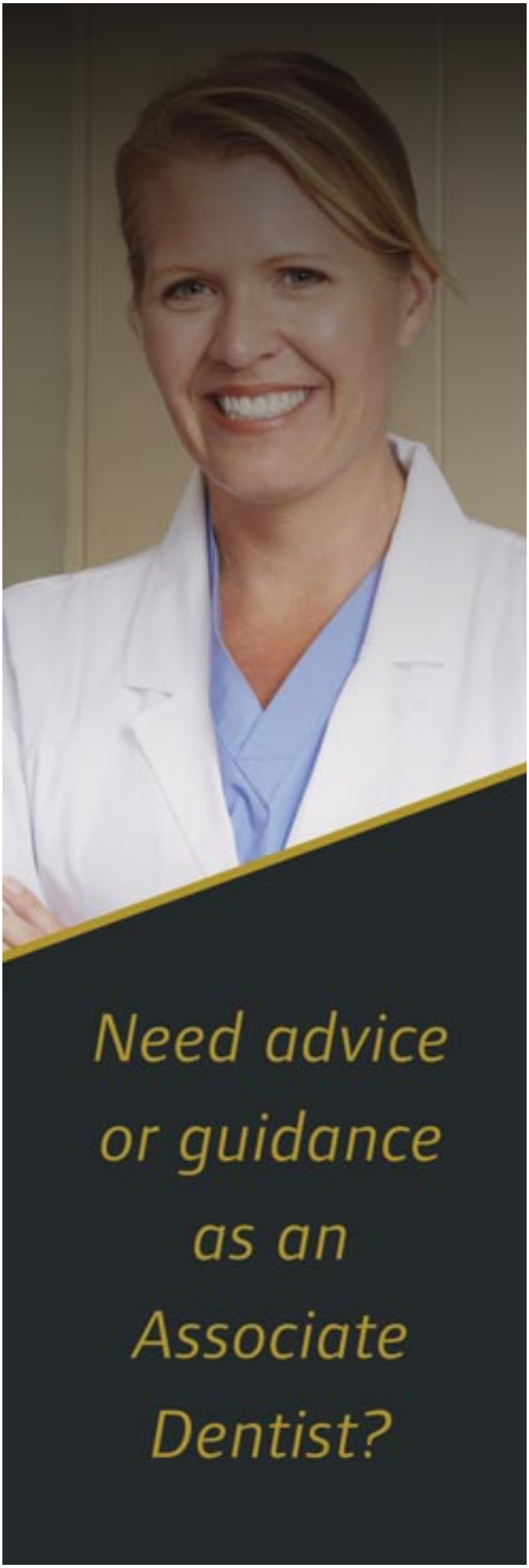
"The findings show how stigma experienced in healthcare settings can put people off engaging in vital care, which can have negative consequences for both individual and public health,"said Stephen O'Hare, Executive Director of HIV Ireland.

Reflecting on the Government's own target of reducing HIV-related stigma in line with international goals, including the global Fast Track Cities initiative, Mr O'Hare added: "This report helps us to identify areas where we can provide information and support to both healthcare workers and people living with HIV, so we can reduce HIV stigma in our healthcare system in line with our global commitments".

The report is available to download from the websites of the University of Galway and HIV Ireland, and was launched at the offices of the Irish Human Rights and Equality Commission, Dublin, on September 20, 2023.

Mouth Cancer Awareness Day 2023

Many thanks for participating in Mouth Cancer Awareness Day 2023 and helping to spread the word on mouth cancer and its effects. Big thanks to the dentists around the country who supported the initiative by speaking to their local radio station or newspaper on the day about the effects of this disease on patients.



New President for HSE dentists

Dr Siobhan Doherty will take over as President of the HSE Dental Surgeons Group for 2023/2024 at the Group's AGM, which will take place on Thursday, October 12, as part of the HSE Dental Surgeons Seminar in Portlaoise. Siobhan is Principal Dental Surgeon in Kildare/Dublin and has been a Director of the IDA for the last seven years. We wish Siobhan well for her year as President.

Annual Conference 2024

The IDA Annual Conference 2024 will take place from April 25-27, 2024, at the beautiful Great Southern Hotel, Killarney. The 2024 Conference will be unique, as it will be held in association with the American Academy of Fixed Prosthodontics (AAFP). Delegates will have the choice of three programmes on Friday and Saturday mornings and two in the afternoon. Pre-conference courses in endodontics, anterior composites, and facial aesthetics are all included on the agenda. We look forward to welcoming well-known national and international speakers, as well as having a full trade show in attendance. The full programme will be available soon.

Kerry is the place to be next April – make sure to book early!

Dates for your diary

Friday, October 13 – Europe Hotel, Killarney
Kerry Annual Scientific Meeting
To view the programme for this day-long event, or to book, please go to www.dentist.ie.

Friday, November 10 – Radisson Hotel, Golden Lane, Dublin, 9.00am-4.30pm.
IDA and EAPD day-long paediatric dentistry meeting
The day will kick off with various presentations on topics of relevance for those treating children. The afternoon will include a series of table demonstrations with more practical tips and advice. Delegates will get the chance to attend all table demonstrations. Full programme available soon.

Friday, November 24 – Fota Island Resort, Cork
Munster Branch Annual Scientific Meeting
President of the Region Dr Bob Philpott and his committee have a very interesting and varied programme for the day. A full trade show will be in attendance also. To book please go to www.dentist.ie. Open to non-members.

Friday, January 19, 2024 – Athlone
Full-day hands-on endodontics course presented by Dr Greg Creavin in association with Endoperfection.
Booking opening soon.

Are you going to the Ball?

Tickets are now on sale for the social event of the year, the Colgate Caring Dentist and Dental Team Awards, which take place on Saturday, November 18, at the InterContinental Hotel Dublin. Dress code is black tie. To book your tickets, go to www.dentist.ie. See you there!

Providing permanent dental professionals

Career Vision Recruiters states that it is an established, professional and confidential recruitment agency with decades of experience and knowledge in both the dental and hospitality sectors.

According to the company, its experience in the dental healthcare industry makes it easier for it to identify new talent and guide candidates on the right path for further career growth. The company's stated expertise and proven track record mean that it can help its candidates make the most of their career potential.

Career Vision Recruiters states that it has built its reputation on exceptional customer service and that it will continue to earn the trust of every client and candidate. According to the company, it prides itself on providing clients with:

- one-to-one engagement every step of the way;
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- collaboration between your dental practice and its recruiters – the team will talk through your business needs and see how it can help;
- better candidate outreach – targeting correct quality talent source;
- a professional, confidential, personable approach to your business needs; and,
- the best possible candidates for your dental practice.

The latest from Coltene

Coltene produces a wide range of tools and consumables in the field of endodontics. The company highlights the HyFlex EDM file canal preparation system, which it states gives flexibility and options for all cases dentists will encounter. Also available is the HyFlex REMOVER for non-surgical retreatments, which Coltene states efficiently cleans away obturation material with no need for a separate solvent.

For clinicians providing both endodontic and restorative dentistry, the company offers the HySolate range of dental dams, which it ensures are low in protein and powder free, reducing the risk of developing a hypersensitivity to latex, and increasing visibility of the treatment site, while creating a dry operating field. Coltene states that the HySolate range is available in a variety of colours, thicknesses and scents, as well as a non-latex option, including the HySolate Black Edition.

Also available in the area of restoration is Coltene's DuoTEMP filling material, which the company believes has great retention and is easy to remove, with additional protection from bacteria due to its zinc oxide and zinc sulphate content, and it has no effect on the curing of composites as it is eugenol free. Coltene states that DuoTEMP can also be used as a temporary seal in endodontic applications, and for inlays and onlays.

Additionally, the company is keen to reward loyal customers by offering a reward programme that provides them with Coltene coins for every purchase, which can be redeemed for a range of items including Coltene products, retail items and experience days.

COLTENE

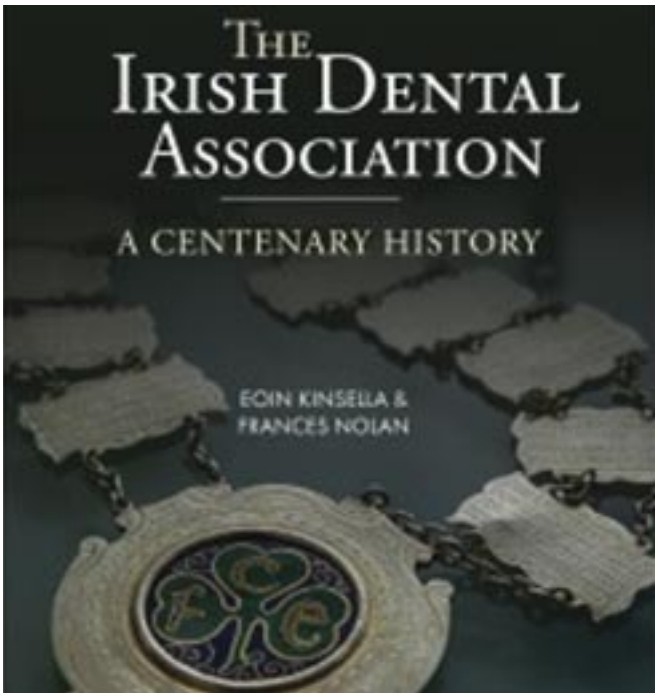
Special offer on IDA history book

Readers of the *Journal of the Irish Dental Association* can avail of a special offer on the recently published *The Irish Dental Association: A Centenary History* by Drs Eoin Kinsella and Frances Nolan. Readers are entitled to purchase the publication for just €19.99, 20% off the RRP.

This thoroughly researched and fascinating history of the Association has garnered high praise since its publication. In the *Medical Independent*, Prof. Brendan Kelly said: "The history of the Irish Dental Association holds a particular mirror up to the history of Ireland and provides absorbing insights into the world of dentistry over the past century".

In his review of the book, Editor of the *British Dental Journal* Dr Stephen Hancocks said the book portrays the "historical landscape of the development of the IDA for the reader to enjoy and visualise by a skilful weaving of otherwise scattered threads. The two authors have diligently sewn together references, facts, photographs, memories and recollections to create a smooth narrative, which blends what might otherwise be merely a series of significant dates and events into a description with a vital human backdrop".

Anyone who wishes to purchase the book at the special rate should contact Liz Dodd at liz@irishdentalassoc.ie. Postage is free to anywhere in the Republic of Ireland.



The future of dentistry

The 100th anniversary of the IDA is a good time to look back, but we also always need to be thinking about what the future holds for dentistry.

The future of dentistry is often thought of in terms of advanced treatments like regrowing teeth. While the prospect of this is exciting and inching closer to reality, there are more pressing matters for the profession to focus on. The *JIDA* spoke to dental professionals about what they see as the major issues that will affect the profession in the years to come and how oral health can be improved.

What is sometimes lost in news stories about potentially revolutionary restorative technology is that dental decay is preventable. It is the number one preventable disease in the world and reducing its incidence is something many dentists believe should be the priority for the future of dentistry.

Colm Quinn
Senior Journalist,
Think Media Ltd

Prof. Avijit Banerjee is Professor of Cariology & Operative Dentistry/Hon. Consultant & Clinical Lead, Restorative Dentistry at King's College London (KCL), and says there are many factors to promoting better oral health and caries prevention, including:

- oral and dental healthcare messaging to the public at large needs to be re-evaluated and reinforced;
- more positive messaging in the media rather than negative communications – the profession and policymakers, alongside media, need to promote positive messages about oral health and well-being to facilitate the public to make the necessary choices;
- controls on sugar in the diet, making healthier options more affordable, as well as education and the use of suitable toothbrush/toothpaste combinations should start at school, if not before; and,
- suitable remuneration systems to incentivise oral healthcare teams to instigate prevention regimens, personalised and risk-related to each patient.

Avijit believes minimally invasive operative interventions carried out by all members of the oral healthcare team should be the norm, but that this is only one

"From the clinical side of it, I think everything will be digital. It's going to be super quick, and we'll be able to fabricate pretty much anything."

What dentists are looking forward to

The future does offer promise and as dental technology continues to improve, some treatments previously only dreamed of will start to appear. One company is claiming it will have a drug to regrow teeth by 2030. Whether that happens remains to be seen, but to even claim that shows how far the research has come.

Avijit says that an exciting part about being a scientist and a clinician is translating lab-based findings to chairside management of patients: "The development of intra-oral scanning technology alongside CAD-CAM for making restorations for teeth has paved the way for the 'digital dentistry' era. Improved earlier detection of diseases/conditions should help with more targeted preventive interventions. The use of artificial intelligence and virtual/augmented reality will help train the clinicians of tomorrow as well as improve the link of care to patients. Research into sustainable materials and fillings that can help heal teeth, as well as the use of natural plant molecules to affect the bacterial balance in the oral cavity, will all help improve oral health and prevent disease in the future, while also maintaining the environment. There is an ongoing transition from the 'dental surgeon' of the past to the 'oral healthcare physician' of tomorrow".

Will has recently invested in a digital scanner, and he can only see these becoming more useful and advanced in the future. The scanner has improved turnaround times and he says while it is not suitable for all jobs just yet, there may come a point where traditional impression methods disappear completely.

Caroline thinks the 3D printer is a game changer and eventually, we could see milling done chairside: "From the clinical side of it, I think everything will be digital. It's going to be super quick, and we'll be able to fabricate pretty much anything and everything in house in your surgery, probably with your 3D printer beside you".

piece of the puzzle: "Within the person-focused, risk-related, team-delivered, prevention-based minimum intervention oral care (MIOC) delivery framework for long-term oral and dental health provision, minimally invasive operative dentistry (MID) forms one of four clinical domains, each having equal importance: clinical detection; diagnosis of the problem; prevention and control of disease; and, suitable recall/re-assessment".

The big issues

Dr Caroline Robins of Kiwi Dental in Carlow says the workforce issue needs to be solved, especially in light of Ireland's rising and ageing population. If we are to provide the level of service that patients require in the future, then we need to ensure there are adequate numbers of dentists and dental team members in the

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country to do the work: "I'm doing dentistry 28 years; I've never seen it like I am seeing it now. It is so hard to get dentists, it's so hard to get personnel. I don't know where the patients have come from, that's probably a discussion in itself, but I'm out the door. I'm booked into January".

One possible mode of assistance is not training more dentists (although there is an obvious need for that) but expanding the role of those who already work in the dental surgery.

In some countries now, you don't train as a dental hygienist, you train as an oral health therapist. The scope of these therapists' work is broader, often allowing them to do basic fillings, take X-rays, and diagnose and treat gum disease. In some jurisdictions, the role of the dental nurse has also been expanded, which alleviates some of the burden on dentists.

Dr Will Rymer of Expressions Dental and Cosmetic Clinic in Roscrea, Co. Tipperary sees potential for dental nurses to play a larger role in dental public health: "I think that for rolling out preventive programmes, such as the similar set-up as they have in Scotland, the Child Smile system, hygienists, therapists and an advanced form of a dental nurse are going to be essential. Dentists have to be involved on the ground floor rather than shutting the door on these professions. We need to be open and we need to be involved in the genesis of these expanded roles so that they are complementary to dentists rather than an alternative dentist".

Not enough graduates

Will says the number of dentists graduating each year is too low and an exacerbating problem is the housing crisis. The situation is so bad, he has decided to invest money in rental accommodation for workers, which he had originally intended to invest on expanding the practice: "Whether or not they want to live in the properties that we develop, it's hard to know, but at least we can then say there are a couple of places available". Caroline is originally from New Zealand and would like to see the Dental Council's registration process for non-EU dentists remain robust but be made easier. Dentistry is an attractive career but it can also be a stressful one and Caroline believes how students are chosen for undergraduate courses needs to be looked at also, saying that those with the most points don't necessarily make the best dentists.

"It'd be nice to see somebody in Government who would advocate for oral health, either in the Dáil or the Seanad, someone the profession could count on as an ally to champion oral health."

A new perspective

Dr Brian Maloney recently qualified with honours from the Dublin Dental University Hospital (DDUH) and is now working as a Junior House Officer there. Having just come out of the undergraduate programme, he thinks it equips young dentists well for practice: "I would like to see more emphasis at an undergraduate level in relation to improving access for students to become involved in research and academia".

In ten years' time, Brian would like to see significant changes in dentistry, and is excited by developments in technology and AI: "I would hope that we as a profession will be better able to address the oral health inequities currently facing the population in Ireland, by emphasising minimally invasive, patient-focused care. However, this will require improvements in staffing, training, and resource provision for the public dental service and considerable input from multiple levels of healthcare and Government".

Another area that interests Brian is prosthodontic care: "I am particularly interested in the digital workflow and its emerging role at the forefront of prosthodontic care. As the available imaging and CAD-CAM technologies continue to develop and improve in accuracy and affordability, it is likely that digital dentistry will become more favoured among clinicians".

Brian is also eager to see a vocational programme reintroduced: "A programme similar to the Dental Foundation Training (DFT) scheme in the UK, to assign new graduates to selected mentors to offer advice and assistance would allow new graduates to gain more experience and confidence in caring for and treating patients while working with greater independence than as a student".

There is also a sensitive issue about the people who are choosing dentistry and the routes they are going down once qualified. Caroline says she sees a lot of younger dentists interested in doing 'high-end' work (often with a focus on cosmetics) but much of the work of dentistry is the day-to-day management and treatment of dental disease, and we need young dentists who want to do that.

In ten years' time

In ten years' time, Will hopes to see new legislation that will support independent practice: "Unfortunately, the drive towards an overburdening administrative side of dentistry means it's pushing the small family businesses into the arms of the large corporate dental system".

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Scan for clinical studies

1. Milleman J, et al. Journal of Dental Hygiene. 2022;96(3):21-34.
2. Bosma ML, et al. Journal of Dental Hygiene. 2022;96(3):8-20.

UK-LI-2200277

"The number of dentists graduating each year is too low and an exacerbating problem is the housing crisis."

