Volume 56 Number 5 October/November 2010

IDA
irish dental association

Journal of the Irish Dental Association
Iris Cumainn Déadach na hÉireann

A bridge too far?

NEW

Rapid* and **long-lasting**** relief for your patients –

provided by deep acid-resistant occlusion

- Clinically Proven Relief.[1,2] Works in just 60 seconds[†1] ✓
- Creates deep, acid-resistant occlusion[3,4] ✓
- Contains fluoride ✓

* When directly applied with finger tip for one minute. ** When used twice daily. † When used as directed on pack.

GSKCH2010/0156

References: GSK data on file. Submitted for publication. 2. GSK data on file. Submitted for publication.
3. Banfield N and Addy M. J Clin Periodontol 2004; 31: 325–335. 4. GSK data on file.

gsk GlaxoSmithKline

SENSODYNE

DAILY PROTECTION FROM THE PAIN OF SENSITIVE TEETH

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

IDA PRESIDENT **Dr Billy Davis**
IDA CHIEF EXECUTIVE **Fintan Hourihan**
JOURNAL CO-ORDINATOR **Fionnuala O'Brien**

The *Journal of the Irish Dental Association* is the official publication of the Irish Dental Association. The opinions expressed in the Journal are, however, those of the authors and cannot be construed as reflecting the Association's views. The editor reserves the right to edit all copy submitted to the Journal. Publication of an advertisement does not necessarily imply that the IDA agrees with or supports the claims therein.

For advice to authors, please see:
www.dentist.ie/resources/jida/authors.jsp

Published on behalf of the IDA by
Th!nkMedia
The Malthouse, 537 NCR, Dublin 1
T: 01-856 1166 F: 01-856 1169
www.thinkmedia.ie

EDITORIAL **Ann-Marie Hardiman**
Paul O'Grady
DESIGN AND LAYOUT **Tony Byrne**
Tom Cullen
Ruth O'Sullivan
ADVERTISING **Paul O'Grady**

Member of the Association of the Irish Dental Industry Ltd

Member of Magazines Ireland

ABC Total average net circulation 01/07/08 to 31/12/08: **3,169 copies** per issue.

Circulated to all registered dentists in the Republic of Ireland and Northern Ireland.

CONTENTS

The specialist **214**

IDA at the Ploughing **218**

Provision of removable partial dentures by dentists in Ireland **224**

Partnership agreements **232**

There is only one right direction for Ireland

When it comes to dental plans, there is only one right direction for Ireland.
The Dental Plan was created by, and is owned and run by, dentists. We understand that there are other plan companies, however The Dental Plan is unique in the expertise, experience and size of the Irish based team we have.

We are not just one of the options for Ireland; we are **THE** option for Ireland. And we offer more than simply a dental plan administration service. We offer a host of services including consultancy, marketing advice, business support and our unique quality management system.

Due to our recent growth we have strengthened both our back-office team and our field based team to offer an excellent level of customer service. Indeed you may already know some of our Irish team from the many years they have spent in the Irish dental profession.

We would be delighted to visit your practice and carry out an assessment of how a dental plan could help increase your profitability. Call us on **01 526 2556** to arrange an appointment. We are not just a dental plan, we are **THE** Dental Plan.

T: 01 526 2556 E: info@thedentalplan.co.uk W: www.thedentalplan.co.uk

Breakthrough in awareness of head, neck and mouth cancers

This editorial is dedicated to all those patients who suffered themselves but then worked selflessly to develop awareness of head, neck and mouth cancers. They are encouraging others to seek help early and hopefully prevent some developing cancer.

Oral cancer awareness day in the Dublin and Cork Dental Schools on September 29 last was a major breakthrough for our patients. Oral health is a public issue and head, neck and mouth cancer patients got together with the Irish Cancer Society and the Dental Hospitals to produce an oral cancer awareness leaflet, self-examination leaflet and mouth cancer patient care pathways. About 1,360 patients were seen in Dublin with about 600 still awaiting assessment. In Cork, 600 patients were seen with another 300 awaiting testing. Congratulations are due to everybody (administration, nursing, hygienists, students and clinicians) but particularly the patients for their efforts.

The organisation was down to a team in Cork marshalled by Dr Eleanor O'Sullivan. In Dublin a team marshalled by Dr Denise McCarthy and Ms Tina Gorman, Director of Nursing, were in charge. I experienced the Dublin awareness day and was struck by the whole Dental Hospital working together to educate, assess and reassure patients. If we can strengthen the patient, dentist, and doctor awareness of oral, head and neck cancer, we can ensure a prompt referral to the hospitals. This can usually improve their treatment outcomes. If mouth cancer is suspected, patients should be directly referred by dental surgeons or medical practitioners to the Dental Hospitals or nearest oral cancer service by letter and telephone.

Two thousand patients assessed in one day and at least another 1,000 to be seen highlights the concerns the public have about this devastating disease. Our new Dental Advisor to the HSE on Oral Health, Dr Dympna Kavanagh, can only be impressed with the public's desire for this form of assessment and the Dental Schools' ability to carry it out. We need more of this but also the resources to carry it out, prevent the disease and save lives by early detection. These are major reasons for maintaining the Medical Card and other State-aided schemes.

Warning signs

What should the dentist or doctor look for?

1. A non-healing ulcer of more than three weeks is a mouth cancer until proven otherwise and requires referral and biopsy. A number of patients underwent a biopsy during the oral cancer awareness day and it is hoped that all are benign.
2. A persistent red/white patch (erythroleukoplakia) of no known cause, velvety like, which might even bleed on touch.
3. An expanding lump on the lower or upper jaw of no known cause.
4. Numbness of the lip (lower or upper), loose teeth, bleeding from the mouth for no known reasons.
5. Inability to open the mouth, ear pain and halitosis.
6. Any salivary (parotid, submandibular or sublingual) or neck lumps especially if any tendency to hardness.
7. Any new lump on the palate, in the buccal mucosa, floor of mouth, or tongue lasting more than two weeks.

1,360 patients were seen at the Dublin Dental Hospital on September 29 as part of the awareness campaign on head, neck and mouth cancer.

8. Discolouration or black pigmentation with satellite lesions in the mouth or on the head and neck skin.

If in doubt – ask for help. We are there to help. Unfortunately in the past too many patients have ben sent from their dentist to their doctor or vice versa and we need, in order to improve outcome, to shorten the time to presentation so treatment can be provided early. The mainstay of management at present involves a biopsy, investigations of the size, local spread and distant spread, discussion at a multidisciplinary conference and a decision based on present research on the best treatment: oral and maxillofacial surgery, head and neck radiotherapy or chemotherapy. Most often it is a combination of treatments. Our mouth cancer patients are also ably supported by nutritionists, speech and language therapists, social workers, hygienists, oral medicine, periodontists, anaesthetists, database managers, cancer co-ordinators, dental and general nurses, maxillofacial technicians and maxillofacial prosthodontists.

Thanks to all those who helped, to those organisations that saw the worth of the project, and to all the media for their support in highlighting the message the Dental Schools have been trying to get out.

Prof. Leo F. A. Stassen
Honorary Editor

PRESIDENT'S NEWS

Looking forward to a challenging winter

The Association has had a busy summer and work is set to continue, says DR BILLY DAVIS.

I hope you managed a good break over the summer, have your batteries recharged and are in an enthusiastic frame of mind as autumn begins to set in. We need to approach the winter in a positive state to enable us to deal with the many challenges that lie ahead. A busy schedule of activity has been arranged by the Association and your involvement is more critical than ever.

A busy summer

Firstly I would like to report on my own activities over the summer. In July I attended a hearing of the Joint Committee on Health and Children with Dr Jane Renehan, Dr John Nolan, Fintan Hourihan and Clare Dowling. I feel that we succeeded in fully apprising the Committee members of the hardship being experienced by medical card patients. They gave us a good hearing and were understanding of our situation. One can only hope that the elected representatives that sit on the Committee will bring the matter forward to their parties and to the Dáil when it resumes in October.

On the PR front, in August the Association issued a press release urging patients to attend their dentist in spite of the confusion in the DTSS and medical card schemes, and we got a reasonable amount of print media coverage. I did a brief interview with Newstalk on their lunchtime news show and endeavoured to encourage people to have a check-up before small dental problems became larger ones.

In September I helped to launch Colgate Oral Health Month, which featured an offer for patients who purchased specific Colgate products to obtain a refund for a dental check-up. This project is a welcome development and should encourage a lot of patients to attend their dentists in the next few months. Subject to a positive experience this year, we are hopeful that we may be able to secure similar promotions with Colgate and other commercial partners in the future. Hopefully, we will not encounter too many difficulties with this novel initiative in its inaugural year.

IDA Strategy

Looking to the months ahead, I would encourage you to have a look at the IDA Strategy Plan 2010 – 2012, which was prepared earlier this year and about which you will have heard already. A lot of work has been put into this plan in a concerted effort to ensure that the Association is relevant to all members both now and into the future. We must now put this plan into action. The plan focuses the activities of the Association in the next few years under five broad strategic headings – Advocacy, Education/CPD, Engaging our Members, Putting the Patient First, and Public Affairs Management. It is available to view in the 'Downloads' section of the IDA website.

In September, for the first time, the Association took a stand at the Ploughing Championships in Athy. This is perhaps the best-attended event in the country with almost 200,000 attending last year. The Association prepared promotional literature for the event that promoted oral health and the importance of attending your local dentist. We were overwhelmed with the level of interest at our stand.

In October the public dental surgeons will head to Sligo for their Annual PDS Seminar. The programme looks excellent and it is not just confined to dentists working in the HSE: all dentists in private practice are also welcome to attend.

Pre-Budget submission 2010

On the political front, the Association is preparing its Pre-Budget Submission ahead of December's Budget and as you are all only too well aware the chaos in the DTSS is continuing. The HSE has not made any public announcements, and as a result is continuing to place dentists and their staff in a very difficult position with their patients. It is the individual dentists and their support staff who have borne the brunt of this mess since last April, and it is our patients who are suffering. I hope the mediation and the legal processes might lead to long-term resolution of this issue as soon as possible.

Also on the political front, I am particularly keen that the Association lobbies hard in the run-up to the Budget for a restoration of benefits under the DTBS. It is crazy that taxpayers are still paying PRSI but not getting any benefit in return.