Access to oral healthcare has decreased in the last ten years, which Will says needs to be addressed. He would like to see an oral health champion in politics: "It'd be nice to see somebody in Government who would advocate for oral health, either in the Dáil or the Seanad, someone the profession could count on as an ally to champion oral health. I think what really needs to happen is whatever government it is or whatever government comes in next, they need to wake up and get serious. We've got through numerous health ministers without meaningful change to how dentistry is provided. Over 15 years, we've seen a lot of spoofing, unnecessary delays by department officials. We'd like to see somebody in Government that has our patients' backs".

Caroline says that the IDA is vital now and will remain so as we move into the future: "The IDA is vital and we are stronger in numbers. The IDA is our voice because it is our advocacy. And we just have to take a moment and think, if we did not have the Association, what would have happened for example, with the VAT issue regarding associates? Where would we be? We'd be in deep trouble. We're a pretty small association by comparison to other professions but punch well above our weight". Caroline would like to see the day when there is no distinction between health and oral health: "Marrying of the two would be brilliant. We could start talking about it in relative health terms rather than just oral health".

Needs and musts

There are two things that the IDA has been at the forefront of campaigning for, a new dental act and a replacement for the medical card scheme.

The need for new dental legislation was highlighted by the recent *RTÉ Investigates programme*, which revealed worrying cases such as a dentist practising who has a conviction for sexual assault and a number of unregistered dentists operating in the State. Following the programme, The Dental Council stated that there have been cases where it "has had suspicions that people have being practising illegally that it has not been able to investigate under the powers available to the Dental Council under the Dentists Act, 1985. Dental patients continue to be at risk because of the shortfalls in the regulatory framework. The Dental Council is frustrated with the delays in introducing new legislation".

Everyone involved in dentistry in Ireland is also frustrated, and this issue must be addressed by Government.

Finding your feet

Going out into the working world as a newly qualified dentist can be daunting, so here are some tips, based on personal experience, to help you find your feet in your new profession.

The joy of graduation for new dentists is often replaced by the realisation that there is a significant learning curve in your first few years in practice. New graduates are required to develop their practical and communication skills, while also becoming independent thinkers.

The following are some practical tips I would like to share, based on the experience I've gained since qualifying as a dentist four years ago, and which I hope will help newer colleagues as you begin your career.

"Remember to take regular annual leave, especially in the first six months, as this is when the learning curve is at its steepest."

In the practice

Don't commit to working six days at the very start

Working three days a week is more than enough for the first few weeks of your dental career. Also, remember to take regular annual leave, especially in the first six months, as this is when the learning curve is at its steepest!

Shadow other dentists in your practice and take their advice

New dentists are expected to settle into a new clinical environment, while also accurately diagnosing oral conditions, building clinical proficiency, documenting contemporaneous notes, and ensuring patient satisfaction. Observing more senior colleagues can ease this transition.

Build a good relationship with your team

When at work, respect your colleagues. Each will have their own concerns and challenges. Remember you are part of a team with patient care being the shared goal.

Accept that it takes time to get to know a practice and patients

Patients appreciate a sense of consistency and familiarity. They may find it daunting attending an appointment with a new dentist, especially if they were cared for by a departed colleague. However, patients will likely gain a sense of trust in their new dentist and with time you will build a loyal cohort of your own.

Dr Aisling O'Sullivan
Clinical Supervisor, Cork University Dental School and Hospital, and general dental practitioner

Prof. Máiréad Harding,
Prof. Máiréad Harding,
Dental Public Health and Preventive Dentistry,
Oral Health Services Research Centre,
Cork University Dental School and Hospital

Keep up to date

It's important to keep up to date with the latest evidence-based advances. The future of dentistry undoubtedly appears to be technologically based and it is highly likely that artificial intelligence (AI) will play a role. Continuing professional development (CPD) courses are invaluable from an educational perspective, but are also opportunities to build supportive networks.

With your patients

Only provide treatment that the patient understands and wants to proceed with

Always let the patient guide the treatment provided. For example, if a discoloured endodontically treated tooth is not a concern for the patient, it is advisable not to suggest providing treatment unless the patient specifically requests it. It is also vitally important to obtain consent when carrying out any dental treatment, preferably written consent when undertaking complex extractions, endodontics or fixed prosthodontic treatment.

Take time to understand the patient's past dental experiences

Along with obtaining a comprehensive medical history, understanding a new patient's past dental experiences can be invaluable in building trust.

Be gentle, communicate, and read body language

Patients who are treated in a gentle manner will gain trust and confidence in their dentist. Check periodically that the patient is comfortable in the dental chair. Make eye contact. 'Tell Show Do' often works well with adults as well as with children. Oftentimes during a procedure the patient's tongue or uvula may start to move or their eyes start to twitch. This is a sign the patient may need a break. Looking down the length of the body will also allow you to see if the patient's breathing is relaxed or not. These simple measures can avoid the patient losing a sense of control and panicking.

Relieve pain

Be sympathetic about the patient's pain history and aim to address it appropriately. If you cannot identify the aetiology of pain, ask a colleague for help or arrange a referral. Administration of local anaesthetic in a safe, painless and effective manner will build your patient's confidence in you as their dentist.

Follow up with a phone call

If an aspect of treatment was more challenging than anticipated, follow up with a phone call and document the call in the patient's notes.

Write up your notes after each patient

Writing your notes immediately after the patient leaves the surgery reduces the chance of forgetting important information. It is also very useful to document what you plan to complete at the next visit.

Remember you are dealing with the public

If you encounter a difficult clinical scenario, it is important to listen and take the patient's concerns on board. Give yourself time and don't be pressured by patients.

If there is a complaint, follow the practice's complaints protocol and take feedback on board. Use every challenging experience as an opportunity to grow. The Dental Complaints Resolution Service (DCRS – dentalcomplaints.ie) is available to advise dentists on handling complaints.

Self-care

Take time to do things you enjoy

After a busy day in practice, it is important to unwind and take care of yourself. A good night's rest cannot be underestimated.

Build a good support network

Meeting up with former classmates and friends is a great opportunity to share clinical experiences (remembering always to protect patient confidentiality). Consider identifying a mentor to help you in your professional development.

Turn up the next day

Everyone has days where things don't go according to plan. Accept what has happened, move on and turn up the next day for work.

Finally, always remember that as a dentist, you have the ability to make life pain free and comfortable for patients. To sustain this ability, take care of yourself, and the best of luck!

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References: 1. Merry A, et al. AFT-MX-1, a prospective parallel group, double-blind comparison of the analgesic effect of a combination of paracetamol and ibuprofen, paracetamol alone, or ibuprofen alone in patients with post-operative pain. Department of Anaesthesiology, University of Auckland, New Zealand 2008. *compared with the same daily dose of standard paracetamol or ibuprofen alone.

Easolief DUO 500 mg/150 mg film-coated tablets Each tablet contains paracetamol 500 mg and ibuprofen 150 mg. **Presentation:** White, capsule shaped tablet with breakline on one side and plain on the other side. **Indications:** Short-term symptomatic treatment of mild to moderate pain. **Dosage: Adults/elderly:** The usual dosage is one to two tablets taken every six hours up to a maximum of six tablets in 24 hours. **Children:** Easolief DUO is contraindicated in children under 18 years. **Contraindications:** Severe heart failure, known hypersensitivity to paracetamol, ibuprofen, other NSAIDs or to any of the excipients, active alcoholism, asthma, urticaria, or allergic-type reactions after taking acetylsalicylic acid or other NSAIDs, history of gastrointestinal bleeding or perforation related to previous NSAID therapy, active or history of recurrent peptic ulceration/haemorrhage, severe hepatic failure or severe renal failure, cerebrovascular or other active bleeding, blood-formation disturbances, during the third trimester of pregnancy. **Warnings and precautions:** This medicine is for short term use and is not recommended for use beyond 3 days. Clinical studies suggest that use of ibuprofen, particularly at a high dose may be associated with a small increased risk of arterial thrombotic events. Patients with uncontrolled hypertension, congestive heart failure, established ischaemic heart disease, peripheral arterial disease and/or cerebrovascular disease should only be treated with ibuprofen after careful consideration and high doses should be avoided. Careful consideration should be exercised before initiating long-term treatment of patients with risk factors for cardiovascular events. The use of paracetamol at higher than recommended doses can lead to hepatotoxicity, hepatic failure and death. Patients with impaired liver function or a history of liver disease or who are on long term ibuprofen or paracetamol therapy should have hepatic function monitored at regular intervals. Severe hepatic reactions, including jaundice and cases of fatal hepatitis, though rare, have been reported with ibuprofen. Paracetamol can be used in patients with chronic renal disease without dosage adjustment. There is minimal risk of paracetamol toxicity in patients with moderate to severe renal failure. Caution should be used when initiating treatment with ibuprofen in patients with dehydration. The use of an ACE inhibiting drug, an anti-inflammatory drug and thiazide diuretic at the same time increases the risk of renal impairment. Blood dyscrasias have been rarely reported. Patients on long term therapy with ibuprofen should have regular haematological monitoring. Like other NSAIDs, ibuprofen can inhibit platelet aggregation, GI bleeding, ulceration or perforation, which can be fatal, has been reported with all NSAIDs at anytime during treatment. Combination therapy with protective agents (e.g. misoprostol or proton pump inhibitors) should be considered, use with concomitant NSAIDs including cyclooxygenase-2 selective inhibitors should be avoided. NSAIDs may lead to onset of new hypertension or worsening of pre-existing hypertension and patients taking antihypertensive medicines with NSAIDs may have an impaired anti-hypertensive response. Fluid retention and oedema have been observed in some patients taking NSAIDs. NSAIDs may very rarely cause serious cutaneous adverse events such as exfoliative dermatitis, toxic epidermal necrolysis and Stevens-Johnson syndrome. Acute generalised exanthematous pustulosis (AGEP) has been reported in relation to ibuprofen-containing products. Products containing ibuprofen should not be administered to patients with acetylsalicylic acid sensitive asthma and should be used with caution in patients with pre-existing asthma. Adverse ophthalmological effects have been observed with NSAIDs. For products containing ibuprofen aseptic meningitis has been reported only rarely. NSAIDs may mask symptoms of infection and fever. In order to avoid exacerbation of disease or adrenal insufficiency, patients who have been on prolonged corticosteroid therapy should have their therapy tapered slowly rather than discontinued abruptly when products containing ibuprofen are added to the treatment program. **Interactions:** Warfarin, medicines to treat epilepsy, chloramphenicol, probenecid, zidovudine, medicines used to treat tuberculosis such as isoniazid, acetylsalicylic acid, other NSAIDs, medicines to treat high blood pressure or other heart conditions, diuretics, lithium, methotrexate, corticosteroids. **Fertility, pregnancy and lactation:** Easolief DUO is contraindicated during the third trimester of pregnancy. **Driving and operation of machinery:** Dizziness, drowsiness, fatigue and visual disturbances are possible after taking NSAIDs. If affected, patients should not drive or operate machinery. **Undesirable effects:** Dizziness, headache, nervousness, tinnitus, oedema, fluid retention, abdominal pain, diarrhoea, dyspepsia, nausea, stomach discomfort, vomiting, flatulence, constipation, slight gastrointestinal blood loss, rash, pruritus, alanine aminotransferase increased, gamma-glutamyltransferase increased, abnormal liver function tests, blood creatinine increased and blood urea increased. Refer to Summary of Product Characteristics for other adverse effects. Adverse reactions should be reported via HPRA Pharmacovigilance, website: www.hpra.ie. **Pack size:** 24 tablets. **Marketing authorisation holder:** Clonmel Healthcare Ltd. **Marketing authorisation number:** PA0126/294/1. Supply through pharmacies only. **Date last revised:** June 2022. **Date of preparation:** July 2022. 2022/ADVEAS/1167H.

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MEMBERS' NEWS

IDA advises dentists to seek individual PRSI fees reviews

In response to the delays in establishing a fees review for the DTBS, the IDA is advising members to engage directly with the Department of Social Protection.

The IDA has expressed its frustration on behalf of members at the ongoing delays in establishing a long-awaited fees review of the Dental Treatment Benefit Scheme (DTBS), also known as the PRSI Scheme. In a recent development, Minister for Social Protection Heather Humphries TD, whose Department administers the Scheme, has now agreed to meet with the IDA on this issue. This meeting will take place on October 25.

Given these disgraceful delays, the failure to review fees in conjunction with the Association, and the rising operating costs dentists have incurred, the IDA is now advising members who hold DTBS contracts to contact the Minister to seek an immediate individual review of their fees by her Department. The Association will assist members in requesting such reviews of fees given that these are provided for in DTBS contracts.

The contract for the Scheme states that an annual fee review should take place, in consultation with dentists who are contract holders and their representatives; however, no such review has taken place since 2009. In May of this year, after almost three years of attempts by the Association to initiate a review, a framework agreement was signed by the IDA and the Department of Social Protection to allow negotiations and discussions to begin.

In August, IDA CEO Fintan Hourihan wrote to Minister Humphries seeking a meeting with her to discuss the lack of engagement from her Department on this issue. In her reply, the Minister stated that the fee review is a priority for her Department. She cited the fact that over 800,000 claimants are expected to avail of services under the Scheme in 2023, with the Department's expenditure provision for the Scheme of €60.6m likely to be "significantly exceeded".

The Minister further stated that the complexity of the matter was greater than initially envisaged, and cited legal issues in regard to competition legislation as a reason why talks had not yet begun.

Minister Humphries referred to the fact that a new contract has been drafted and NDP Delivery and Reform to bring proposals forward on a new contract with a change to the schedule of fees.

The Association will update members on the outcome of this meeting.

IDA submission

In April of 2023, the IDA made a submission to the Department of Social Protection setting out the background to the current discussions, and its position on what a review of fees for the DTBS should include. The submission explains that the DTBS was established in the 1950s to help lower-paid workers access dental care. The Department of Social Protection paid some or all of the costs for a range of routine dental treatments in return for a qualified patient's PRSI contributions, and the Scheme benefitted over 2m citizens.

In regard to professional fees paid to participating dentists, Section 20 of the DTBS Agreement deals with the scale of fees and provides that:

"The contracting dentist shall be entitled to payment for dental treatment undertaken by him/her on foot of this agreement, by reference to the agreed scale of fees which from time to time shall be negotiated by the Minister with such persons or bodies including the Association, who are representative of the interests of a significant number of persons on the dental panel. The Minister undertakes to engage in an annual review of the scale of fees payable for dental treatment so as to provide the contracting dentist with fair and reasonable levels of remuneration for the services provided by the contracting dentist under this contract. This review will take cognisance of movement in the consumer price index, dental practice goods and dental procedures generally, and any other matters which may have a bearing on the agreed scale of fees, including recent developments in clinical practice and treatment procedures. Every effort will be made by all parties to have each annual review completed over a period not

However, the submission goes on to say that in spite of the obligation on the Minister responsible for the Scheme to undertake an annual review of fees payable for dental treatments, no such review has been undertaken since 2009.

Cuts to the Scheme

In the Budget of December 2009, the Scheme was restricted to one treatment item only, i.e., claimants could only avail of the free annual oral examination. Access under the Scheme to preventive treatments such as the cleaning of teeth and basic treatments such as fillings was denied. The total spend on the scheme in 2009 was €62m; between 2010 and 2017, annual spend fell to as low as €9m per annum before the adjustments made in terms of the provision of scale and polish/protracted periodontal treatment and the introduction of a significant new cohort of (mainly self-employed) eligible patients.

In October 2017, there were some ameliorations introduced, with provision for the introduction of a scale and polish/protracted periodontal treatment benefit. No increase was provided in the examination fee for participating dentists and the fee paid by the State for a scale and polish was set at €42 (with provision for a co-payment of no more than €15).

The IDA's contention is that the changes in the fees arrangements agreed in 2017 merely sought to narrow the gap between the rates payable for the scale and polish/protracted periodontal treatment and those being charged privately, which both the Department and the Association agreed was the appropriate benchmark to apply. There was no suggestion or acceptance on the IDA's part that these new fee arrangements could be seen as partially addressing, in any sense, the failure to address rising costs since 2009 when the fees had last been reviewed. The submission also noted that there was no increase applied in the examination fee payable and this remains the situation almost three years later.

Fees review

The Association believes that any fair and reasonable review of fees must conclude that fee levels must be increased significantly to take account of the extra costs for dental practices as a result of inflation and the Covid-19 pandemic, as well as the cost to dentists of not arranging annual fees reviews since 2009 – in spite of a contractual obligation to undertake such a review – which left participating dentists to effectively subsidise their practices with other sources of income in order to meet their many fixed and variable costs, which have risen consistently in the intervening period.

The submission asserts the need to take account of the failure to increase the fee payable for dental examinations since 2009 and, likewise, for the scale and polish/protracted periodontal treatment benefit. It argues that

higher in line with the rise in the cost of providing such treatments. In its submission to the Department, the IDA outlines a recent review it has carried out of private practice fees as advertised on 100 dental practice websites (including a number of large dental conglomerates) for the treatment items provided under the DTBS. This shows that the fees paid to dentists under the DTBS are considerably less than the median fee charged privately (**Table 1**).

In addition, the submission describes research from MedAccount independent financial experts, which found that the average overhead cost per treatment in 2023 is €48 for an examination and €72 for a scale and polish. Based on this analysis, dentists treating patients under the DTBS are currently incurring a significant loss. Average practice wages increased by 11% between 2019 and 2022 and the impact of Brexit can be seen in the rise in consumable materials costs as a percentage of turnover – from 8.7% in 2019 to 10.6% in 2021/22.

Table 1: Difference between private practice and DTBS fees.