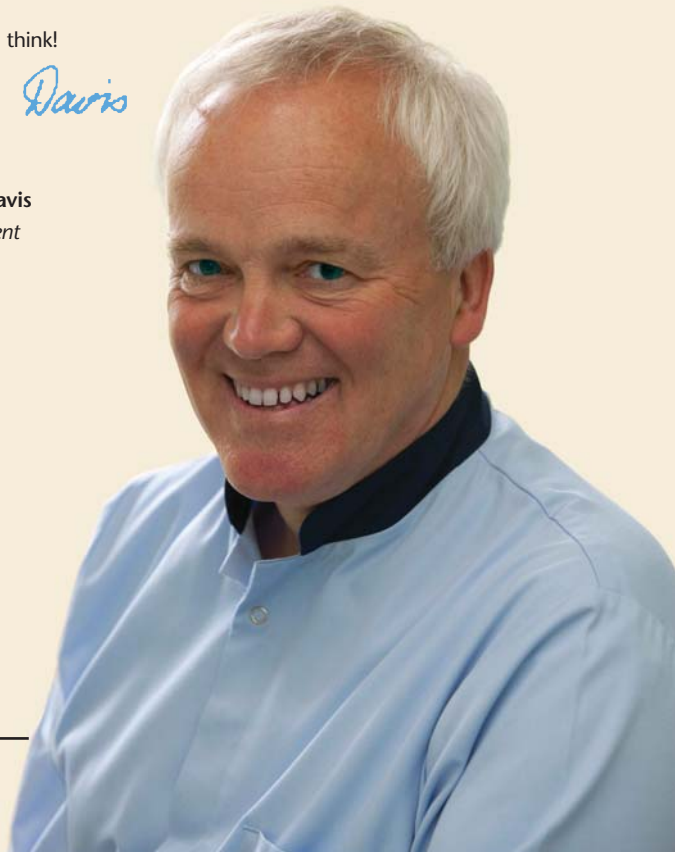
Finally, I came across a document – 'Some Dates of Interest to the Irish Dental Association' – that was prepared by some of our more senior colleagues some years back. It makes for very interesting reading. Here is the entry for 1939:

- *Dental Benefit Scheme suspended about this time.*
- *IDA Annual Dinner discontinued until 1945.*
- *Approximately 36,000 patients seeking extractions at Dublin Dental Hospital.*
- *Second World War declared. !!!*

Makes you think!

Billy Davis

Dr Billy Davis
IDA President



Oral cancer awareness day – free screening

Prof. Stephen Flint, Dr Alison Dougal and Dr Denise McCarthy providing the screening service at the DDH.

Staff at the DDH on duty for the awareness day were (from left): Erin McGauley; Sarah Lawlor; Paula Galvin; Katrina Sippola; Graham Campbell; and, Kellie McConnell.

IDA attacks Minister's statement

Chief Executive of the IDA, Fintan Hourihan, has attacked the comments by Minister for Health and Children, Mary Harney, made at the Dublin Dental Hospital, that reductions in funding will not be reversed in the Budget. In a letter to the Editor of *The Irish Times*, where the comments were reported, Fintan said: "Is it not ironic that the Minister made comments from the Dublin Dental Hospital, when 3,000 people were queuing to be screened for oral cancer in Dublin and Cork?" He continued: "The only consequence of failure to reverse these cuts will be queues for treatment and waiting lists becoming the everyday norm".

Top online discussion topics

Among the most popular discussion topics this month in the members' discussion forum on www.dentist.ie are the following: medical cards crisis, autoclave choices, clinical audit, oral health policy, digital radiography, charitable fund-raisers, and Invisalign.

Access to the discussion is exclusive to IDA members who must log in.

Don't miss out on helpful tips from colleagues and your chance to take part in discussing the latest developments.

Email us at info@irishdentalassoc.ie or contact Eileen in IDA House (telephone 01 295 0072) today to become a member.

REDs Day

The Association's REDs (Recently Established Dentists) Group has organised an interactive workshop day for all REDs members. Students in their final year in the Cork and Dublin Dental Schools are particularly welcome. The date will be confirmed shortly.

The REDs Group was formed earlier this year by younger members of the Association:

- to consider the needs of young dentists in the profession;
- to act as a channel of communication within the Association;
- to assist the Association to develop services to support young dentists; and,
- to make recommendations on behalf of young dentists.

This interactive day is essential for all REDs members and will provide all the information and advice needed to survive the early years of practice. The session conveners will be experienced dental professionals who are able to provide helpful insights.

The day will also provide an opportunity for younger dentists to have an input into the policy making and political lobbying of the Association. To book your place, please contact IDA House.

Quality and Patient Safety Committee

The Quality and Patient Safety Committee is continuing its work. The Committee is working at developing protocols for infection control in dental surgeries, to include an audit tool. The Committee will act as an umbrella group for the redevelopment of the 'Best Practice' area of the IDA website. The group is liaising with the Health Information and Quality Authority (HIQA) and hoping to develop working guidelines that will comply with HIQA guidelines and will be workable in dental practices of all sizes.

High achievers

Congratulations to the Cork University Dental School & Hospital BDS Class of 2010.
Back row (from left): Finbar O'Mahony; Leone McCarthy; Ronan O'Neill; Elizabeth Murphy; Una McAuliffe; Cathy O'Leary; Erin Bolton; Ontiretse Kebalapile; Joseph Nyepetsi; Jean Long; Marian Cottrell; Daisy McCarthy; Ciara Noonan; Sarah Delap; Orla Herlihy; Martha Dempsey; Michael Durkan; Cathal Hayes; Stephen O'Connor; Mohamed Al Junabi; Richard Stokes; and, Ruth Scanlon.
Second row (from left): Emma Sheehan; Harry Lightfoot Stevenson; Lorna Murphy; Wyatt Lintott; Khumo Tlhalerwa; Aoife Banbury; Sarah Mannion; Dr Kieran McDermott; Prof. Michael Prentice; Dr Kellie Dean; Dr Hassan Ziada; Dr Noel Ray; Fionnuala Cowhie; Julie-Anne Cronin; Julia Mangan; Elizabeth Boland; and, Claire Waldron.
Front row (from left): Prof. Helen Whelton; Dr Paula O'Leary; Dr Donal McDonnell; Dr Kieran Doran; Prof. Robert McConnell; Prof. Michael Berndt; Dr Pixie McKenna; Dr Maurice Manning; Prof Finbarr Allen; Dr Frank Burke; Dr Sharon Curtin; Prof. Duncan Sleeman; Prof. David Kerins; Dr Christine McCreary; and, Prof. Nollaig Parfrey.

Pre-Budget Submission by IDA

A comprehensive Pre-Budget Submission (PBS) has been made by the Irish Dental Association. The Association has also circulated it to other relevant bodies, including the opposition political parties, and the chairmen of relevant Oireachtas committees. As expected, there is a strong argument for the restoration of the benefits under the DTBS, and an increase in the funding for the DTSS to ensure basic dental care for medical card holders.

In relation to the Public Dental Service, the PBS states that the HSE moratorium on recruitment should not apply to the Public Dental Service – as per the HSE's own PA Consulting Report. An explicit commitment is sought to prioritise the employment of front-line clinical staff. The Submission also covers training, orthodontics, special needs dentistry, patient impact assessments, investment in IT, children's services and senior appointments in the HSE.

There is a long section linking primary care reform and general recommendations for private practice dentistry, with a very notable call for State support for dentists: "We believe that dentists should receive a similar level of funding as is provided to medical general practitioners." Additionally, the IDA states that tax reliefs for dental treatment should be extended to bring these more into line with reliefs available for medical treatment.

There is also a significant case made for action in relation to both patient safety and the related matter of developing better practice facilities.

Website

The Association's Website Committee is working on the development of a new edition of the website. It is hoped to launch the new edition of the site before Christmas 2010. The new website will be the first stop for patients looking for information on dental matters in Ireland, and will include an improved 'Find a Dentist' section using Google maps.

Basic life support training

The IDA has organised basic life support (BLS) training in a number of venues over the autumn/winter months. Medical emergencies, including CPR, is a core subject for continuing professional development (CPD) for dentists and this course is CPD verifiable.

Further dates and venues to be announced.

Alternative dispute resolution

The IDA, in conjunction with Dental Protection, is in discussions regarding the development of an alternative dispute resolution (ADR) process for the Association. Many countries offer an ADR pathway for dissatisfied patients. The development of an ADR model will bring a variety of benefits, including reduction in complaints to the Dental Council, raising patient confidence, satisfaction among complainants, and maintaining a good professional relationship between the dentist and the patient.

IDA Strategy Plan 2010 – 2012

The IDA Strategy Plan 2010 – 2012 is now available to view in the 'Downloads' section of the IDA website. The strategy document commits the Association to work towards five high-level aims over the next three years. The Board of Directors is to assume responsibility for the roll out of the extensive range of activities outlined within these five broad strategic headings. Lead responsibility for each of the five objectives has been assigned to members of the Board of Directors.

1. Advocacy: Dr Conor McAlister
To establish the IDA as an authoritative and primary advocate for patients and dentists in promoting better dental health.

2. Education/CPD: Dr Billy Davis
The Association seeks to consolidate its position as the best in business in terms of providing CPD and education, by serving as a one-stop shop for the profession in Ireland.

3. Putting the Patient First: Dr Donal Blackwell
The strategy aims to establish the profession and the Association as putting patients' interests first and being seen as putting patients at the centre in terms of individual patient care and national policy in partnership with the general public and patients.

4. Engaging our Members: Dr Michael Crowe
The strategy document aims to ensure an active engagement with IDA members.

5. Public Affairs Management: Dr Jane Renehan
The document sets out the objective of seeking to influence Government policy through a proactive public affairs management plan.

Each of the leads with responsibility will be seeking the assistance of colleagues and working closely with the Secretariat in the coming months and years. A detailed timeline for realisation of the strategy objectives has also been agreed and regular progress reports will be prepared and circulated to members.
We hope that we now have a very clear direction in terms of where we need to get to as an Association and a robust plan to guide us there.

The specialist

The responsibility for the oversight of dental consultant training lies with the Irish Committee for Specialist Training in Dentistry. PAUL O'GRADY spoke to its Director, David Ryan, for the *Journal*.

David Ryan is an oral maxillofacial surgeon – a 'max-facs' in the vernacular of the dental and medical professions. While he operates out of the Mater, St James's and the Dublin Dental Hospital, he is also Director of the Irish Committee for Specialist Training in Dentistry (ICSTD). When we met at the Royal College of Surgeons in Ireland (RCSI), where the the ICSTD has its secretariat, he explained the background to its establishment.

The 'how' and 'why' of the Committee

"Following the establishment of specialist dental lists in both orthodontics and oral surgery by the Dental Council in 2000, the Council requested the Irish Committee for Higher Training in Dentistry (ICHTD), a Standing Committee of the RCSI, to be the designated body that provides evidence of completion of specialist training in this country under Section 37 of the Dentists Act 1985. The ICHTD then became the Irish Committee for Specialist Training in Dentistry (ICSTD). The ICHTD had been established in the 1960s to oversee consultant training. Its remit was through the Joint Committee for Higher Training in Dentistry, which operated a UK and Ireland system of Specialist Advisory Committees (SACs).

The new Committee – the ICSTD – was put under the interim Chairmanship of Professor McGimpsey and Dr Cowan, while its first elected Chairman was Mr Barry. Mr Barry and his Committee worked at creating and providing a Directorate, establishing specialist specific guidelines for the statutory specialties of oral surgery and orthodontics, and also established advisory committees. These structures were set up to oversee a robust system of inspection and accreditation of training bodies and courses. It is important to note that the Committee reports directly, and only, to the Dental Council.