Treatment type	Exam, treatment plan	X-rays (small/ bite wing)	Exam and X-ray	Scale and polish
Median private practice	46.00	15.00	61.00	75.00
DTBS fee (max. including co-payment)	33.00	0.00	33.00	57.00
Difference (€)	13.00	15.00	28.00	18.00
Difference (%)	28%	100%	46%	24%

The IDA asserts that it is unsustainable that the examination treatment item would continue to include a small X-ray, and is calling for the two items to be uncoupled and for separate payment for the X-ray, either from the Department of Social Protection or by the patient.

The DTBS contract predates the current regulatory environment and the digital technology that is now in wide use. The area of dental radiographs is more complex, more regulated and more costly than was envisaged when the DTBS began or when the last contract review regarding radiographs took place. Compliance costs include circa €1,800 per annum for a radiation protection advisor (RPA) visit. An intra-oral X-ray machine is approximately €5,000 and a digital X-ray scanner costs approximately €35,000. Computer hardware/software costs €14,000 including a digital X-ray software package. There are also ongoing costs associated with continuing professional development (CPD), audit and so on.

Work permit rules

The Association continues to argue for changes to work permit rules.

The IDA has made a submission to the review of the Occupational Lists for Employment Permits, arguing that dentists and dental hygienists should be placed on the critical skills list and that dental nursing should be removed from the ineligible list.

The submission is part of our continuing campaign to highlight the workforce crisis in the dental sector, whereby the critical shortage of dentists and dental practitioners means that it is becoming more and more difficult for patients to access important dental care.

Our submission asserts that the shortage of staff in dental care has consistently been identified as the greatest challenge and concern for dentists in Ireland across all settings, locations and practice types.

As part of our workforce plan for the dental sector, launched last April, the IDA has previously called for dental nursing to be removed from the ineligible occupations list for work permit purposes and for work permits for dentists to be brought in line with the recent changes made for non-EEA doctors.

State at the Department of Enterprise, Trade and Employment, requesting a meeting to discuss his Department's review of the critical skills occupations list for non-EEA employment permits.

We pointed out that recently published healthcare data from the Department of Health indicates that there are 2,420 dentists currently registered in Ireland. This amounts to one dentist per 2,128 population (47 per 100,000) and is therefore at the lower end (bottom quartile) of Organisation for Economic Co-operation and Development (OECD) countries.

Furthermore, nearly two-thirds of dental practices who tried to recruit dentists in the 12 months to May 2023 could not fill the vacancy; half could not recruit a dental nurse and three-quarters could not recruit a dental hygienist during the same period.

We told the Minister that the Association believes that the inclusion and expansion of dentists, dental nurses and dental hygienists to the list will go some way to alleviating the pressure on dental practices and ensure that there is access to necessary and vital healthcare services for our patients and the public.

Christmas holidays and rewarding staff

Guidance for practice owners for rewarding staff and providing some well-deserved time off.

It's nearly the end of the year and we've put together some guidance for practice owners to help ensure that public holidays and annual leave are allocated to staff in a fair and compliant manner over the Christmas period.
In addition, at this time of year, employers might be considering the best way to reward and retain their staff in an ever-competitive jobs market.

Bonus

For those thinking about giving a token or bonus to staff in the run-up to Christmas (or at any time of the year), the Small Benefits Exemption Scheme represents the most efficient way of rewarding staff and can be both a tax saver and an effective employee incentive. Under the Scheme, employers can give a reward completely tax free each year. Last year, the Small Benefit Exemption increased from €500 to €1,000 and employers can now give two vouchers or gifts to their employees each tax year.

Christmas parties

Staff parties are another way to show employees some appreciation at the end of the year. However, it is important to remember that when an employer hosts a staff party, their duty of care to their employees extends as if they were at work. The employer is fully responsible and held liable for incidents that happen at Christmas parties, even if the party is off site and out of hours. Employers remain responsible for the well-being, protection and behaviour of employees during such events.

Public holidays over the Christmas period

There are three public holidays over the Christmas period:

- Christmas Day (Monday, December 25, 2023);
- St Stephen's Day (Tuesday, December 26, 2023); and
- New Year's Day (Monday, January 1, 2024).

- a paid day off on the day of the public holiday;
- a paid day off within a month of the public holiday, on a day decided by the employer;
- an additional day of annual leave; or,
- an additional day's pay.

The employer should choose which one option they would like to grant and inform employees of this one month before the public holiday is due to fall.
Full-time employees have an immediate entitlement to public holiday benefits. Part-time employees must have worked at least 40 hours in the five weeks ending on the day before the public holiday in order to qualify for public holiday benefit.
In the case of a part-time employee who qualifies for public holiday benefit, the days the employee would normally work must also be established. If the employee would normally work on the day the public holiday is due to fall, they are entitled to the full benefit for the day.
Where the public holiday falls on a day the employee would not normally work, they are entitled to one fifth of their normal weekly wage. This benefit can be given in the form of payment or time off in lieu.

Is the menopause relevant to your practice?

Menopause is an issue practices need to think about in order to manage risk, and support and retain colleagues.

No doubt most readers will be aware of the spotlight on the issue of menopause in the media over the past two years. This topic was bubbling away under the radar as a 'women's issue' – it had failed to reach the national airwaves and was certainly not discussed in boardrooms in Ireland. This has changed radically, both from a health policy and information viewpoint, but also within the national conversation.

In May 2021, an email from Sally Anne Brady of the Irish Menopause Group to the RTÉ's *Liveline* first raised it as an issue publicly and brought it into kitchens, workplaces and vehicles around the country – listeners of all ages, genders and backgrounds. What followed was ten days of discussions and conversations from women all over Ireland about what had previously been considered a taboo subject, avoided even by some women in their own friendship groups and families. It was the first time the show needed to create a dedicated phone line.

After ten days of devoting the show to this subject, the impact of this period in every woman's life was recognised as an issue that required far more attention and education, not only from women but also policymakers, employers and GPs.

Why should this be of interest to the dental workforce?

In the UK, 77.2% of the dental workforce is female; females make up 52% of dentists and 92.8% of dental care professionals (DCPs, e.g., hygienists, therapists and nurses), based on 2022 General Dental Council statistics.[1] Although, I don't have accurate figures for Ireland as they do not appear to be recorded or based on anecdotal knowledge of how similarly practices are staffed in both jurisdictions. I believe the make-up of the dental profession in Ireland is similar.

When we look at the age groups of registrants, we see that 25% of dentists are aged between 41 and 50 and 18% between 51 and 60; therefore, 43% of practising dentists. The numbers for DCPs are broadly similar – 22% aged 41-50 and 15% aged 51-60, which amounts to 37% of the DCP workforce. Perimenopause and menopause usually occur between the ages of 40 and 55 years of age. The average age for a woman to reach menopause is 51. Just under 50% of dentists fall into the 41-60 age range. The implication for dental practices is that, at any time, it is possible that 40-50% of your team may be experiencing symptoms of the menopause or perimenopause, which may significantly affect their well-being and performance.

Dr Nuala Carney
Dentolegal Consultant and member of the Menopause Network at Dental Protection

Symptoms

According to a survey carried out for The Menopause Hub by B+A in Ireland, there are as many as 40 symptoms of menopause, including psychological, emotional, physical and genitourinary symptoms. The hot flushes of menopause are often referred to with a grimace and are well known, but little is known or acknowledged about the psychological symptoms, which include anxiety, depression, panic attacks, mood swings, anger and rage. The mental health impact is enormous and unspoken about. Loss of sleep and the impact of this on daily performance is largely ignored, despite it being a huge source of stress and potential cause of error at work. This is particularly pertinent to the dental workplace where teamwork and human error play such an important role in managing risk every day.

Based on the information collated by The Menopause Hub, 80% of women have symptoms, 76% describe them as moderate to severe, and 25% describe their symptoms as severe.

In November 2022, 1,290 adults were surveyed as part of the Department of Health's Menopause Awareness Campaign. Results showed that 55% of women experiencing the perimenopause and menopause described it as a negative experience. One in three women reported constant symptoms with, on average, women experiencing up to seven symptoms at any given time. Common symptoms included vasomotor symptoms, menstrual changes, fatigue, insomnia, changes in body shape, cognitive issues, mood changes and joint pain.

The Menopause in the Workplace Survey of 1,132 Irish women undertaken by the Menopause Hub in October 2022, reported that almost half of women did not feel confident talking with their GP about the menopause. Furthermore, 25% of respondents described their symptoms as severe, with 79% considering that the level of information and support for menopause in Ireland was poor. Some 84% of survey participants felt that the menopause had affected their performance in the workplace, while 38% admitted that they had considered stopping work due to their symptoms.

Sobering European research conducted by a research team at the Menopause Experts has shown that suicide rates in women aged between 45 and 54 – the common age to be experiencing menopause or perimenopause – have risen by 6% in the last 20 years.[2] These harrowing findings defy the trend of falling suicide rates in older women, indicating that menopause may be a pivotal factor.

Impact on dental staff members

At Dental Protection, we recognise that the menopause and associated symptoms can vary widely and aim to ensure that female colleagues do not

suffer in silence during this phase of their lives. Brain fog, forgetfulness, poor concentration and insomnia can make any job difficult, but particularly so in a challenging environment like dentistry.

All female dental colleagues suffering with symptoms should feel comfortable to discuss workplace adjustments and seek mental well-being support. A menopause workplace policy can ensure wider understanding and provide reassurance that support will be available if needed.

Managers and practice owners should consider training on the menopause and how the symptoms can impact on the well-being of some individuals and the wider team. Practice owners should also consider whether they have adequate procedures and support in place to help all staff affected by the menopause.

If menopause is not destigmatised, workplaces risk losing many skilled and highly valued dental colleagues during a time when the profession can ill afford it. A supportive culture will alleviate additional stress, encouraging individuals to continue to perform at their best for patients, and to thrive in their careers for longer.

Government support

The Government and the Minister for Health have finally recognised the critical importance of supporting women both within and outside the workforce in Ireland, and this is welcome news. It acknowledges that we need to start a new conversation around menopause.

In October 2022, Minister for Health Stephen Donnelly TD launched National Menopause Awareness Week to encourage these conversations and empower women to talk about their experiences. A new website – https://www.gov.ie/en/campaigns/menopause/ – has also been launched to increase awareness of the menopause and its symptoms.

While most people experiencing menopause can manage their symptoms at home or with the support of their GP, five specialist menopause clinics have opened across Ireland to date – in the National Maternity Hospital, Nenagh Hospital, the Rotunda, the Coombe, and University Hospital Galway – with another in Cork opening in late 2023. These clinics are designed to treat more complex symptoms of menopause and have been established based on the work and research carried out by the Women's Heath Taskforce.

The Irish College of General Practitioners (ICGP), supported by the Women's Health Fund, has recently published a Quick Reference Guide on the Diagnosis and Management of Menopause in General Practice. In addition, the 2023 Budget saw the removal of VAT from hormone replacement therapy (HRT) to improve equality of access for women across Ireland.

MPS – a menopause friendly workplace

MPS, which Dental Protection is part of, received Menopause Friendly Accreditation this year due to its commitment to talking openly about the menopause and putting the right help in place for colleagues and members. A wide range of interventions was created and led by colleagues, including:

- establishing a MenoChat group, which provides amazing peer-to-peer support and has been instrumental in helping people to manage the symptoms of menopause in a safe, friendly environment;
- 'Ask me anything' sessions, which have been significant in normalising the conversation;
- the formation of a Menopause Network, which seeks to understand the wider impacts on colleagues and the business, build awareness and smash taboos;
- training and supporting menopause advocates;
- conducting menopause awareness training for senior leaders, managers and colleagues;
- calling for more training, and supported and flexible working arrangements, for dentists and dental professionals going through the menopause, to reduce the risk of a potential exodus of passionate and skilled clinicians from the workforce; and,
- providing free, confidential counselling for members struggling with menopause symptoms at work.

The Menopause Friendly Accreditation recognises high standards and proven practices that embrace menopause in the workplace. Employers are required to demonstrate evidence of their effectiveness in six key areas: culture; policies and practices; training; engagement; facilities; and, evaluation. As such, accreditation is truly meaningful and considered by many as a mark of excellence for menopause in the workplace.

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Quiz

Submitted by Dr Clair Nolan

How well do you know the radiation safety procedures for your dental practice?

1. What are the legislation and guidance documents that must be legally complied with?
2. What are the five roles that must be assigned to those in your practice?
3. What information must be recorded for every radiograph taken?
4. How regularly must you get a quality assurance test report for each x-ray unit?
5. What does ALARA stand for?

Answers on page 261

Recreating morphology for improved Class IV restorations

A restorative treatment that uses tooth morphology to achieve successful results.

Background

The fractured incisor is a common occurrence in general dental practice. Achieving a positive aesthetic outcome and maximising bond strength is central to patient satisfaction and ensuring restoration longevity. Correct shade selection and the reproduction of natural anatomy in composite resin can be challenging in the anterior labial segments where the human eye's ability to detect asymmetry plays an important role.[1] An understanding of tooth morphology and how to replicate it will aid in this procedure. This article aims to describe a step-by-step approach towards successful morphological replication in Class IV composite resin restorations. Composite shade selection, placement techniques and polishing methods will be covered.

Table 1: Relevant terms (see Figure 1).

Term	Explanation
Primary anatomy	This refers to the overall external outline shape of the tooth
Secondary anatomy	This refers to the lobes and depressions of the tooth
Tertiary anatomy	Commonly known as perikymata, this refers to the surface roughness of the tooth and it can be pronounced (younger) or absent (older)
Line angles	The lines of intersection between the different surfaces of the tooth
Embrasures	These are the triangles of space between proximal surfaces of teeth
Facial planes	This refers to the gentle slopes of the tooth from the cervical region to the incisal tip (commonly three planes exist)
Reflective zone	The central flat labial surface of the tooth that reflects the most light

Considerations for correct shade selection

- Permanent teeth dehydrate in approximately three minutes,[2] so shade selection should be done as soon as possible while the teeth are still hydrated and the clinician's eyes are not fatigued;
- where possible, natural light should be used from an open window;
- placing a 'button' of different shades of (cured) composite can be helpful in making a final decision; and,
- if the clinician is still unsure, taking a black and white photograph of the composite buttons on the tooth surface can aid a final decision as the human eye is better at detecting greyscale (value) discrepancies.

TIP: When a layering composite resin system is being used, the enamel shade button should be placed incisally as there is little to no dentine in this area. The dentine shade button should be placed cervically as the enamel is thinnest in this area, thus allowing for the underlying dentine shade to show through. In single shade restorations the button should be placed centrally on the tooth as this zone corresponds to the most even blend of enamel and dentine.

FIGURE 1: Important anatomy of the anterior dentition.

Steps for improved restoration placement

Preparation

- Prior to restoring the Class IV cavity, assess the adjacent tooth. Look out for over-contoured or rough interproximal restorative surfaces. These may need polishing or reduction to improve interproximal contours for the new required restoration.
- Restoration placement under rubber dam has a positive impact on bond strength.[3] Remember to allow approximately 3mm between each hole

Dr Meriem Abbas BDS (NUI) MFDS RCSEd PGDip TLHE
Ardfallen Dental Practice
Douglas Road
Ballinlough
Co. Cork

Corresponding author: Dr Meriem Abbas E: Meriem.abbas.ma@gmail.com

FIGURE 2: Putty matrix prior to adjustment.

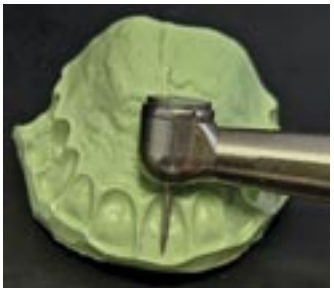

FIGURE 3: Putty matrix adjusted using needle bur.

FIGURE 4: How to assess and adjust line angles.

FIGURE 5: Before fractured incisor with bevel in place.

FIGURE 6: After restoration immediately post op.

punched in the rubber dam to allow space for the dental papilla and enough material to invert the dam for optimal isolation. Ensure the size of the holes are not too large to maximise moisture control.

- Place a 2mm wide bevel, starting from the amelo-dentinal junction (ADJ), on the labial surface only. This will allow for a transition zone to blend the composite to the natural tooth, which can be achieved with a red band needle bur. A bevel also increases the enamel bonding area, resulting in improved retention and reduced micro-leakage.[4]

Restoration

- Etch and apply the bonding system of your choosing, ensuring that a sufficient area past the margin is incorporated.
- Use a putty matrix to place the palatal shelf increment. In trauma cases the putty can be adjusted using a finishing bur at low speed to create a matching palatal contour (**Figures 2** and **3**). A second option is to use a mylar strip supported by a flat plastic incisally to recreate the palatal shelf.
- Place the interproximal increment using a sectional matrix band. This is a useful tool to create tight interproximal contours. The curvature of sectional bands aids in avoiding a flattening of the interproximal wall and subsequently the incisal transportation of the contact point.
- Fill the cavity in small increments to ensure depth of cure and minimise shrinkage stresses. When using a layered composite resin system, remember that the enamel shade should only be 0.5mm thick palatally, interproximally and labially. The remaining bulk of composite should be in the dentine shade.
- Place the entire labial surface as one increment to ensure a smooth and polished final restoration.

TIPS:

- Composite should be patted into shape with slow and light touches and not packed in with small quick touches as this will risk the incorporation of air bubbles.
- Use of a brush and a small drop of modelling liquid can aid in the delicate smoothing and shaping of the final composite increment. Alternatively, a clean and polished flat plastic or composite shaping instrument could be used.

Morphology

- Using a mechanical pencil while holding the lead at 45º, outline the line angles and facial planes of both the restored tooth and the adjacent tooth to compare and correct discrepancies (**Figure 4**).
- The aim is to create matching reflective zones. Line angles can be moved closer together to give the illusion of a narrower tooth (smaller reflective zone) or conversely moved further apart to give the illusion of a wider tooth (larger reflective zone).
- Use a coarse grit polishing disk to achieve the correct primary anatomy, moving systematically from (a) incisal edge length to (b) facial planes including labio-palatal thickness and finally (c) line angles.
- Review the shape and definition of the embrasures and, using a medium grit polishing disk, make the necessary adjustments to ensure symmetry.
- When using polishing disks, it is advised to use a gentle stroking motion, keeping the disk constantly moving to achieve the best results. It is critical that you use each grit in the correct sequence to achieve the best lustre (**Figures 5** and **6**). Skipping a step will only ensure a dull finish.