At the end of the first three years, the Constitution of the Committee was reformed. In 2003, the ICSTD, then under the Chairmanship of Professor Brian O'Connell, appointed its first Director, Professor Bernard McCartan. This appointment was for a period of five years and came with a half-time secretary. Initally funding was from the Post-Graduate Medical and Dental Board (PGMDB) but it is now funded directly by the HSE.

Professors O'Connell and McCartan continued to reform the Constitution of the Committee, produced a manual of specialist training, and established training programmes in the non-recognised specialties. These non-recognised specialties include the broad area of restorative dentistry (prosthodontics, periodontics and endodontics); paediatric dentistry; additional dental specialties (oral medicine, oral pathology and oral radiology); special needs dentistry; and, dental public health.

This work was carried on and developed by Dr Therese Garvey as Chairman and I was appointed Director in 2007. The current Chairman is Professor Finbar Allen, Dean of the Cork Dental School."

When asked about his own role, he is typically precise: "The Director implements the policies of the Committee and advises the Committee on the progress of the trainees, and of training programmes. Our function is to inspect, recommend approval of, and oversee the conduct of specialist training programmes. In doing that, we maintain a roll of trainees and give evidence of the satisfactory completion of specialist training to the Dental Council."

"Our function is to inspect, recommend approval of, and oversee the conduct of specialist training programmes."

Surgeon, soccer player and fan, family man

David Ryan qualified in dentistry from UCD in 1971, and in medicine in 1977. He obtained his fellowships in dentistry and surgery in 1983, and underwent higher training in oral maxillofacial surgery. He was appointed consultant to the Mater and Dublin Dental Hospitals in 1989. He became the first director of the Oral Surgery Training Programme in the mid-1990s, an appointment made by the then Dean of the Dental Faculty in the Dublin Dental Hospital in recognition of the likely setting up of dental specialist lists (as happened in 2000).

He is a sports enthusiast, proud of having played soccer for UCD as well as rugby and cricket, and of being a Manchester United fan since 1957, when Matt Busby introduced the 'Busby Babes' prior to the Munich air crash.

Married to Mary, they have three children: Mark who is in accountancy; Paul who is currently seeking graduate entry to medicine; and, Ann-Marie who is in teacher training in St Pat's College in Drumcondra.

David is originally from Rathmines and finds the Dublin Bike Scheme an excellent way of avoiding city traffic when getting from hospital to hospital on his busy schedule.

Who's on the Committee?

The Board of the ICSTD is made up of:

- two persons from each of the recognised training bodies – RCSI, TCD, UCC;
- one from the Irish Dental Association;
- one from the Dental Council;
- one from each of the Specialist Advisory Committees; and,
- two enrolled trainees.

There are also non-voting representatives of:

- the Health Service Executive;
- the Chief Dental Officer (or a representative);
- the Joint Committee for Higher Training in Dentistry (UK and Ireland); and,
- the Hospital Dental Committee of the Northern Ireland Council for Postgraduate Medical and Dental Education.

Anomalies and difficulties

It is clear that there is an anomaly in the situation of those dentists who have practices limited to areas which are not statutorily recognised as specialties. David Ryan says: "Anticipating the day when other specialties are recognised, we issue certificates to those who have completed our recognised training programmes. And the training for those disciplines is at the same standard as the training for the specialists who are recognised [by the Dental Council]".

"Anticipating the day when other specialties are recognised, we issue certificates to those who have completed our recognised training programmes."

But what about others who might have limited practices, but who have not come through the ICSTD system? That's a matter for the Dental Council, not for the ICSTD, says David.

As for his own view, David says that it is a pity that these 'other' specialists are not recognised, but stresses that changing that situation is not in the power of the ICSTD. Pushed further on the matter, he says his personal view is that the other specialists should be recognised and may well be under grandfathering clauses should the other specialties become recognised.

David also points out that there are other difficulties facing the issue of dental specialties. "While the issue of the shortage of orthodontists has largely been addressed in the past through Health Board funding of training, there are now difficulties in obtaining funding for other trainee posts. In addition, it is difficult to access funds for specialist and consultant posts at the present time. For example, there has not been an oral radiologist in Dublin since Donal McDonnell moved to Cork some eight or nine years ago. There is a huge clinical need for an oral radiologist to interpret oral imagery, and especially to assist in teaching undergraduates how to interpret x-rays in dental practice."

Numbers in training

There are currently 26 trainees – 20 in Dublin and six in Cork. Six are in oral surgery, six are in orthodontics, and the remainder are spread between the other non-recognised specialist disciplines.

Relationships

David states that the relationships between the various bodies involved in the dental profession and the ICSTD are good and observes that there are ongoing negotiations between the Irish Faculty of Primary Dental Care (IFPDC) and the Faculty of Dentistry in the RCSI about establishing training programmes to suit general dental practitioners in Ireland. He says he would like to see an alliance between the IFPDC and the RCSI.

High standards

Looking at the standard of dentistry overall in Ireland, David Ryan says that it is good, and that the standard of undergraduate training is high. "We're a small country and you just couldn't get away with bad dentistry here – you wouldn't last. In bigger countries maybe, but not here. We cannot be complacent, however, and a new Dental Act will make continuing professional development compulsory."

It's a good place to finish – a high standard of training – something that is evidently close to David Ryan's heart.