TIP: If you wish to include secondary anatomy, this can be drawn on with your mechanical pencil to guide the yellow needle bur in creating the subtle grooves.

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Aggressive pyogenic granuloma mimicking a malignant lesion: case report and review

Précis

Pyogenic granulomas could mimic the behaviour of malignant lesions, and have been reported to be associated more with dental implants. Histopathological assessment is essential to exclude any malignancy.

Abstract

A pyogenic granuloma is a reactive hyperplastic inflammatory lesion that arises as a result of various stimuli such as low-grade local irritation, trauma, hormones, and certain medications. In the oral cavity, it is a relatively common gingival soft tissue lesion, which originates as an expansile growth of the mucous membrane. It could exhibit aggressive behaviour mimicking that of malignant lesions with different presentations. This article aims to present the case of a patient who attended the dental clinic while complaining about a large and rapidly growing intraoral mass with aggressive behaviour, which had manifested as a fast-growing lesion causing rapid expansion of the buccal and palatal bone, bleeding, and alveolar bone destruction associated with mobile teeth. The article also aims to compare this case with current reported cases of aggressive pyogenic granuloma in the literature.

Key words: Pyogenic granuloma, malignant lesion, bone loss, bleeding, bone expansion.

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Introduction

A pyogenic granuloma (PG) is a benign inflammatory hyperplastic lesion located in the skin and the mucous membrane.[1] In the oral cavity, PGs have a higher propensity to present in females, especially in their second decade, during pregnancy, and after menopause.[1,2] PGs are more commonly observed in the maxilla than the mandible, and in the anterior rather than the posterior region of the oral cavity.[3] It appears under a microscope as a highly vascular proliferation that resembles granulation tissue.[4]

Numerous studies have tried to reveal the aetiology of PGs; however, the exact aetiology remains unclear.[5] The commonly reported causes are local irritation and chronic trauma, which are responsible for initiating reactive lesions characterised by connective tissue proliferation.[6] Other causes may include poor oral hygiene, parafunctional habits, a history of dental extraction, and overhanging dental restorations.[5,7] In addition, medications such as calcium channel blockers, and anticonvulsant and immunosuppressant drugs, are known to induce gingival hyperplasia.[8] Other researchers believe that PGs appear because of an infectious process or hormonal changes.[9]

A PG diagnosis depends on a biopsy and histopathological assessment, which help to differentiate from other common oral diseases.[10] Its differential diagnosis includes haemangioma, peripheral giant cell granuloma, hyperplastic gingival inflammation, pregnancy tumour, peripheral ossifying fibroma, drug-induced gingival hyperplasia, and malignant lesions.[11] However, the aggressive behaviour of a PG can be diagnostically challenging.[12]

The treatment of choice for a PG is an excisional biopsy.[4] Other treatment modalities include cryosurgery. The use of an Nd:YAG laser, flash lamp pulsed dye laser, injection of ethanol or corticosteroid, and sodium tetradecyl sulphate sclerotherapy has also been documented.[4]

This article aims to present the case of a patient who attended the dental clinic while complaining about a large, rapidly growing intraoral mass with aggressive behaviour, which had manifested as an extensive loss of alveolar bone, as well as mimicking a malignant lesion. The article will also compare this case with current reported cases of aggressive PGs in the literature.

Assim Banjar BDS[1]
Nehal Al-Masri BDS[2]
Abbad Akil MS (OMFS)[2]
Abrar Demyati MS FFDRCSI[1]
Hassan Abed PhD[3]

1. Department of Oral and Maxillofacial Surgery and Rehabilitation, Faculty of Dental Medicine, Umm Al-Qura University, Makkah, Saudi Arabia
2. Department of Dentistry, Oral and Maxillofacial Surgery Division, King Faisal Hospital, Makkah, Saudi Arabia
3. Department of Basic and Clinical Oral Sciences, Faculty of Dental Medicine, Umm Al-Qura University, Makkah, Saudi Arabia

Corresponding author: Assim Banjar BDS, Department of Oral and Maxillofacial Surgery and Rehabilitation, Faculty of Dental Medicine, Umm Al-Qura University, Makkah, Saudi Arabia
E: ambanjar@uqu.edu.sa

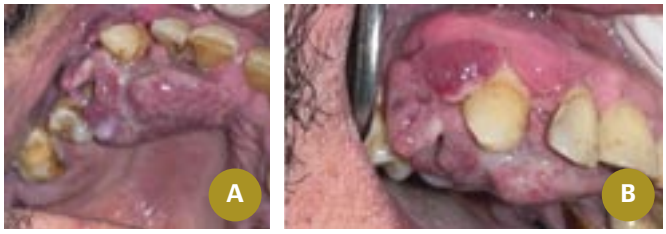

FIGURE 1: Pre-operative intra-oral photos. A: Occlusal view – notice the speckled whitish-red area. B: Lateral view – notice the purplish-red buccal interdental papilla.

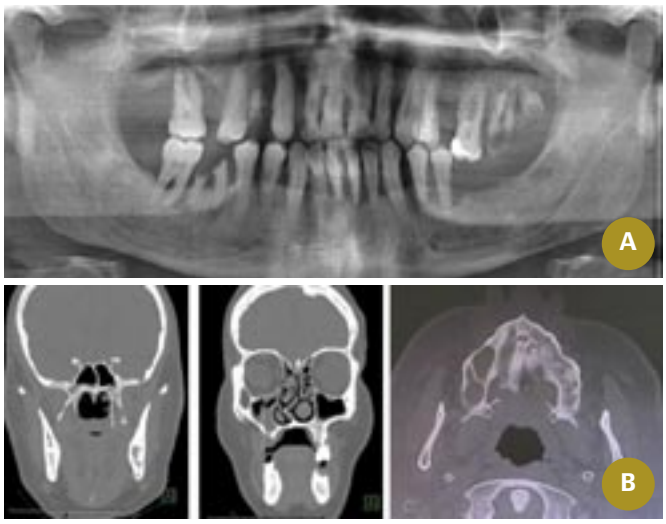

FIGURE 2: A: Pre-operative orthopantomogram showed bone destruction on the upper right side and a remaining root right first premolar and carious right lateral incisor; B: Cone beam computed tomography showed an ill-defined soft tissue mass measuring 19x20x17mm on the palatine process of the right maxillary and alveolar bone with underlying bone erosion, mucosal thickening of the maxillary, ethmoidal, frontal and sphenoid sinuses, and hypertrophied inferior conchae. The nasal septum deviated to the right.

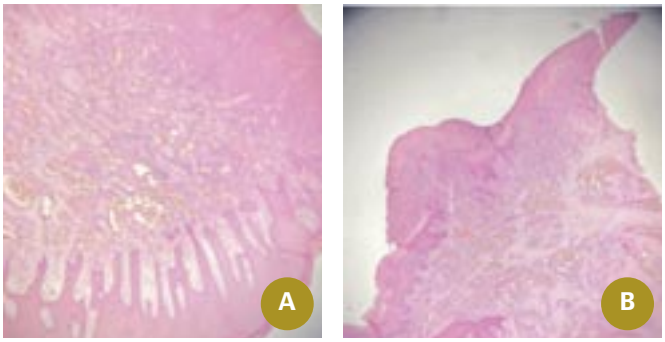

FIGURE 3: Histopathologic investigation using H and E stain. A: Magnification degree ×100; B: Magnification degree ×40. The histopathologic investigation revealed small capillaries arranged in a lobular fashion and vascular sinusoidal spaces. The overlying surface is ulcerated and covered by a fibrinous exudate. The endothelial cells and keratocytes of the lesion showed no atypia. No melanocytic nests were observed.

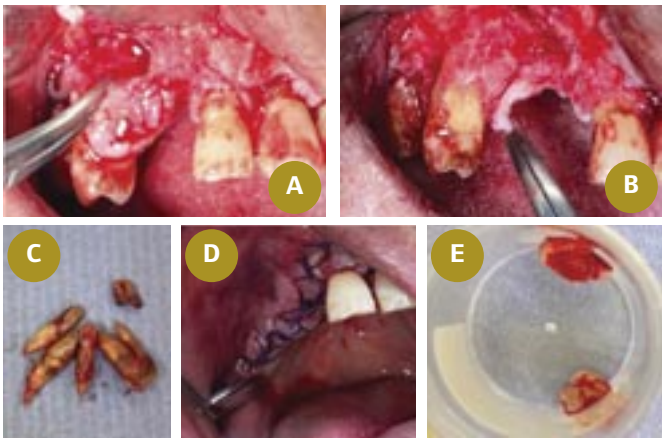

FIGURE 4: Part of the surgical field during the removal of the lesion (A and B), extraction of the hopeless teeth (C), wound suturing (D), and part of the lesion after the excisional biopsy (E).

Clinical presentation

A 50-year-old male was referred by his general dentist in a private dental clinic to the Oral and Maxillofacial Surgery Department at King Fahad Hospital (KFH) in Makkah, Saudi Arabia. The referral was for a large lump that needed further evaluation and treatment. The patient's medical history was remarkable for controlled diabetes and hypertension. His medications included long-acting insulin and rapid-acting insulin analogues for diabetes mellitus. The patient took calcium channel blockers and long-acting angiotensin-converting enzyme inhibitors for hypertension. The patient had been a smoker of two packs per day for more than 25 years. The lesion had developed for almost a month and a half before the first visit.

Upon extra-oral examination, no abnormalities were detected. Intra-oral examination revealed a large, exophytic, rapidly growing, soft swelling with an irregular surface extending from the upper right central incisor to the upper right first molar, causing rapid expansion of the buccal and palatal alveolar bone (**Figure 1**).

When palpated, the swelling was soft, compressible, and bled easily. Grade III mobility was associated with the upper right lateral incisor, upper right canine and upper right first premolar. In addition, grade II mobility was associated with the upper right central incisor, upper right second premolar, and upper right first molar. The patient was not in pain, but felt discomfort due to the rapid growth of the lesion. In addition, the presence of the lesion made it difficult for the patient to maintain oral hygiene, thereby favouring the lesion's growth.

The patient denied having unexplained pain, fevers, lymphadenopathy, persistent cough, hoarseness, swallowing difficulty, loss of appetite, night sweats, or numbness in the lesion's area, or any other warning manifestation that might raise the index of suspicion for malignancy.

A pre-operative orthopantomogram (OPG) showed multiple non-restorable teeth in both jaws, as well as generalised, horizontal moderate to severe bone loss (**Figure 2a**). Pre-operative cone beam computed tomography (CBCT) showed an ill-defined lesion on the palatine process of the right maxillary and alveolar bone (**Figure 2b**).

Management

The treatment plan was discussed with the patient and began with advising him to quit smoking and participate in a smoking cessation programme. Thereafter, an incisional biopsy of the lesion was performed under local anaesthesia to detect the precise diagnosis. The surgical site was sutured using polylactic acid suture 3/0. The biopsy was sent to the histopathology laboratory, and following histopathological assessment (**Figure 3**), the diagnosis was of a PG.

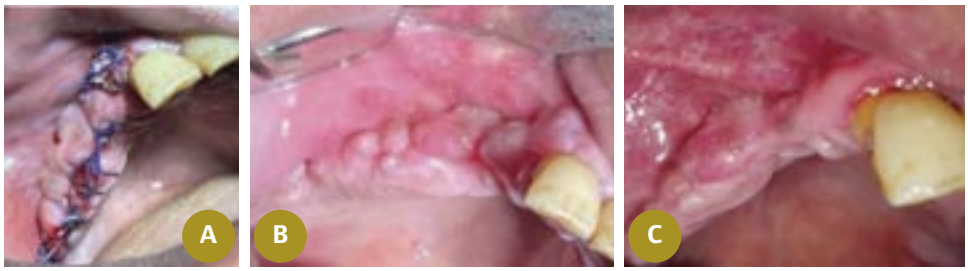

FIGURE 5: One week (A), three weeks (B) and one year (C) after the operation, showing good healing with no signs of infection. The patient reported a satisfactory result.

Table 1: Case reports included in the literature review (total = 10).

Authors	Summary of the case			Site of the lesion	Management	Conclusion
	Gender	Age	Clinical characteristics			
(Shetty *et al.*, 2020)[12]	Female	13	Gingival swelling that bleeds easily while brushing, started about five months previously	Anterior maxilla	Excisional biopsy and extraction of affected teeth	Awareness of the aggressive behaviour of pyogenic granuloma is crucial to avoid the inadvertent treatment of this reactive lesion
(Kumar and Agarwal, 2019)[11]	Female	11	Growth in the oral cavity located at the marginal gingiva	Posterior mandible	Excisional biopsy and extraction of affected teeth	The appropriate management of pyogenic granuloma is related to accurate diagnosis
(Gefrerer *et al.*, 2016)[20]	Female	55	Growing granuloma three weeks after dental implants were loaded with splinted porcelain-fused-to-metal crowns	Posterior mandible	Excisional biopsy	It is important with high recurrent types of pyogenic granuloma to have a long-term follow-up
(Sharma *et al.*, 2012)[19]	Female	13	Irregular gingival growth in the past two years that bleeds easily, associated with a difficulty chewing and erosion of the alveolar bone	Posterior maxilla	Excisional biopsy	The aggressive type of pyogenic granuloma is associated with erosion of the alveolar bone, maxillary sinus invasion, mobility, and disablement of affected teeth
(Martins, Piva, da Silva, 2011)[17]	Female	20	Asymptomatic nodular mass of three weeks' evolution on the buccal and palatal gingiva with bone resorption around the right lateral incisor	Anterior maxilla	Incisional biopsy followed by excisional biopsy	Pyogenic granuloma can mimic tumours associated with extensive loss of alveolar bone
(Mubeen *et al.*, 2011)[18]	Female	63	Growth in the right molar region lasting for three months	Posterior mandible	Excisional biopsy and antibiotic coverage of amoxicillin 500mg *tid* for five days	Maintaining good oral hygiene and preventing recurrence of the lesions, with regular follow-up, is required when managing the aggressive type of pyogenic granuloma
(Ababneh and Al-Khateeb, 2009)[16]	Female	28	Massive gingival swelling with alveolar bone loss beneath the lesion	Posterior mandible	Excisional biopsy under general anaesthesia during pregnancy with no untoward reactions	The aggressive type of pyogenic granuloma can mimic malignant tumour behaviour
(Jadwat *et al.*, 2008)[15]	Male	14	Overgrowth lasting for 18 months with loosening of the upper anterior maxillary teeth	Anterior maxilla	Excisional biopsy, antibiotic coverage and chlorhexidine mouthwash	It is important to have an appropriate histopathological investigation to determine whether the granulomatous mass may not be a malignant lesion
(Lee and Polonowita, 2007)[14]	Female	37	Recurrent vascular swelling	Anterior mandible	Deep scaling, chlorhexidine mouthwash for two weeks and oral hygiene instruction followed by an excisional biopsy after one month	It is mandatory to identify all the possible causes of the pyogenic granuloma before treatment initiation to help avoid expensive and complex treatment
(Ramirez *et al.*, 2002)[13]	Female	9	Reddish, sessile swelling	Posterior mandible	Excisional biopsy	Severe pyogenic granuloma is a common oral lesion during puberty

Table 2: Review study included in the literature review.

Authors	Type of study	Summary of the study	Site	Management	Conclusion
(Janê-Salas *et al.*, 2015)[3]	Review	Sixteen case reports of 21 patients (i.e., 15 patients diagnosed with peripheral giant cell granuloma and five patients diagnosed with pyogenic granuloma)	Mandible > maxilla	Excisional biopsy and curettage, although one case involved excision with Er-YAG laser	The aggressive nature of pyogenic granuloma and peripheral giant cell granuloma was associated with dental implants; however, the robustness of the evidence is unclear

Table 3: Retrospective study included in the data analyses.

Authors	Type of study	Aim	Site	Management	Conclusion
(Shuster *et al.*, 2021)[21]	Retrospective study	To investigate the clinical and histopathological parameters of lesions mimicking peri-implantitis in 65 patients (age range 39-80 years; 62% female, 38% male)	Associated with dental implants	Excisional biopsy and curettage	Pyogenic granuloma with aggressive behaviour was represented at 25% with a recurrence rate of 6% when associated with dental implants. The histopathological analysis is crucial to reaching a definitive diagnosis and treatment

Definitive treatment included a complete excision of the lesion from the buccal and palatal aspect associated with extraction of all hopeless teeth (upper right lateral incisor, upper right canine, upper right first premolar, upper right second premolar, and upper right first molar). Curettage and alveoloplasty were performed, followed by irrigation and haemostasis achieved by suturing to promote primary healing (**Figure 4**).

Postoperative instructions were given (i.e., maintain good oral hygiene and a soft diet, and avoid spitting in the first 24 hours), and antibiotic coverage of amoxicillin 500mg three times daily for seven days, as well as painkillers, was prescribed. The patient tolerated the procedure without complications and was discharged on the same day.

The patient attended his recall visits (at one week, three weeks and one year postoperatively). Clinical examination showed sufficient healing with no signs of recurrence or infection (**Figure 5**).

Discussion and review of the literature

The current case report was conducted based on the CARE (CAse REport) Checklist developed by the Joanna Briggs Institute (JBI) at the University of Adelaide, South Australia. Ovid, Medline and Embase (1946 to 2022) were searched for relevant articles related to an aggressive PG. Clear search strategy keywords (i.e., pyogenic granuloma.mp. or granuloma, pyogenic, aggressive granuloma.mp., aggressive.mp., and a combination of these keywords) were used to search the relevant articles. Three evaluators worked independently to include or exclude the relevant studies. All types of studies in the English language were included from 1946 to January 14, 2022. Only 12 articles were found to be related to aggressive PG. Ten of these were case reports (**Table 1**),[11-20] one was a review (**Table 2**),[3] and one was a retrospective study (**Table 3**).[21]

Site of PG

Similar to the current case, five case reports reported that the site of the PG was in the maxilla.[12,13,15,16,19] In the remaining five case reports, the PG was reported in the mandible.[11,14,16,18,20] One review included in this article discussed PGs and found that the location of the majority of included cases was the posterior part of the mandible without bone loss.[3] In addition, a retrospective study showed a site of a PG associated with a dental implant.[21]

Treatment modalities

In our case report the treatment of choice was an excisional biopsy under local anaesthesia as well as the extraction of hopeless teeth that were associated with the lesion. Similar to the current case, three case reports were found to treat a PG by means of an excisional biopsy.[16,19,20] In one case, the treatment was oral prophylaxis followed by teeth extraction and an excisional biopsy.[11] Another case used an incisional biopsy followed by an excisional biopsy after the histopathological report.[17] Two other case reports used antibiotics after an excisional biopsy without teeth extraction.[15,18] One case report outlined treatment of localised aggressive periodontitis combined with an excisional biopsy.[15] Additionally, one of the included case reports was that of an excisional biopsy with extraction of the affected teeth without oral prophylaxis.[12] What is more, chlorhexidine mouthwash was used for two weeks to decrease the lesion size, and then an excisional biopsy after one month was also reported.[14] In addition, a bone trough was reported as a method of management.[20] The included review in the data analyses illustrated 16 cases of PGs, with successful treatment including an excisional biopsy and curettage.[3]

Aggressive pyogenic granuloma

The current case presented a diabetic and hypertensive patient, who attended the dental clinic while complaining about an aggressive lesion. Our case, supported by other reported cases in the literature, showed that an aggressive PG could appear clinically as an irregular soft lesion, purple and reddish and bleeding easily, with resorption of the alveolar bone. On the other hand, the clinical picture of a PG is often characterised as an asymptomatic, painless lesion covered by a yellow fibrinous membrane that grows slowly without bone loss.[20] In addition, an aggressive PG can be associated with mobile teeth in the lesion area.

The appearance of the aggressive PG in our case report is similar to that of aggressive PG developing in association with dental implants. For example, Janê-Salas *et al.* (2015) emphasised in their review that aggressive PG is associated with cases that include dental implants.[3] Similarly, in their retrospective study, Shuster *et al.* (2021) found that aggressive PG was represented at 25%, with a recurrence rate of 6% when it was associated with dental implants.[21]

Conclusions

A PG could exhibit aggressive behaviour that mimics malignant lesion behaviour, with fast growth, rapid expansion of the buccal and palatal bone, bleeding, and alveolar bone loss associated with mobile teeth. Aggressive PGs were reported to be more commonly associated with dental implants, mimicking peri-implantitis. Histopathological assessment is essential in order to exclude any potential malignancy and help with early referral to formulate a definitive diagnosis and treatment plan.

Acknowledgement: The authors would like to acknowledge histopathology consultant Dr Nasir Al-Noor at King Faisal Hospital (Makkah, Saudi Arabia) for his contribution to this project by reporting and reading the histopathological slides.

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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. One of the following is a differential diagnosis of pyogenic granuloma:

- ○ A. Haemangioma
- ○ B. Median rhomboid glossitis
- ○ C. Herpes zoster virus
- ○ D. Erythema multiforme

2. One of the widely used treatments for pyogenic granuloma is:

- ○ A. Cryosurgery
- ○ B. Excisional biopsy
- ○ C. Incisional biopsy
- ○ D. Injectable medication/solution

3. Which of the following statements is correct?

- ○ A. Pyogenic granuloma is a benign inflammatory hyperplastic lesion
- ○ B. Pyogenic granuloma is a malignant lesion
- ○ C. Pyogenic granuloma has a higher propensity to present in males
- ○ D. Pyogenic granuloma is more commonly observed in the mandible

Care and treatment of frail older adults in the dental office

Learning outcomes

Readers should be able to:

- understand that ageing is a worldwide phenomenon, and has resulted in an increase in frail older adults who now have maintained all or part of their dentition and require continuing oral health services in the community;
- recognise that decision making and treatment planning for these frail older adults is complicated by their social circumstances, their systemic health, the consequences of the medication they are using, and their ability to access care and pay for it; and,
- develop a rational treatment plan for frail and dependent older adults who are still living in the community.

Introduction

According to national surveys, the population of the Republic of Ireland (ROI) and Northern Ireland (NI) is ageing.[1,2] In 2019, the population in the ROI aged 65 years old or older was approximately 700,000, and approximately 315,000 in NI.[1-3] Currently, 14% of the ROI population and 17% of the NI population are aged 65 or older.[3] The projection for 2051 is that these populations will make up 26% of both countries.[3]

There is greater heterogeneity among Irish older adults as compared to any other age groups.[4] This heterogeneity is influenced by the person's genotype and modulated by environmental factors such as cultural, social, economic, and cohort experiences, which result in their lifestyle and health beliefs.[5] These same factors also determine their oral health and the amount of oral healthcare they have received over their lifetime. Therefore, a dental provider should consider the consequences of how the proposed treatment fits into the patient's health, beliefs, and lifestyle.[6]

In medicine, once a diagnosis is made, there is usually enough scientific evidence to support a therapy. However, in dentistry there may be multiple treatment plans and many of these plans lack data to support them. Dentists, like surgeons, need complex operating equipment to remove plaque, calculus and infected carious tissue, extract teeth, and restore the dentition to shape and function.[7]

Dentists function best in their dental office with all their equipment. If an older adult can use public transport or drive their own vehicle, then access to dental care is not a limiting issue. However, it is estimated that half of people aged 65 and over in NI and one-third in the ROI report limitations on their daily activities and lives.[3] These older adults can be designated as frail, since they have lost some of their independence.[5] Many still live independently or semi-independently with support from their family and friends, and whatever professional support services are available in their communities.[5] The access to dental services is limited for these frail older adults, unless other people provide transport and the dental offices are accessible for patients using walkers and/or wheelchairs. Dentists treating frail older adults need to understand the implications of the patients' medical problems and pharmacology on oral health and oral healthcare. A critical evaluation is of the patient's ability to maintain daily oral hygiene independently.[8] Also, the dentist must assess the patient's ability to tolerate the prescribed treatment.[7]

In this paper, the authors will discuss the care and treatment of frail older adults in the private dental office using a case history to illustrate some of the issues, problems and decision-making required for the care of this population.

Case history

Social history

Fred is a 67-year-old retired farmer who is living with his wife in a flat attached to the main farmhouse where his son and family live. He was brought for treatment by his son because he said "I need some teeth to chew with" and thought he might need complete dentures. His son drove him for one and a half hours to the appointment.

Medical history

Fred is allergic to sulfa drugs and tells us that he had a stroke about 10 years ago, which has left him with a minor weakness in his right leg that he now uses a walker for. He is taking clopidogrel, which acts as a platelet aggregation inhibitor. This prevents further strokes but can increase the risk of gingival bleeding.[9] To control his hypertension, he has been prescribed lisinopril, an angiotensin-converting enzyme (ACE) inhibitor, which reduces peripheral arterial resistance and reduces his blood pressure.[9]

To access a dental clinic, Fred needs a parking spot near the entrance to the clinic with a ramp to the pavement. The clinic doors should be opened electronically and be wide enough to accommodate a walker/wheelchair. If the clinic is not on the ground floor, there needs to be a lift.

Leonardo Marchini
Professor and Chair
Department of Preventive and Community Dentistry
The University of Iowa College of Dentistry and Dental Clinics
Iowa City, IA, USA

Ronald L. Ettinger
Department of Prosthodontics
The University of Iowa College of Dentistry and Dental Clinics
Iowa City, IA, USA

Corresponding author: Leonardo Marchini, Department of Preventive and Community Dentistry, The University of Iowa College of Dentistry and Dental Clinics, Iowa City, IA, USA E: leonardo-marchini@uiowa.edu

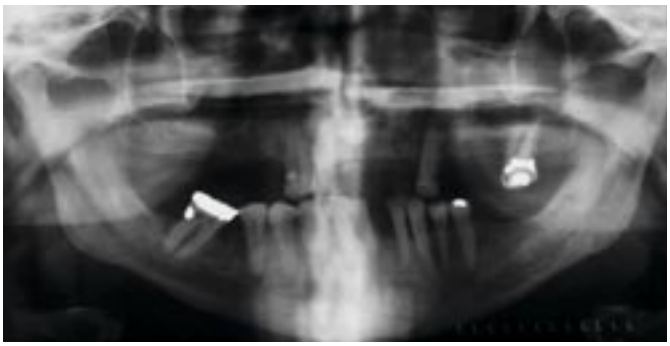

FIGURE 1: Orthopantomograph showing remaining teeth at the time the patient sought treatment, showing universal bone loss.

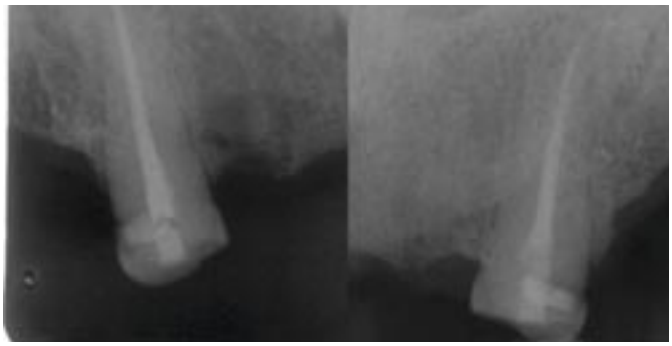

FIGURE 2: Periapicals of #13 and #23 after root canal therapy, and having been prepared as overdenture abutments.

Fred's medical history also includes adult-onset diabetes, which he controls with oral antidiabetics, i.e., metformin and glyburide. His appointments should be in the mid-morning, after he has had breakfast and taken his medication. Blood glucose levels should be measured on a regular basis, which Fred does not do. Therefore, before any invasive surgical procedure, it is wise to measure his blood glucose levels so that the stress of the procedure does not cause any unwanted side-effect, such as a hypoglycaemic episode.[10]

Fred has benign prostate hyperplasia and takes oxybutynin for it, which has a very high xerostomic potential.[11] Oxybutynin contributes to a higher risk for caries and periodontal disease, as well as reducing the patient's ability to adapt to removable dentures. Fred should be escorted to the restroom prior to treatment in order to prevent an accident.

Fred reported osteoarthritis of his knees and back. Therefore, it is important to put pillows under his knees and to not tip the chair too far back so that he is comfortable in the dental chair. Also, seeing Fred in the mid-morning gives him time to stretch after lying flat in bed all night.[12] He has been prescribed 650mg of an enteric-coated aspirin three times daily for pain associated with his osteoarthritis.

Fred was diagnosed with Parkinson's disease three years ago, and presents with mild tremors, which he controls with levodopa/carbidopa and ropinirole HCL. Both of these medications are potentially very xerostomic and increase his risk of caries and periodontal disease.[13]

Fred has been very forgetful recently and has lost interest in his hobbies. Recently, he forgot to turn off the gas underneath a pot and nearly caused a fire. Consequently, his family had his physician administer a quick screening test for early dementia, as well as the clock drawing test. These tests suggested that Fred was suffering from early dementia and was frustrated. To help him control his frustration, his physician has prescribed sertraline, a selective serotonin reuptake inhibitor (SSRI) antidepressant.[14]

Dental history

Fred's dental history five years ago included two failing fixed partial dentures (FPDs) from #14 to #16, and from #24 to #26, which were found to have extensive root caries and periapical lesions. These teeth were extracted, and were not replaced with a prosthesis. On the mandibular arch, the molars were missing on the left side and tooth #31 was mobile with deep pockets and has been extracted.

All teeth remaining in the maxillary arch were periodontally involved and mobile, except for teeth #13 and #23 (**Figure 1**). In the mandibular arch, the remaining teeth were from #35 to #32 and from #41 to #45 and also #47. There was significant bone loss associated with these remaining teeth, with no significant mobility.

Treatment planning and implementation

After evaluation and discussion with the patient and his family, the chosen treatment plan was to maintain #13 and #23 as overdenture abutments after elective endodontics (**Figure 2**). This decision was made because the maintenance of the other maxillary teeth would have required intensive periodontal therapy followed by splinting of the mobile teeth, and either dentures or implants to replace missing teeth. This alternative treatment plan would require extensive and complex personal oral home care and has a high risk of failure because Fred's dementia will advance and result in progressive deterioration of daily oral hygiene.

The overdenture abutment teeth were cut down to 1.5mm above the free gingival margin, rounded, and restored with Fuji II LC (GC America, Alsip, IL). An immediate complete overdenture was fabricated opposing his mandibular dentition. The patient and his family were not concerned about the missing #31, so no removable partial denture (RPD) was planned as it would have increased his risk of caries and periodontal disease. The treatment provided for the mandibular arch was disease control, i.e., periodontal maintenance and direct restorations, as well as preventive care, which included fluoride varnish (22,600ppm sodium fluoride) applications on all remaining teeth and a prescription for 5,000ppm neutral sodium fluoride toothpaste.[15]

Patient

Fred's appointments were all at mid-morning, using stress reduction protocols, and limiting the use of epinephrine to a maximum of 2.5 carpules of lidocaine with 1:100,000 epinephrine.[16] Stress reduction protocols for people with dementia include a quiet environment, minimal distractions, a familiar and consistent dental team, and short appointments. To prevent cheek biting, use of a short-acting anaesthetic was required for the procedure. To prevent confusion, we used simple commands, and to ensure co-operation during treatment, we made sure that Fred was comfortable in the chair by adjusting pillows and/or chair position as well as allowing restroom breaks. A family member had to be either at chairside or in the waiting room in case Fred had a panic attack, in which case all dental procedures would have to be ceased as quickly as possible, allowing Fred to leave the chair right away.[7]

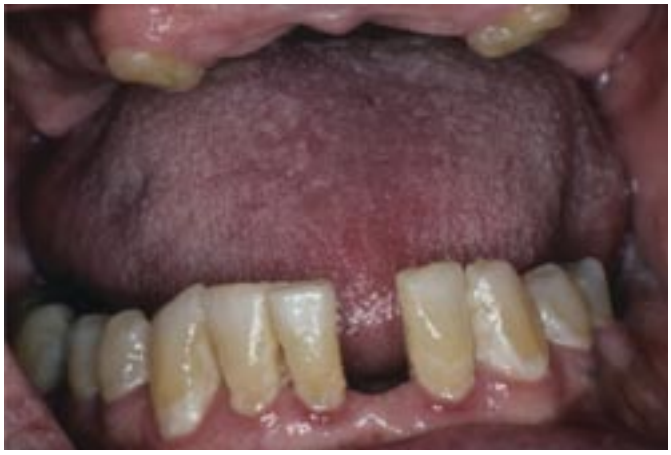

FIGURE 3: Intra-oral photograph of the patient after three months, showing marginal gingivitis and demineralisation due to poor oral hygiene.

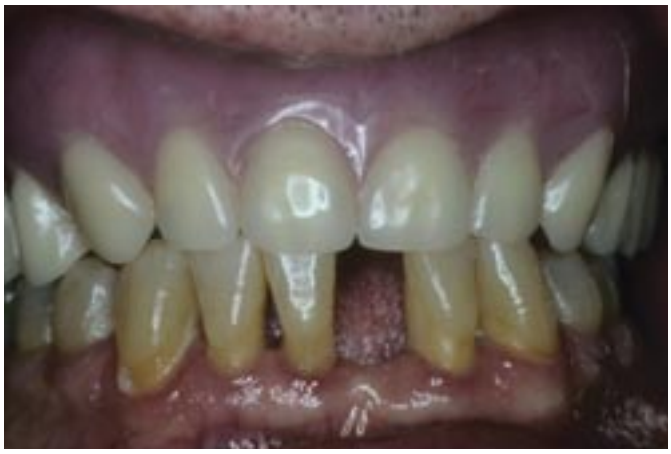

FIGURE 4: Intra-oral photograph taken two years after initial treatment. The photograph was taken after cleaning the teeth and the dentures, but the marginal gingivitis is still present, and the probing depths of the posterior teeth have increased. The patient has not returned for further care after this appointment.

Managing xerostomia

Several of Fred's medications have the potential to affect the quality as well as the quantity of saliva produced by the mucous and serous salivary glands and result in a dry mouth. Medications are the main cause of dry mouth among older patients.[17] However, the patient's physician may be able to change a xerostomic medication for one that is less xerostomic. Often, such a change is not possible due to the patient's medical problems. Therefore, the dentist needs to try and manage xerostomia by using saliva stimulants and substitutes,[17] including xylitol chewing gums and lozenges.[18] Drugs can also be used to stimulate saliva production, such as pilocarpine and cevimeline. Saliva substitutes include liquid and gel formulations containing glycerin and water to provide lubrication and moisture, as well as a flavouring agent. Unfortunately, saliva substitutes seem only to be effective for a short period of time, unless they contain a mucin.[18]

To reduce caries risk due to xerostomia, in-office fluoride varnish applications are useful for remineralisation because the varnish adheres to the tooth surface and releases a high quantity of fluoride for a longer period of time.[15] Additionally, the daily use of high-fluoride-concentration toothpastes constantly replenishes the oral cavity with fluoride. However, it is difficult for patients with progressive cognitive impairments to use a fluoride rinse.[15]

MI Paste (GC America, Alsip, IL) helps to supply calcium and phosphate to saliva, thus helping remineralisation. MI Paste is a useful preventive agent for patients with high caries rates as it can be easily applied to the tooth surface using fingertips after brushing and can be left on teeth. MI Paste should be applied at night, as the casein provides some moisturising capacity and helps to alleviate the patient's dry mouth. Another version of MI Paste is MI Paste Plus (GC America, Alsip, IL), which contains fluoride and should be used with 1,100ppm toothpaste and not with those containing 5,000ppm.[19]

Maintenance care

Fred returned after three months (**Figure 3**) complaining of a loose maxillary denture. On evaluation, he had marginal gingivitis associated with his mandibular dentition and a maxillary denture that was loose. His teeth were scaled and cleaned, and fluoride varnish was applied to all natural teeth, including the overdenture abutments. After cleaning the denture, the anterior intaglio was prepared for an in-mouth reline using Bosworth Truliner (Keystone Industries, Oss, Netherlands).