Important to encourage rinsing as bacteria multiply across all surfaces

A leading authority on aesthetic dentistry, Dr David Winkler was in Ireland recently as a guest of Listerine Total Care when he outlined recent advances in restorative dental treatments and new developments in oral hygiene. According to Dr Winkler, teeth account for only 25% of the mouth's surface area. He states that, despite best efforts at brushing and flossing, bacteria are constantly multiplying across all surfaces. "That's why it's important to encourage patients to rinse with an antiseptic mouthwash containing essential oils in order to treat the entire mouth including inaccessible areas. The benefits are clearly borne out by studies, which show that flossing and rinsing with a mouthwash, in addition to brushing, can provide a significant improvement to a person's overall oral health."

Dr Winkler is president-elect of the International Federation of Esthetic Dentistry, founding president of the Scandinavian Academy of Esthetic Dentistry, past-president of the European Academy of Esthetic Dentistry and founding member of the British Academy of Aesthetic Dentistry.

Listerine from Johnson & Johnson is the only mouthwash accredited by the Irish Dental Association.

Dr David Winkler

Tongue piercings linked to gap between teeth

'Playing' with a pierced tongue stud could lead to a gap between the front teeth, according to a study published in the *Journal of Clinical Orthodontics*. The report claimed that those with tongue piercings were likely to push the metal stud up against their teeth and consequently cause gaps and other problems to arise.

Chief Executive of the British Dental Health Foundation, Dr Nigel Carter, said the study highlighted the risks that tongue piercings have for oral health: "The temptation to play with the stud in the mouth would be very high and in time this could lead to hundreds of pounds worth of corrective treatment. As well as causing an apparent gap, they can also lead to chipped teeth and infection. In order to avoid such health problems, along with the spiralling costs of any related treatment, I would advise people to stay clear of tongue piercings."

The study featured a 26-year-old female patient and showed that a space between the upper front teeth had appeared over a period of seven years, as the metal bar was pushed against and between the teeth. The patient provided researchers with photographs to show that she had no diastema before having her tongue pierced. It was strongly thought that the positioning of the tongue stud between the maxillary central incisors caused the midline space between the front teeth. The only solution was for the patient to wear a fixed brace for an extensive period of time.

The authors concluded that tongue piercings could result in serious injuries, and are associated with haemorrhages, infections, trauma to the gums and, in the worst cases, brain abscesses.

Preventing legionellosis from dental chair waterlines – training course

Dental chair waterlines are a potential risk of exposure to *Legionella* bacteria. National guidelines for the control of legionellosis in Ireland, published by the Health Protection Surveillance Centre (HPSC) in 2009, advocate a systematic and multidisciplinary risk management approach to the prevention and control of exposure to *Legionella* bacteria through waster systems. Legionellosis, more commonly known as Legionnaires' disease, is contracted by the inhalation of water droplets contaminated with *Legionella* bacteria. If inhaled, the bacteria can colonise the lungs and readily proliferate causing pneumonic illnesses and, in the worst case, death. The case fatality rate is about 12%, rising to about 30% in hospital-based cases.

In Ireland, perhaps the most well-known cases were at Waterford Regional Hospital in 2003 but dental practices are specifically outlined within the HPSC guidelines as a sector that must have heightened awareness with regard to the risks.

Engineers Ireland will provide a one-day training course at its Dublin training centre on October 28, specifically aimed at those who have been given the responsibility for the management of water systems. Delivering the programme will be UK-based expert David Shippey, who has been involved in the installation and maintenance of water systems for more than 40 years, specialising in the prevention and control of legionellosis.

Contact Engineers Ireland for more details.

Effective enamel defence. Superior plaque control.* Combined.

Choosing a mouthrinse has often meant choosing between effective enamel protection and effective plaque reduction. Until now. New Listerine Total Care Enamel Guard contains 225 ppm fluoride with high uptake and comparable re-hardening *in vitro* to formulations with twice the fluoride.[1] Add this to it's ability to kill bacteria associated with dental caries[3,4] and reduce plaque by up to 52% more than mechanical methods alone[5] and you can see why you should consider adding it to certain patients' oral care routine.

LISTERINE®

TOTAL CARE ENAMEL GUARD

All-round protection for enamel

05849

*Superior to other daily-use mouthwashes

1. Study 103-0193. Data on file 1, McNEIL-PPC, Inc. **2.** Study 103-0196. Data on file 2, McNEIL-PPC, Inc. **3.** Tanzer JM et al. J Dent Ed 2004; 65(10): 1028-37.
4. Data on file A, McNEIL-PPC, Inc. **5.** Sharma NC et al. J Am Dent Assoc 2004; 135: 496-504.

Orthodontic bonding… en route to Wexford

In November 2009 at the Orthodontic Society of Ireland (OSI) meeting in Wexford, incoming OSI President Paul Dowling made a request for colleagues to join him on the annual Welcome Home Wexford Cycle, a 138km cycle to Wexford from UCD in aid of the Peter McVerry Trust. Everyone knows that orthodontists love bonding, so his request was met with some enthusiasm. Over the following months 16 orthodontists registered for the ride and began their training (or not) and fundraising for the big day.

The cycle (not a race) took place on Saturday September 18 and was extremely well organised and stewarded. It was possible to eat your own body weight in bananas and Fig Roll bars at the rest stops. Ciara Scott reports: "By Gorey it was gruelling, by Ballyedmond the worst idea ever; by Wexford we were relieved; by Sunday, euphoric, and now we're all doing it again next year!"

To date the OSI has raised about €20,000 for the Welcome Home Charity. Anyone that would like to sponsor the event can do so on www.mycharity.ie and sponsor the OSI's Wexford Charity Cycle 2010.