After six months, Fred returned for a regular recall with no complaints. His oral hygiene had not improved and the probing depths on the mandibular molars had increased slightly. An adult prophylaxis followed by fluoride varnish application was performed and oral hygiene instructions were re-emphasised to Fred and his family members. Fred returned after one year with no changes in his medical history, except for an increased level of confusion. His oral hygiene had not improved and his periodontal condition remained relatively stable with no visible caries lesions. Therefore, we scaled and cleaned his teeth and applied fluoride varnish. We also tried to convince his son to help him with brushing his teeth at least once a day.

At his two-year follow-up (**Figure 4**), Fred was a little more agitated and his oral hygiene was still poor. His probing depths had not increased very much, nor were there any visible caries. We were able to scale and clean his teeth, and apply a fluoride varnish. After this appointment, Fred did not return for any further appointments and all efforts to contact him or his family were unsuccessful.

Final considerations

This case history illustrates that it is possible to care for frail and dependent older adults in the office of a general dentist; however, the dentist needs to take a careful medical and drug history, and be able to interpret how these diseases and medications may influence the management and treatment planning for these individuals.[7,8] The dentist also needs to be capable of modifying the concept of an ideal treatment plan to appropriately accommodate to the patient's individual health and social issues.[20] If patients have progressive cognitive impairments, it is important to simplify the treatment, and reduce the duration and number of appointments.[14] This

kind of treatment has been called rational dental care, as it is the most appropriate treatment for that particular patient after evaluating all of the patient's modifying factors.[20] The principles of rational dental treatment planning are firstly to eliminate pain and infection, and secondly to try to improve oral function. All other treatment after that is elective, and dependent on the patient's desires, their capacity to tolerate that treatment, their ability to pay for the care required, and the dentist's skills to be able to deliver that care.[20]

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Quiz answers

Questions on page 250.

1. Statutory Instrument (SI) No. 30 of 2019 Radiological Protection Act 1991 (Ionising Radiation) Regulations 2019 (Protection of Staff and Members of the Public), and SI No. 256 of 2018 European Union (Basic Safety Standards for Protection against dangers arising from Medical Exposure to Ionising Radiation).
2. The five roles are: undertaking; designated manager; radiation protection officer (RPO); radiation protection advisor (RPA); and, medical physics expert. You must assign a person to each of these roles.
3. A record must be kept for every radiograph taken, which includes the following information: date; patient reference; type of x-ray; justification for exposure; pregnancy status; dose Kv/mA/time; if an aiming device was used; image report; image quality grade (1/2/3); repeat and reason; and, practitioner initials.
4. Each x-ray unit must get a quality assurance test report every two years from your qualified and registered medical physics expert.
5. ALARA stands for "As Low As Reasonably Achievable". Good practice must be followed so that doses of radiation to patients, staff and members of the public are as low as reasonably achievable without compromising the quality.

A randomized clinical study of the performance of self-etching adhesives containing HEMA and 10-MDP on non-carious cervical lesions: a two-year follow-up study

de Oliveira RP, de Paula BLF, Alencar CM, Alves EB, Silva CM.

Objective: To evaluate the association of HEMA and 10-MDP in the clinical performance of self-etching adhesives in the restoration of NCCLs during two years.

Materials and methods: A total of 60 restorations were performed in 17 volunteers and randomised into three groups: G1 (n = 20) – Prime and Bond Universal (10-MDP); G2 (n = 20) – Optibond All-in-One (HEMA); and, G3 (n = 20) – Clearfil SE (10-MDP and HEMA). No cavity preparation was performed. After two years, the restorations were evaluated using the modified USPHS criteria for retention, marginal adaptation/staining, postoperative sensitivity and secondary caries. The results were analysed using Fisher's exact test and Kruskal-Wallis test.

Results: All groups showed 100% retention rates, except G1, which lost two restorations ($p > 0.05$). Regarding marginal adaptation, G1 showed greater deficiency, as only eight restorations (40%) remained intact ($p < 0.05$). Regarding marginal staining, G1 and G2 showed higher rates, as only 12 restorations (65%) in each one were free of staining ($p < 0.05$). All groups showed similar results for postoperative sensitivity and secondary caries ($p > 0.05$).

Conclusion: The association of HEMA and 10-MDP monomers in the self-etching adhesives did not influence the clinical performance of the NCCL restorations with respect to retention, postoperative sensitivity, and incidence of secondary caries. However, they positively influenced the marginal adaptation and marginal staining at the two-year follow-up.

Clinical significance: The association of HEMA and 10-MDP monomers in the self-etching adhesives positively influences the clinical performance of the NCCL restorations with respect to marginal adaptation and marginal staining.

J Dent. 2023;130:104407.

Chlorhexidine in dentistry: pharmacology, uses, and adverse effects

Poppolo Deus F, Ouanounou A.

Objectives: The aim of this work was to review the current uses of chlorhexidine (CHX) in dentistry based on its mechanism of action, while highlighting the most effective protocols that render the highest clinical efficacy while limiting adverse drug reactions.

Methods: A literature search was conducted using the key words chlorhexidine, mechanism of action, adverse effects, and dentistry, using databases in the University of Toronto library system. The titles and abstracts were read, and relevant articles were selected.

Results: A total of 1,100 publications were identified, 100 were investigated, and 67 of them were used. Out of the 67 selected articles, 12 were reviews on CHX, five articles focused on CHX gels, 13 focused on CHX mouthwashes, eight focused on CHX products, 13 discussed adverse effects associated with CHX, 13 focused on periodontal pathology and treatment, six focused on implant periodontal and dental surgeries, seven evaluated effects on caries, six looked at the mechanisms of action, and 12 focused on the antibacterial and antimicrobial impact on the oral biome. There were multiple areas of overlap among the articles, and results showed that CHX provides different uses, but mainly as an adjunct to various treatments. Mouthwash was the superior medium when used in short time spans when mechanical prophylaxis was not possible for the prevention of gingivitis and maintenance of oral hygiene. CHX products are often used in periodontics, post oral surgical procedures, and as a prophylaxis for multiple invasive procedures, with minimal adverse effects. Tooth staining was the most negative adverse effect reported by patients.

Conclusions: CHX's antimicrobial properties make it an ideal prophylactic when mechanical debridement is not possible. CHX mouthwash appears to be more effective compared to gels. Concentrations of 0.12% to 0.2% are recommended; any mouthwash with concentrations above 0.2% will unnecessarily increase the unwanted side effects. CHX is useful among various areas of dentistry including oral surgery, periodontics, and even general dentistry. For long-term treatments, especially in periodontitis patients (stage I-III) undergoing nonsurgical treatments, CHX chips are recommended. CHX chips are also recommended as an adjunct to implant debridement in patients with peri-implant mucositis and peri-implantitis over CHX mouthwash and gels.

Int Dent J. 2022;72(3):269-277.

Effects of oral inflammatory diseases and oral hygiene on atrial fibrillation: a systematic review

Zhang Z, Chen F, Gao X, Xiao B, Liu F, Lu J.

Objective: Research evidence suggests a link between periodontitis (PD) and atrial fibrillation, but the nature of this link is unclear. This study aimed to systematically review and evaluate the association between PD, other oral diseases, and atrial fibrillation, and the role of oral hygiene in preventing atrial fibrillation.

Methods: We searched the Medline, Embase, Cochrane Library, and Web of Science databases for the clinical study of oral health and atrial fibrillation from inception to November 2022. Oral health conditions included PD and other oral inflammatory diseases, regular oral hygiene, and tooth brushing. The primary outcomes were the risk of new-onset atrial fibrillation in patients with oral disease, the effect of regular oral care on preventing atrial fibrillation, the effect of frequent tooth brushing on preventing atrial fibrillation, and the incidence of atrial fibrillation in PD patients.

Results: Eight clinical trials with a total of 4,328,355 patients were included. The result of the research showed that PD and other impaired oral health may be associated with new-onset atrial fibrillation, and its severity was dose-responsive to the risk of atrial fibrillation. The incidence of atrial fibrillation in patients with severe PD was about 16.3%. Moreover, PD may increase the risk of long-term arrhythmia in patients with atrial fibrillation. Regular oral care and frequent tooth brushing can reduce the incidence of atrial fibrillation.

Conclusion: Regular and moderate oral hygiene, frequent tooth brushing, and prevention of PD and other oral inflammatory diseases could reduce the occurrence of atrial fibrillation. It is recommended to strengthen the popularisation of oral health knowledge in the publicity related to atrial fibrillation.

Int J Clin Pract. 2023;2023:1750981.

SITUATIONS WANTED

Experienced caring general dentist available for Botox sessions in the greater Dublin and surrounding areas. Contact irishdentist@hotmail.com if of interest and for further details.

Dentist available for full-time position. Contact admin@woodstonpersonnel.com.

SITUATIONS VACANT

Associates

Part-time associate required for busy practice. Full book guaranteed. Fully computerised. Digital x-ray. Eligible to work in Ireland and IDC registration required. Contact annedental@hotmail.co.uk.

South Dublin: Part-time associate (two to three days) wanted for long-established busy practice with possibility to expand. Fully computerised, digital X-rays. Great support team in friendly environment. Contact scddental99@gmail.com.

North Dublin: Part-time dental associate (two to three days) position available in busy, modern, fully private practice with digital scanner, OPG, Exact and digital radiographs. Great support team in friendly environment. Hygienist and specialists on site. Contact northdublindentalassociate@gmail.com.

Experienced dental associate required in busy modern practice in Dublin 14. Private/PRSI, free parking, hygienist, full support from our friendly team. Email dublin14dentist@gmail.com.

Experienced dental associate required for a busy, modern practice in Cork City. Private/PRSI, free parking, Hygienist and full support from our fantastic team. Contact jennifer.meagher@gmail.com.

Associate dentist needed for busy private family practice. Generous terms, long-term support staff and relaxed environment. Initial two days a week with scope for increase. Interest in endo and implant restoration helpful. Contact campbelldentald@yahoo.ie.

Dublin associate job. Two to three days available in busy, modern, fully private practice with beautiful surrounds. Friendly patients, staff and hygienists. Excellent remuneration. Contact cosullivan7@icloud.com.

Dublin dental associate position. Two to three days available in busy, modern, fully private practice with state-of-the-art facilities. Experienced and friendly support staff. Excellent remuneration. Specialists and hygienist on site. Mentoring available. Contact dublindentistrecruitment@gmail.com.

Dr Paul O'Boyle seeks full-time associate to take over busy list of private patients for a colleague moving home. Eact, iTero scanner, biomimetic interest helpful. https://1drv.ms/p/s!Au2G9pTl1owEvSl11YyoIiXaGsYt?e=rEndAE. Contact poboyleriverside@gmail.com.

Cork City: Associate required for multi-surgery practice. Full support with scanner and on-site lab. Flexible working conditions. Contact corkcityassociate@gmail.com.

Associate dentist needed for busy private/PRSI practice. 50%, training provided in orthodontics, full/part-time. Modern friendly practice. Fully booked. Position also available for a dental hygienist. Contact: diamondsmilesjobs@gmail.com.

Aesthetic-minded associate dentist required for busy clinic in Chatham Street, D2, with heavy influence on Invisalign and bonding. Full digital workflow with iTero scanners, digital x-rays, etc., in operation. Invisalign training provided for the right candidate. Contact louise@clearbraces.ie.

Part-time dental associate required for two to three days in a modern four-surgery practice in Ennis, Co. Clare. Experienced and friendly support staff. Excellent remuneration. Contact gbrowne.ennis@gmail.com.

Dental associate required for modern four-surgery practice. Cavan Town. Progressive, supportive practice. OPG, computerised surgeries, iTero scanner, endo microscope, in-house endo and oral surgery referrals available. Hours can be flexible if required. 50% remuneration for all treatments. Apply with CV to frances@railwaydentalsurgery.com.

Associate required for Saturday mornings 9.00am to 2.00pm in busy practice in Ongar Village. Fully private, replacing outgoing dentist, 50% remuneration, experienced nurse, hygienist services, starting September. Please send CV to Ongar.dental@gmail.com.

Associate dentist sought, Cork City. Busy, friendly, family practice, general dentistry. Experience essential. Contact amonahan1962@gmail.com.

Experienced dental associate required in Carlow Town. Full-time position available in private, well-established clinic. Be part of a great multidisciplinary team with many visiting specialists. Excellent backroom support. Cerec, in-house laboratory, digital scanner, CBCT. Please send CV to bbarrett@pembrokedental.ie.

Associate required to replace departing colleague in busy west Limerick practice. Practice has in-house prosthodontist, orthodontist, hygienists. Mentorship available for the correct candidate. Experienced support staff. Friendly working environment. Please reply with CV to Shane Mullane at info@mullanedental.ie.

Associate dentist required for busy practice in north Co. Dublin. Must be IDC registered. Flexible hours. Good pay rate. Contact northcitydental@gmail.com.

Part-time associate dentist required two days (Tuesday and Saturday) for modern practice. Fully private. Experienced and friendly support staff. Please send CVs to team.stardental@gmail.com.

Donegal: Finn Dental Care is expanding. We are seeking an associate dentist to accommodate our high patient demand. Modern practice established 25 years+. IV sedation, implants, Invisalign, CBCT, 3Shape digital scanner. Experienced dentist preferred. Email bradley@finndentalcare.com.

Part-time dental associate required for busy, modern, fully private practice in Dublin. Friendly, experienced support team. Specialist and hygienist on site. 3shape scanner, OPG, digital X-rays, Exact software. Flexible days/hours. Excellent remuneration. Mentoring available. Contact northdublindentalassociate@gmail.com.

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, November 17, 2023**. 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	€123	€246
26 to 40 words	€147	€295

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.

Part-time associate needed for busy north Dublin mixed practice. Digital OPG, friendly experienced staff. Email CV to app2dental@gmail.com.

Associate needed for fully private, modern practice in Kilkenny. Experienced friendly staff. Digital OPG, hygienist, orthodontics, prosthodontics, endodontics, cosmetic. Free parking. Email dentistkilk22@gmail.com.

Associate needed for busy practice in Wexford Town centre specialising in all aspects of family and cosmetic dentistry. Send CV to mmarsg@gmail.com.

Associate required for a busy specialist/general, state-of-the-art, modern and friendly private practice in Naas. We offer great remuneration with flexible working hours and a very supportive team. Forward your CV to info@naasdental.ie.

Dental associates required for modern south Dublin practice. Full/part-time. Excellent terms given. Call 087-130 9310.

Part-time associate needed for busy south Dublin mixed practice. Digital OPG, friendly experienced staff. Email CV to info@squaredental.ie.

Associate dentist, part or full-time required to replace departing colleague for long-established general practice in south west Dublin City. IDC registered only. CV to mftcleary@gmail.com.

Co. Cork: Associate wanted to replace departing colleague in Youghal. Easy commute to Cork City. Busy four-surgery practice. Fully digital, scanner, longstanding support staff. Please send CV to Youghaldentist@gmail.com.

Part/full-time associate position in modern, independently owned private practice in Kildare Town. Full range of treatments provided including implants, orthodontics, sedation and oral surgery. CBCT and IOS available. Mentoring available in any of specialist disciplines above. Contact Info@kildaredentalcentre.ie.

Part-time associate required to replace a departing colleague in our Newbridge practice. Fully digitised, Cerec. Mentoring for candidates interested in developing their skills. Reply with CV to james@theclinicnaas.ie.

Dental associate required for a busy, modern, private practice in Dublin City. Private/PRSI, free parking, hygienist and full support from our experienced and friendly team. Contact dublindentistrecruitment@gmail.com.

We are hiring an experienced associate to join our growing team in Drogheda on Thursdays and Fridays. All private practice. Immediate start. Digital workflow. Excellent support staff. Interest in endodontics would be advantageous. CV to angelamkearney@gmail.com.

Associate position available for full/part-time dentist in our busy Cootehill practice. Full book assured, Exact. Accommodation available and excellent terms for the right candidate. Email drcolmsmith@gmail.com, visit www.colmsmithdental.ie, or phone 087-235 4963.

Full-time or part-time dental associate position in fully private, well-established practice approximately 10-minute drive from Dublin city centre. State-of-the-art facilities, Exact software, digital radiographs, digital scanner, hygienists present. Friendly and experienced support staff. Contact dentalassociatepositiondublin@gmail.com.

Associate required for an award-winning dental practice in north Dublin. Come and join our team of dentists and specialists in a modern, family-friendly environment only 20 minutes from Dublin city centre and 10 minutes from the M50. Full or part time. Contact Orthosull@gmail.com.

Associate dentist required, part-time to replace departing colleague. Modern D2 practice near Luas. Exact, OPG, hygienist and excellent support staff. Experience required. Contact marycreddy@gmail.com.

Associate required for full-time position in busy Tipperary practice five days/week – part-time also available. Great working atmosphere, fully computerised practice. Immediate start available but all options considered. Please reply with CV to dentalpost1@gmail.com.

West Cork: Associate required to replace departing colleague. Full book. Friendly, modern, computerised surgery with digital OPG and intra-orals. Full support available. Contact obrien100@gmail.com.

Associate wanted to replace departing colleague in Athy. Busy practice. Fully digital, scanner, longstanding support staff. Please send CV to info@dentalsuite.ie.

Dentists

Part-time position available (one to two days per week) in busy south Dublin practice. Established book. New graduates welcome. Friendly, supportive team environment. Contact hello@ballybrackdental.ie.

Dentist wanted for a busy private Wicklow practice. Qualified support staff and digital equipment. Not corporate. No weekends or late evenings Monday to Friday, 9-5. Excellent earning and learning. Position also available for a dental hygienist. Contact: info@rathdrumdental.ie.

Full-time dentists required for modern, computerised, friendly and expanding practice. Guaranteed minimum €130k salary with higher earning potential. Own nurse, surgery and equipment required will be supplied. Excellent support staff. Email your CV to northdublindentalclinic@gmail.com.

Dentist wanted for a busy practice in Carlow town. Wonderful support staff in a friendly, professional environment. Fully digital. Experience preferable but not essential. Excellent earning and learning. Contact montgomeryhousedc@gmail.com.

Part-time position available (one to two days per week) in busy north Dublin private practice. Established book. New graduates welcome. Friendly, supportive team environment. Contact northdublindentalassociate@gmail.com.

Full/part-time dentist required to replace departing colleague in a busy, well-established clinic in Cork City. Fully computerised, digital X-ray, scanner and OPG available. Please email CV to info@grangedentalpractice.ie.

Portman Ireland has opportunities for GDPs and specialists in Dublin and Cork. Established practices with high earning potential and flexible hours, including options for overseas clinicians, e.g., one week on three weeks off. Full clinical and operational support provided. Contact grania.oconnell@portmandental.ie.

Dentist wanted, Monday to Wednesday, additional day could also be Saturday. Busy, well-established, modern, fully private practice in Dublin 7. Fully computerised, digital X-ray, CBCT, OPG, 3D scanner. Friendly staff, specialists, hygienists and excellent remuneration. Contact info@artmedica.ie.

Full/part-time dentist required for a busy practice in Arklow, Co. Wicklow. Excellent earning potential. Work permit and accommodation will be arranged if needed. Email CV to drgiri26@gmail.com.

Dental Care Ireland Waterford – new opportunity for a dentist with 2+ years' experience. High earnings, strong established book, fully flexible part/full-time on offer. Must be eligible to work in Ireland and have IDC certification. Contact careers@dentalcareireland.ie.

Dentist required for full-time permanent position located south Dublin/north Wicklow. Four days per week, no weekends/evenings. Well-established book, excellent support team in a custom-built dental clinic. Experience essential. Excellent remuneration. Contact begleycaitriona@yahoo.ie.

Ful- time dentist required to join our team in a longstanding, modern, busy practice in Dublin 22. Full book. Experienced staff. Great work environment. Please send CV to practicemanager221@gmail.com.

Dentist required for full-time position in busy, well-established general dental practice in Celbridge, Co. Kildare. Mostly PRSI and private patients. New graduate considered. Mentoring/support available. Replies with CV to brian.corcoran26@gmail.com.

Full-time dentist, two-year fixed term contract, busy practice in Galway. Experienced

staff. Guaranteed salary of €75k + negotiable OTE bonus. Experience an advantage, IDC registration, eligible to work in Ireland. Email practicemanagergalwaycity@gmail.com.

Kenneally Dental is seeking an experienced dentist on a full/part-time basis in a brand new surgery. The practice is located in Ballincollig. Private patients only. Applicants should mail info@kenneallydental.ie.

Dublin 24: Experienced dentist needed full-time or part-time in a busy, mixed, modern dental practice. Please send your CV to hrdental22@gmail.com.

Dentist needed in Australia for one-year contract. Competent in all areas of dentistry and willing to supervise new dentists seeking Council registration. Contact oaa2214@gmail.com.

Are you a passionate dentist or orthodontist looking for an opportunity to make a difference in patients' lives? Look no further! Our reputable clinic is seeking professionals like you to join our team based in Drumcondra. Contact Dublinsmilecenter@gmail.com.

Part-time dentist required three to four days per week. Experienced and friendly support staff. Immediate start. Computerised and digital X-rays. IDC registered. Must be able to work in Ireland. Send CV to annedental@hotmail.co.uk.

Dental Care Ireland Rathfarnham – high earning opportunity to join our established practice, which is ideally located. 7.5 to 30 hours per week, fully flexible days/hours. Strong patient books on offer. Experienced and friendly clinical team already in place. Contact careers@dentalcareireland.ie.

Dental Care Ireland Waterford – part-time, 14 hours on Wednesday and Thursdays. High earning opportunity to join our experienced and friendly clinical team. Strong patient books on offer within modern facilities. You must be registered with the IDC. Contact careers@dentalcareireland.ie.

Dentists required to join our expanding Dublin-based team. Must have two years' experience in general practice. Please email CV with cover letter to dublindentalclinics10@gmail.com.

Part-time position to replace a departing colleague in Newbridge and Celbridge, Co. Kildare, with potential to have a full position between both practices. Contact shackletonclinic@gmail.com.

Part-time general dentist position available two to three days per week in busy well-established practice in Celbridge, Co. Kildare. IDC registered. Free private parking. If interested, please send resumé to manager@oreillysdentalpractice.ie.

Malahide Dental Care – exciting opportunity to join our team. Full-time and part-time positions available. Lovely dentists and colleagues. Apply with CV to cirociao4@gmail.com.

We have an exciting opportunity for a dentist to work in our practices in Smithfield, Castleknock and Maynooth. A strong consultative approach to dentistry is required, with an interest in composite bonding. Contact Bobby@healthcaremarketingireland.ie.

Full/part-time in Kerry, close to Tralee and Killarney. Flexible hours. Recently renovated clinic. Fully digitalised, scanner, implants, RCT, facial aesthetics. Contact claire.osullivan91@gmail.com.

Part-time general dentist position available in a busy, well-established practice in Waterford (associate is reducing his hours). Must be IDC registered. Please reply with CV and cover letter to waterfordteeth@gmail.com.

A private general/specialist practice in Skerries, with highly equipped surgeries delivering quality service, alongside an excellent support team, is seeking a general dentist, experienced in restorative field, on a part-time basis. New graduate considered, support available. Contact yoursmile2612@gmail.com.

Beautiful state-of-the-art specialist orthodontic practice seeks newly qualified, passionate, enthusiastic general dentist to join our expanding team. Successful candidate will be mentored and provided opportunity for further orthodontic training. Fully integrated digital workflow, onsite laboratory. Contact doctord@ncdental.ie.

Cork city practice requires experienced dentist. Flexible working hours. Full support. Trios scanner and lab on site. www.onslowdental.ie.

Part-time dentist required for two to three days per week in busy computerised general practice. Digital X-rays, OPG and trios scanner. Friendly staff. Please contact associatenorthdublin@gmail.com.

Position available for Monday, Tuesday, Wednesday. Flexibility with hours if required. Modern surgery. October start. Contact seaportdental@hotmail.com.

Full/part-time dentist required for busy clinic in Swords. Fully digitised practice. Invisalign training provided and ongoing support from principal dentist. New graduates welcome! Flexible schedule. Up to five days a week. Car space. Contact practicemanager@oneilldentalcare.ie.

Dental Care Ireland Waterford – new opportunity for a dentist with 2+ years' experience, high earning potential, fully flexible full/part-time hours within our established modern practice. Experienced, friendly support team in place. Full IDC registration is required. Contact careers@dentalcareireland.ie.

Dental Care Ireland Limerick – dentist opportunity, high earning potential, fully flexible full/part-time hours within our established modern practice. Full IDC registration is required. Strong established books are on offer. Friendly, experienced support team in place. Contact careers@dentalcareireland.ie

Dental Care Ireland West of Ireland – Claregalway, Tuam, Westport practices have new opportunities due to expansion. High earning potential, fully flexible full/part-time hours within our established modern practices. Experienced, friendly support teams in place. Full IDC registration. Contact careers@dentalcareireland.ie.

A modern digitalised orthodontic practice in south Co. Dublin is looking to recruit an orthodontic therapist/dentist with a specialist interest (DwSI) in orthodontics to join their team. Modern, high-end practice. Well-established patient list. Contact Lynn.Hudson@sop.ie.

Part-time dentist required for busy, well-established north Co. Dublin dental practice. Experience required. Contact sfngsale@gmail.com.

Dentist: We are seeking a dentist to join our bilocation practice of Rathcoole and Newcastle Dental. Our practice has a good client basis, modern equipment with OPG/CBCT. Three years' experience and an interest in restorative dentistry preferable. Contact rathcooledental@gmail.com.

Locums

Locum dental associate required part/full-time from November 2023 to April 2024 in Ennis, Co. Clare. Accommodation/petrol allowance available. Excellent remuneration. Contact gbrowne.ennis@gmail.com.

Locum dentist required for a busy, modern, private practice in Ballina, Co. Mayo. Private/PRSI, hygienist and full support from our experienced and friendly team. Contact joemorrin@outlook.ie.

Specialist/limited practice

Oral surgeon required in Wexford and southeast. Long waiting lists. Experienced support team. CBCT on site. Please email Bbarrett@pembrokedental.ie for further details.

Orthodontist needed for a north Dublin specialist and dental centre, excellent support, hygienists, therapists, etc. Friendly patients and staff alike. Excellent remuneration and progression plan. Contact cosullivan7@icloud.com.

Portman Ireland has opportunities for GDPs and specialists in Dublin and Cork. Established practices with high earning potential and flexible hours, including options for overseas clinicians, e.g., one week on three weeks off. Full clinical and operational support provided. Contact grania.oconnell@portmandental.ie.

Dental Care Ireland South East – orthodontist opportunities, high earnings, strong established patient books, modern facilities, fully flexible part/full-time options. Must be eligible to work in Ireland and have IDC certification. Experienced clinical support teams in place. Contact careers@dentalcareireland.ie.

Orthodontist required for busy orthodontic practice Midleton. Excellent opportunity to work as a locum without commitment or as an associate with own patient list. 400 plus patients on waiting list. Must be IDC registered. Email to arrange a confidential chat. Contact vacancies@corabbeyortho.ie.

Very busy Limerick city centre practice looking for a specialist orthodontist to join our team. Strong, established patient books, high earnings. Modern, state-of-the-art practice, CBCT, hygienist on site. Contact cornmarketdental@gmail.com.

Are you a passionate dentist or orthodontist looking for an opportunity to make a difference in patients' lives? Look no further! Our reputable clinic is seeking professionals like you to join our team based in Drumcondra. Contact Dublinsmilecenter@gmail.com.

Paediatric dentist required for busy, fully private dental practice in Dublin. Excellent equipment and materials including nitrous oxide sedation facilities, OPG, 3shape digital scanner, digital X-rays and Exact software. Experienced and friendly support team. Excellent remuneration. Flexible days/times. Contact northdublindentalassociate@gmail.com.

We are seeking an orthodontist to join our established practice in Dunboyne. Fully flexible part/full-time options. Must be IDC registered. Contact dunboyneorthodontics@gmail.com.

Orthodontist/specialist dentist required for busy, private practice in Cork city centre. Fully Digital. iTero. Experienced, friendly support team. Excellent remuneration. Flexible days/times. Contact drerikawhitesmile@gmail.com.

Endodontist, Navan, Co. Meath. One day per week. Bridge View Dental is seeking an endodontist to join our team. High-spec. equipment including CBCT. Experienced ancillary team. Three general dentists, periodontist, hygienists. Dublin 50 minutes, airport 40 minutes. Email gh@bridgeviewdental.ie.

Orthodontic therapists

A modern digitalised orthodontic practice in south Co. Dublin is looking to recruit an orthodontic therapist/dentist with a specialist interest (DwSI) in orthodontics to join their team. Modern, high-end practice. Well-established patient list. Contact Lynn.Hudson@sop.ie.

Hygienists

Motivated, friendly hygienist wanted for a Tuesday in our busy Dublin 8 clinic. Modern clinic with excellent support. Email info@cleardentalcare.ie.

Hygienist position available Wexford Town. Up to three days, flexibility on days. Established book in a modern, recently refurbished practice, with a friendly and supportive team. Guaranteed daily rate, employee status. No late evenings/weekends. Contact ailbhelouisemurphy@gmail.com.

Dublin hygienist position, two days available, flexibility on days. Established book in a busy, fully private, state-of-the-art, award-winning practice. Friendly and experienced team. Excellent remuneration. Contact dublindentistrecruitment@gmail.com.

Looking for a dental hygienist for three days per week with a view to being full time. Flexible days and hours. Blackrock. Previous practice being renovated. Will have new chairs and equipment. Contact Flanners@tcd.ie.

Dental hygienists wanted! Explore part-time/full-time roles at our Waterford Dental & Aesthetic clinic. Benefit from flexible working hours, earning €35-€50/hour based on experience. Ideal for new grads. Immediate start. Contact us to seize this opportunity! Contact Jack@modeclinic.ie.

Slievemore Dental seeking enthusiastic dental hygienist to work at least two days. Wednesday plus another ideally, option to add more. EMS and airflow machine available. Contact jbutt@tcd.ie.

Dental hygienist required in a very busy Limerick city centre dental practice. Part-time or full-time hours available. Flexible options. New graduates are welcome. Friendly, supportive environment. Contact cornmarketdental@gmail.com.

Part-time dental hygienist required for a busy, modern and fully private dental practice in Dublin. Excellent equipment. Flexible hours/days. Nursing staff provided. Excellent remuneration. Very friendly and supportive environment. Contact northdublindentalassociate@gmail.com.

Dental Care Ireland Dublin South – due to exciting company growth, we have high-earning, fully flexible hygienist roles available. Strong patient books on offer in our Ranelagh, Knocklyon, Kimmage and Rathfarnham practices. You must be registered with the IDC. Contact careers@dentalcareireland.ie.

Dental Care Ireland – our south east practices have high-earning hygienist roles available. Strong patient books are on offer within our established, modern practices. Part- and full-time hours, flexible options. Registration with the IDC is required. Contact careers@dentalcareireland.ie.

Enthusiastic hygienist sought to join Blackrock Dental. Recently moved to our state-of-the art clinic. Brand new surgery. Generous terms. Part- or full-time. Close to DART and public transport. Busy private book. Contact morgan@blackrockdental.ie.

We are looking for a hygienist for a busy practice based in Ballyconnell. Our practice is modern, fully computerised with an experienced, supportive team. Full chair-side assistance. Established patient base with new patients joining daily. Contact info@ballyconnelldentalsurgery.com.

Hygienist position for Monday and/or Friday. Flexible hours to suit you. Busy book in modern practice with parking. Dedicated hygienist surgery with Cavitron. Friendly and supportive team. Excellent remuneration. Contact hannah@southdublindental.ie.

Merrion Square Dental presents unique opportunity to set up hygiene department in beautiful, leafy, Georgian, Merrion Square location. Full-time/flexible hours. Computerised. Ample growth opportunity. Contact paddysteed@hotmail.co.uk.

Carton Dental (Maynooth) seeks genuinely friendly and enthusiastic hygienist for probably the best hygienist position in Ireland. Part-time now, full-time available in the future. For more information, please send CV to cartondentalclinic@gmail.com.

Our practice is looking for a hygienist to take over a full book on Thursdays 1.00-7.00pm. We are flexible with hours if required. Contact management.kbmdental@gmail.com.

Hygienist position in modern Galway practice. Excellent conditions and flexibility. Busy book. Dedicated hygiene surgery with Cavitron. Easily accessible with free parking. Contact clarinbridgedental@gmail.com.

Galway. Hygienist position available in busy, modern dental practice. Flexible hours/days. Friendly and supportive environment. Please email info@loughreadental.com.

Dental hygienist required to cover maternity leave in Ballina, Co. Mayo. Full book and excellent rates. New practice with dedicated hygienist surgery. Cavitron scaler and IO camera. Contact bernard@btdental.ie.

Full-time hygienist required for maternity cover (starting January 2024) for newly refurbished, busy, modern, computerised practice in Galway. Send CV to office@renmoredental.ie.

Dental nurses/receptionists/managers

Dynamic dental receptionist required for full-time position in award-winning private dental practice in a primary healthcare centre. Excellent communicator with experience in private practice preferred. Modern and fully computerised. Send CV to aidan@kinnegaddental.ie.

Kildare: Experienced dental nurse required for a well-paid full-time position approx. 34 hours. Position is mainly nursing with occasional reception duty. Joining a very capable team with a nice work atmosphere. Email KildareDentist@proton.me If interested.

Dental nurse/treatment co-ordinator required to join a great team in a modern, bright, digitised orthodontic practice in Glenageary. Fluent spoken/written English essential. Contact Lynn.hudson@sop.ie.

Blackrock: Full-time position available for an experienced dental nurse in a practice in Blackrock Village. Good terms and conditions. Please reply with CV to Flanners@tcd.ie.

Rogers Dental seeks part/full-time dental nurse/receptionist. Busy general practice. Friendly working environment. Great team. Apply with CV to info@rogersdental.ie.

Exciting opportunity for full-time dental nurse/receptionist to join our award-winning team in Meath. Experience is essential, and knowledge of Exact is desirable. Excellent working conditions, with staff benefits. Car park available. Start date September 2023. Contact david@navandental.com.

Kilkenny city centre dental practice seeks dental nurse part-time, to join a busy, friendly, modern team. Apply with CV to marketcrossdental@gmail.com.

Exciting new opportunity in Waterford! Seeking a skilled dental nurse for full/part-time role. Compensation: €17-€30 per hour depending on experience. Enjoy flexible hours, great conditions, and benefits. Starting September 2023. Apply today to jack@modeclinic.ie.

Dr Paul O'Boyle seeks friendly nurse to join experienced team. Permanent, full-time position replacing team member moving abroad. Would suit someone upskilling to modern approaches. Contact poboyleriverside@gmail.com.

Opportunity for friendly, professional and motivated dental nurse to join our orthodontic team. Modern surgery, friendly and professional team. Mainly at our Ballina clinic with some days in Sligo. Full-time with excellent conditions. Contact practice.westcoastortho@gmail.com.