At UCD prior to the start of the Dublin-Wexford cycle in aid of the Fr Peter McVerry Trust were (from left): Don Ryan; Michael Ormond; David McConville; Paul Dowling; Tony Coughlan; Claire O'Sullivan; Seamus Keating; Ciara Scott; Brian Halton; Shona Leydon; Jarlath Durkan; Gerry Murray; and, Maghnus O'Donnell.

IDA at the Ploughing

Working on the busy IDA stand at the National Ploughing Championships were IDA Assisant Chief Executive, Elaine Hughes, and Dr Andrew Bolas.

Huge numbers attended this year's National Ploughing Championships, which were staged at Cardenton, near Athy in Co. Kildare. For the first time, the Irish Dental Association took a stand and used its presence to promote good oral health among the rural population. There was also a 'Guess the Celebrity Smile' competition to attract attention.

Assistant Chief Executive Elaine Hughes reported a strong response to the Association, as well as satisfaction with the numbers coming to the stand. This is in keeping with the Ploughing Association's own satisfaction at the very high numbers in attendance this year.

Colgate promotion proves a huge success

At the launch of Colgate Oral Health Month 2010, which was run in partnership with the Irish Dental Association, were: back row (from left): Colm Morrison, National Sales Manager Ireland of Colgate Palmolive; President of the IDA, Dr Billy Davis; Chief Executive of the IDA, Fintan Hourihan; and, Peter Hatton from Colgate Palmolive. Front row (from left): Katie Morrison, age 11; Aoife Moran, Colgate Palmolive; and, James Morrison, age 13.

Denplan in Ireland

Helping you stay in control of your practice and income

Now is the ideal time to find out what Denplan, as the market leader in dental payment plans, can offer you and how it can benefit your practice.

- **Guaranteed, predictable and secure income**

  Monthly dental payment plans allow patients to budget for their routine dental care

- **You'll have a dedicated business consultant**

  Your Consultant will be on hand to provide advice from the start

- **Your needs come first**

  We offer free business, marketing and financial support to help maximise your income

- **You remain completely in control**

  You maintain control of your fees, your patients and your practice

When choosing a dental payment plan provider we've learnt over 25 years that flexibility and support are the most important factors. That's why we'll help you to develop your practice the way you want to.

For more information please contact: **1 800 812 936**
or email: **dentist@denplanaxa.ie**

Denplan Limited, Denplan Court, Victoria Road, Winchester, SO23 7RG, UK
Tel: +44 (0) 1962 828000. Fax: +44 (0) 1962 840846. Email: denplan@denplan.co.uk

Irish specialist in amalgam disposal

Initial Medical Services provides a range of solutions to dentists to manage their waste amalgam products. These solutions meet with waste regulations and benefit the environment by eliminating contamination via discharge to drain and entering the water infrastructure. They include:

- an amalgam capsules container with mercury vapour suppressant to protect staff and patients;
- a waste amalgam box for residues of amalgam waste;
- a sludge box for disposal of filters from dental chairs; and,
- amalgam separators (as required by EU Directive Article 4 Waste Directive (75/442/EEC) and manufactured to BS ISO EN 11143:2000).

Initial Medical Services' associate company in Germany, Medentex Gmh, provides a recovery service for all amalgam products as above and has a customer base of more than 25,000 dental practices within the EU. Medentex has framework agreements on dental waste with eight dental associations. The group also recently made a further acquisition of a major EU dental waste recovery business in Sweden to further increase their client base.

Irish dentists can now avail of these products and services through Initial Medical Services, based in Carlow. Initial will dispose of waste amalgam at no charge to dentists other than cost of containers, as our income is made from the recycled products. This offer applies for all locations in Ireland.

Brian Rogers, Managing Director of Initial Medical Services, which specialises in amalgam waste disposal.

The Dental Plan on tour

Speakers at The Dental Plan seminar were (from left): Dr Garry Heavey; Dr John Barry; Kevin Coyle; and, Steven Lynch.

At The Dental Plan seminar, Dr Sean O Seacnasai received his Skills 4 Life draw prize of a defibrillator from Niamh McNamara (left) and Siobhan Sullivan of Skills 4 Life.

The Dental Plan held a series of seminars on 'The Right Direction' for Irish dentists at various locations in early September. Speakers at the Dublin seminar were Dr Garry Heavey, Steven Lynch of MedAccount, and Kevin Coyle and Dr John Barry, both of The Dental Plan.

Dr Heavey stressed the importance of systems in the dental practice and that to decrease stress, you have to increase your control. As a general principle, he advises dentists to blame and fix the system, not the people. The system should always include daily income sheets, a check on all invoices and orders received, and a record of repairs on all equipment.

Steven Lynch observed that a 25-30% reduction in GMS fees is likely for this year, while some PRSI clients are converting to private treatment. He said that knowing your own business profile is essential for decision-making.

Kevin Coyle said that the marketing of dentistry is new to dentists and patients in Ireland and that marketing is essentially about personal projection, presentation and information. He also stated that he is certain that The Dental Plan offering is the best offering for Ireland and that The Dental Plan website has considerable resources to assist dentists with their business.

Dr Barry stated that The Dental Plan helps dentists to be successful. He pointed out that up to two years ago it was relatively easy to make money. He said: "Now there is still a bond of trust with patients. What The Dental Plan does is sort out cash flow. It is the best solution we know of to help you grow and preserve your dental business. Under our system, patients return regularly, are motivated, want better dental health, accept advice, and trust you."