Dental nurse required for our expanding dental practice. Dental knowledge not necessary but preferable as training will be provided. Part/full-time position available in a friendly environment. Please send CV to dentaljobtuam@gmail.com.

IT/management

D24. A highly skilled, full-time IT professional needed with background of hospital/practice management. Please send your CV to hrdental22@gmail.com.

PRACTICES FOR SALE/TO LET

Nice ground floor, two-surgery, long-established practice, well-equipped with free parking for sale Dublin 10. Leasehold or freehold, keenly priced. Principal happy to remain to facilitate transition. Enquiries to fiachloir86@gmail.com.

Ennis, Co. Clare: Busy two-surgery practice. Long-established, excellent location. Large, loyal patient base. Huge potential to expand premises, patient numbers and services. Computerised, digital X-ray. Experienced staff. Leasehold or freehold premises. Principal retiring, priced to sell. Contact ennispracticesale2022@gmail.com.

Kilkenny City practice for sale. Low rent. Private/PRSI. Retirement planned. Principal available for transition. Priced to sell. Email dentalpractice3.1415@gmail.com.

Donegal: Busy practice. Superbly equipped, OPG, computerised. No medical card. Large new patient numbers. Excellent staff. Low overheads – high profits. Long lease/freehold property. Principal's transition period negotiable. Area wide open. Excellent expansion possible. Contact niall@innovativedental.com.

Turn-key practice ready for immediate use Cork city centre location. Located within a working medical facility. Huge patient demand. For lease. Contact managingdirector@mdclinic.ie.

Cork – excellent, well-maintained, three-surgery, ground floor modern practice. Computerised (SOE) with digital OPG and X-ray room. Great hygiene book (25 hours per week). Contact steven@medaccount.ie or call 086-068 1242.

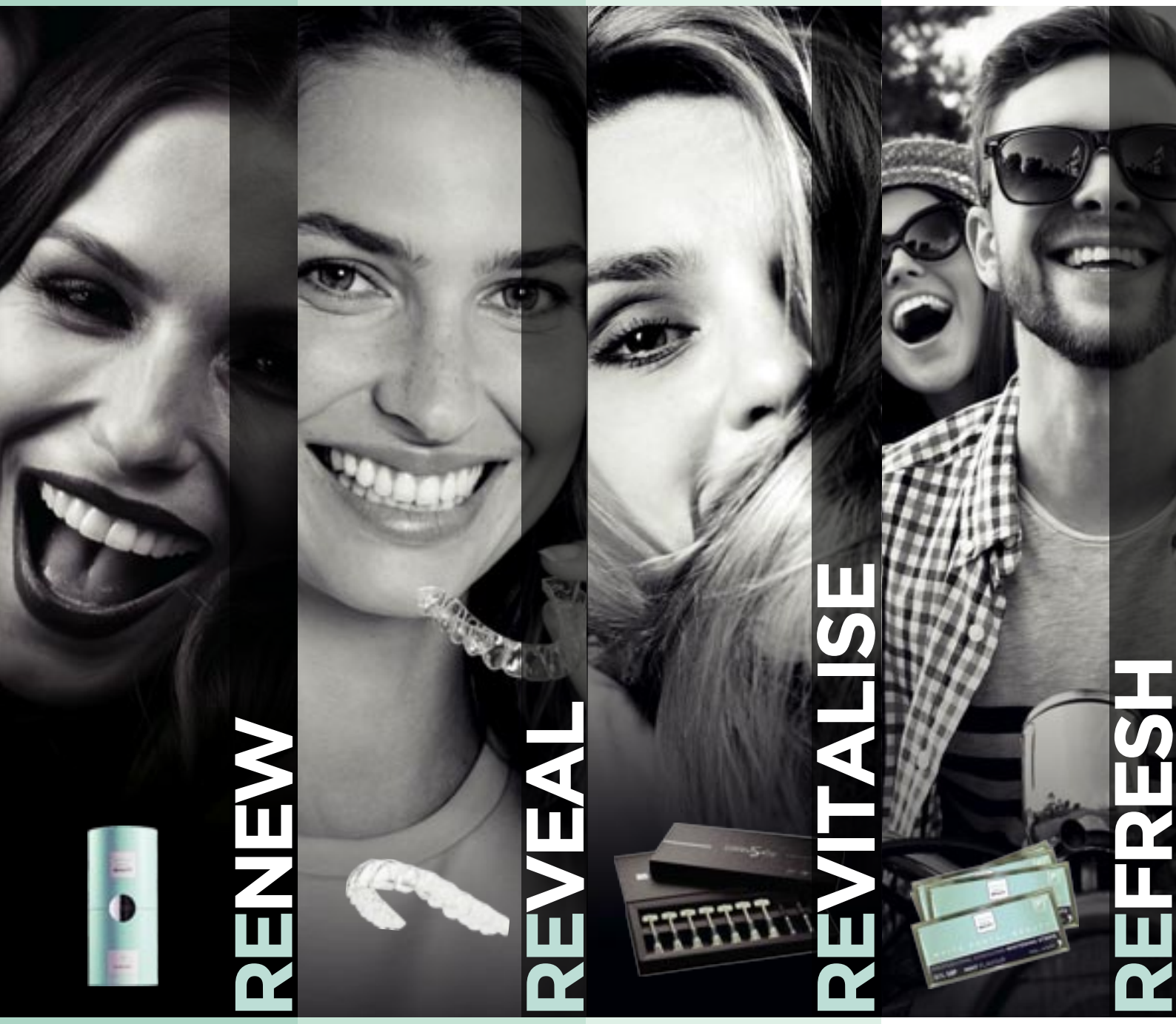
Busy two-chair private/PRSI practice for sale/lease Wicklow. Digital equipment. Visiting CDT. OPG. Fully compliant planning and regulations. Free parking. Huge demand for orthodontics/oral surgery and implant treatments. Principal can remain part time. Returning to postgrad study. Contact info@dentalhub.ie.

Dublin south/north Wicklow. Excellent location. Long established in the area. Very busy/large passing trade. Two surgeries, separate decontamination room. Low overheads. Rent good. Room to expand. Modern equipment – digitalised OPG. Ample parking available. Very reasonably priced. Contact niall@innovativedental.com.

EQUIPMENT FOR SALE/WANTED

Five new Stern Weber S220 TR dental chairs for sale at Murray Woods at discount price (mistaken order). Contact Richard Woods on 086-878 0037.

Full equipment inventory from a two-surgery practice for sale. Chairs, suction motors, OPG, I/O X-ray units, etc. Moved to a new location with new equipment reason for sale. Blackrock, south Dublin. Contact morgan@blackrockdental.ie.



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Caring for children

Dr Charlotte McCarra is a paediatric dentist in private practice at Happy Teeth in the Hermitage Medical Clinic, Dublin, and a Clinical Supervisor at Dublin Dental University Hospital.

Can you tell me about your background and what led you to a career in dentistry?

When I look back, I actually didn't know that I wanted to do dentistry, but I shadowed my family dentist in Cork and that was quite a good insight into the day-to-day life of a dentist, the practice and how it runs, so I decided to just take the chance and am really happy I did.

Can you tell me about your current career and specialism?

I graduated from Trinity in 2014, which was a tough time for new graduates. There was a system called vocational training (VT) in the UK that most Irish graduates would have done, but that pathway changed and there wasn't as much availability. As a result, it was a bit of a struggle in terms of getting jobs. I locumed for a while and then I went to Singapore for over a year as I was offered a job there in a private clinic. It was a steep learning curve as a new graduate. It was then that I started seeing children in a practice setting and just really liked it. I found the days when I was treating children more enjoyable, so that was my first inkling that I might like to focus on paediatric dentistry.

I worked in practice for around two years and then I decided to go back to hospital dentistry. I applied for a job in the Dublin Dental University Hospital (DDUH). It was a paediatric dentistry house officer role, so I did that for a year and then a position came up in Crumlin in the children's hospital for a registrar role, which was a wonderful experience.

I went back to Trinity in 2018 to do the three-year specialty paediatric programme, and now I am working in a private paediatric dentistry clinic and also as a Clinical Supervisor. I feel really lucky to be part of such supportive teams and I love the mix of hands-on clinical practice and teaching.

What motivated you to specialise in the field of paediatric dentistry?

I think the hospital years are what really made me realise that this is what I wanted to do in terms of just treating children. I have had fantastic mentors who were so willing to teach and share their knowledge, and I wouldn't be where I am today without their support.

When I was in Crumlin, I learned so much from working with children and families there. These children are going through so much and it gives you a lot of perspective. You learn it's not just about dentistry, it's actually about people and supporting them. It is really rewarding work.

By seeing children at an early point, you have the ability to shape their oral health and I feel really privileged to be able to help children in this way. While there are tough days, and there is an emotional burden to dentistry that people maybe don't talk about enough, overall it's really worthwhile work.

Do you have any involvement with the IDA?

I have been a member since I graduated, and in my postgraduate training, I have been involved in a joint IDA paediatric workshop for general dentists. I've always liked getting the *Journal*. I think it is really a great way of staying connected. Also in November, there's an event coming up between the European Academy of Paediatric Dentistry and the IDA, and I'm involved in that, so I think it's great that we have the IDA's support in these kinds of events.

What do you think are the biggest issues in paediatric dentistry today that the IDA should focus on?

I think two things come to mind for me. The first being how oral healthcare is delivered to children in Ireland. In the oral health policy, Smile agus Sláinte, one of the priority actions was in relation to access to early oral healthcare, and in particular on giving advice and prevention, and I feel that still hasn't come to fruition. When most patients come to see me it's too late, and instead of giving advice, you have to treat. So it would be great if the focus could shift to early intervention and preventing a lot of these problems from arising in the first place.

The other major issue is in regard to waiting lists for GA [general anaesthesia]. Access to GA is becoming more and more limited and as a result we have children waiting for long periods. These children are really struggling. It's affecting the whole quality of life of the family and we're not able to get to them soon enough. I think the IDA needs to continue to advocate for paediatric dentists so that we can do our best for our patients and provide the necessary treatment in a reasonable period of time.

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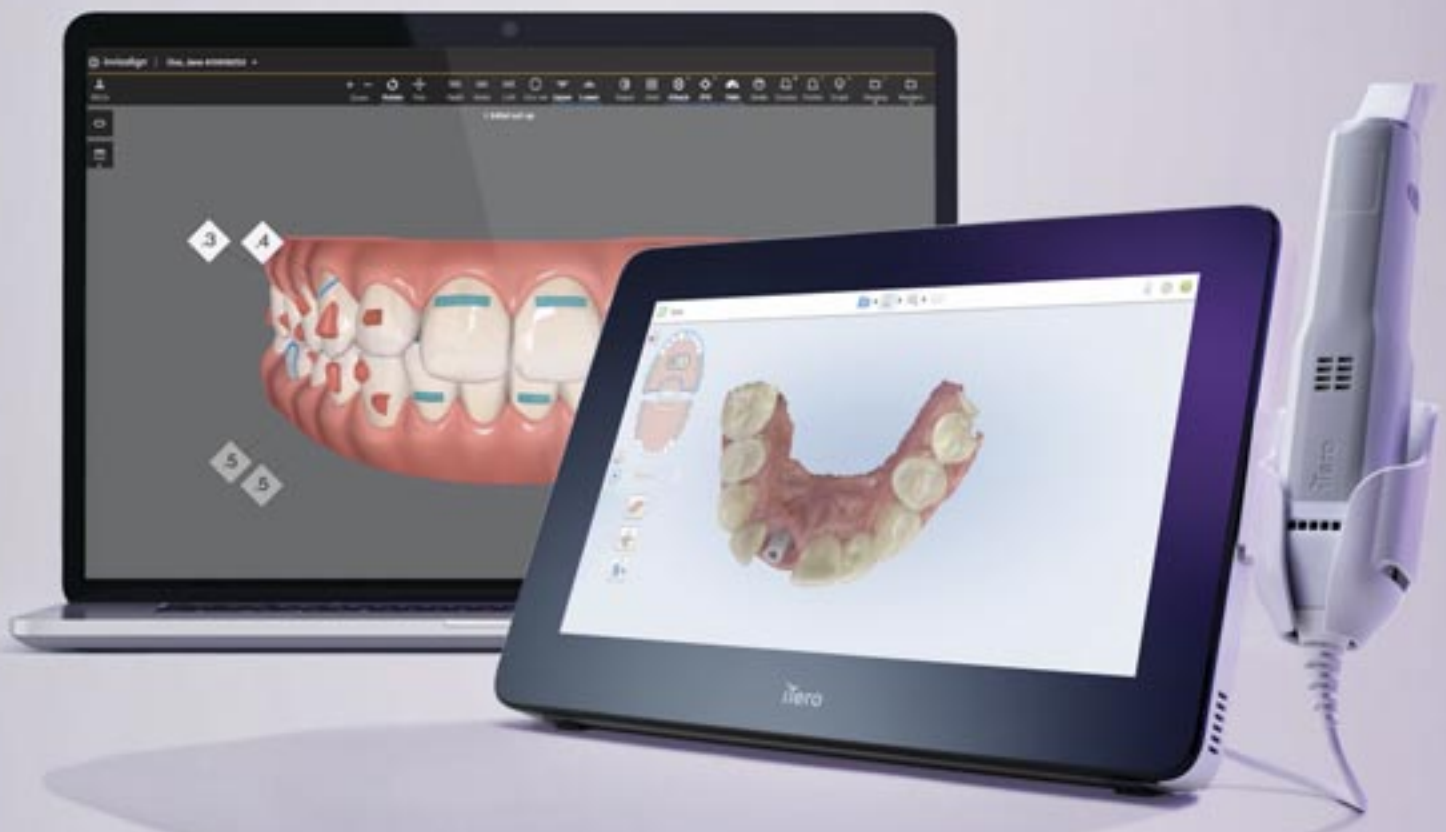

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BDA NI MESSAGE

Dr Darren Johnston
Chair of the Northern Ireland
Dental Services Forum

New Forum pushing for progress

A newly formed Forum within the Northern Ireland BDA has pushed for much-needed progress on key issues in hospital dental services, including the Dental Core Trainee (DCT) system, which is inherently unfair.

The Northern Ireland Hospital Dental Services Forum (NIHDSF) is newly established, but already working hard to give hospital dentists space to discuss concerns and bring attention to the important issues they are facing.

Recruitment and retention, waiting lists, workforce planning, pensions, and pay disparity for junior dentists are all areas of concern. We still have no government, no Health Minister, and no First Minister. There is no one at the helm to drive us forward. The longer these issues go unanswered, the worse the situation becomes.

Dental Core Trainee pay

After undertaking Dental Foundation Training (DFT), if junior dentists want to specialise and become a Dental Core Trainee (DCT), they move onto the core trainee year one pay scale in England, but in Northern Ireland they instead move to the foundation year two pay scale, similar to doctors.

Some time ago, we carried out a survey of junior dentists, which found that many were taking a pay cut when moving across to a DCT pay scale in Northern Ireland. For dentists undertaking DFT in England, who then come back to Northern Ireland to be a DCT1, there is a £6-7k disparity per year compared with colleagues staying in England, with juniors taking a pay cut even when moving into a more senior post.

Junior dentists apply via national recruitment, so expect to be on the same pay as colleagues in other nations. The system is inherently unfair. The disparity is caused by a change in the pay scales 10 years ago, which included a revaluation of competencies across the UK. Northern Ireland was not included in that process, and this is the reason why our juniors have been left behind. I was meant to be working with a DCT2 in September for one day a week, but they resigned the post a few days ago. It is hard to be certain of the reasons, but realising that you are paid significantly less could be a contributing factor.

Dire consequences of pay disparity

There is no doubt that the differences in pay between nations is having a detrimental impact on future generations of dentists. Northern Ireland Medical and Dental Training Agency (NIMDTA) figures indicate that in 2021-22, 27% of DCT posts were vacant. In 2022-23 that figure has increased to 41%. Following a Freedom of Information (FOI) request, we discovered that as of July 27 last, the vacant posts now stand at 50%.

The figures speak for themselves. How can you run a hospital service when you have a 50% shortage of junior dentists? The vacant posts leave hospital trusts needing to find locums to cover gaps, because DCTs are usually the first on call for patients with facial injuries or dental trauma. The locums covering these roles are typically paid more, which causes further unhappiness. This is clearly an issue for patient safety. With 50% of posts vacant, you cannot provide the same service.

If locums are not available, more senior staff including specialty and associate specialist dentists and consultants are called upon to cover gaps, effectively meaning that dentists on much higher pay scales are doing the job of a junior dentist, which makes no financial sense. With a total of 22 DCT posts in Northern Ireland, it would not cost a huge amount of money to fix this problem.

Progress on pay negotiations

On June 19, we met with the Permanent Secretary and gave an update on the impact of pay disparity on junior dentists. This was followed up by a joint BDA and BMA letter, to which we received a reply on August 24, confirming that the Department of Health Workforce and Policy Director has asked the Chief Dental Officer and Postgraduate Dental Dean to undertake an evaluation of the competencies of this group. Although things will not change overnight, we are making steps in the right direction.

The insufficient number of dentists in the training grade, and historic lack of workforce planning, leaves us wondering who the dentists of the future will be, but forming the NIHDSF has been a huge help in enabling us to carry out more formal engagement with the Permanent Secretary. As Chair of NIHDSF and the dental representative on the BMA Consultants Committee, I have the unique opportunity to pass information between the two committees and join things up, which is something I hope to build on in the future.

We are spending time on other areas too, including looking at the newly launched My Waiting Times NI system, where the waiting times stated to patients do not provide an accurate reflection of reality, creating more administrative work and frustration for hospital dentists. We also have a Hospital Study Day coming up soon at the Hilton Hotel, Templepatrick, on November 6. The themes are 'Head and Neck Cancer' (morning) and 'Interactions between Dental Specialties' (afternoon). This will not only be a great opportunity for hospital dentists to learn, but also to meet and catch up with colleagues in other units.