PEER-REVIEWED

An audit of the quality of referral letters received by the Department of Oral and Maxillofacial Surgery, Dublin Dental School and Hospital

Abstract

One hundred consecutive referral letters, sent by dental practitioners to the Department of Oral and Maxillofacial Surgery, Dublin Dental School and Hospital, were audited in terms of quality. The audit was based on the Scottish Intercollegiate Guidelines Network (SIGN) recommendations of 1998. The audit demonstrated that in general referral letters required modification and did not give the clinician the required information. This paper sets out the results of the audit and suggests a template that should be used for future referrals.

Journal of the Irish Dental Association 2010; 56 (5): 221-223.

Justin Moloney BDentSc MFD RCSI
Specialist Registrar in Oral Surgery
Dublin Dental Hospital
Lincoln Place
Dublin 2

Leo FA Stassen FRCS(Ed) FDS RCS MA FTCD FFSEM (UK) FFD RCSI
Professor of Oral and Maxillofacial Surgery
Dublin Dental School and Hospital
Lincoln Place
Dublin 2

Background

Referral letters of high quality are an essential part of good clinical care as they act as the interface between healthcare professionals in the primary and secondary environments. They are a flexible means of transferring information and can be adapted in form and content to cover both straightforward and complex clinical cases. The referral letter provides demographic as well as clinical information and is used by clinical staff and medical records appointments staff. Adequate information is essential to allow the secondary care professional to assess clinical need and urgency, and for administrative staff to arrange appointments. All referrals are reviewed by the clinician responsible for their care and given a priority.

In 1998 the Scottish Intercollegiate Guidelines Network (SIGN) established a multidisciplinary working group to review the literature and to assess examples of good practice. Their aim was to make recommendations on a minimum essential dataset for communication from primary to secondary care. A detailed review of the literature yielded 60 articles that were deemed relevant. No evidence existed from randomised controlled studies to show that better communications improved patient outcomes. Evidence came from non-experimental descriptive studies that used consensus methods to judge referral letters and score them. The information was extracted and synthesised, and presented to a national consensus forum of healthcare professionals. Delegates were asked to complete a questionnaire before and after the conference. This information was added to the literature review to help the working group to make recommendations on essential information to be included in a proposed pro forma referral letter. The group did not grade the information in terms of importance. All data included was considered equally important and completeness of the referral letter was paramount.

Their recommendations were presented in the form of a referral letter template.[1] Several recent dental articles have addressed the issue of referral quality.[2,3,4]

Aims of the audit

The Department of Oral and Maxillofacial Surgery receives referrals from many healthcare professionals and wished to assess whether these can be improved. The aim of the current audit was to assess the quality of referrals and to establish a referral pro forma that practitioners may wish to use. By using this pro forma, the gold standard in referrals can be attained.

Method

The study population consisted of 100 consecutively received referral letters. They were analysed using the following categories:

1. Patient details.
2. Referring practitioner details.
3. General medical practitioner details.

4. Clinical information provided.
5. Social issues.
6. Legible and comprehensible.

Data was captured on a pro forma and simple totals were obtained.

The data are presented in the following tables:

Patient details	
Full name	100
Complete address	99
Telephone number	78
Date of birth	55
Gender	78
Hospital number	0
Medical card number	13
Previous names	0

Referring practitioner details	
Name of referring practitioner	99
Address	100
Telephone number	98
Fax number	29
Email address	10

GP details	
GP details	0

Clinical information provided	
Presenting complaint	57
History of presenting complaint	22
Clinical findings mentioned	51
Investigation results	20
Specific treatment requested	86
Urgency of referral	14
Past medical history	34
Past or current medications	9
Medical alerts, e.g., allergy	2

Social issues	
Patient issues	12
Social circumstances	2
Special needs	0
Ambulance required	0

Other relevant information	
Legible	100
Comprehensible	100

Discussion

Patient details were satisfactory in terms of name, address and date of birth. Gender was mentioned in 55% of letters. Society is now multinational and names often do not give clear indication of whether the patient is female or male. This is important because of childbearing age, radiographs, chaperoning and childcare. One in five letters gave no telephone number for the patient. This made it difficult to contact the patient to confirm an appointment. Name, address and telephone number for the referring practitioner were almost universally provided; however, only one in three letters gave a fax number. One in ten gave an email address. In an electronic age, email is becoming a more efficient and cheaper form of correspondence.

No general medical practitioner (GMP) details were given in any letter. This element was considered essential by the SIGN and it implied that many GDPs do not possess this information. Contact with the GMP is required for those patients with a complicated medical history and treatment outcomes may be copied to them by letter.

The category of "clinical information provided" demonstrated that key information was frequently omitted. A presenting complaint was absent in 43% of letters and a history of presenting complaint was absent in 78%. Half of the letters only included clinical findings. One in five contained results of investigations. It is impossible to prioritise without the presenting complaint and many patients may be disadvantaged if the history of the presenting complaint is not given, e.g., pain, ulcer, possible cancer. One in three letters mentioned medical history and one in ten stated medications. Medical alert warnings were given in only two out of 100 letters. In the absence of a warning such as an allergy or a blood-borne virus, good practice warrants stating the negative, i.e., "there are no special warnings for this patient", or simply striking out the relevant area of the pro forma. On social issues, for example phobia, social difficulty and special needs such as wheelchair use, scant information was provided. Again, it should be stated in the negative that there are no special issues pertaining to the patient if this the case.

Conclusions

It is clear that the information required in referrals to the Department of Oral and Maxillofacial Surgery is not being received and this warrants improvement. Not one referral letter fulfilled all criteria for referral as highlighted by the SIGN. Key clinical information was too often missing. This may be contributing to the long waiting list for assessment clinics, as lack of information makes prioritisation and organisation of these lists more difficult. Suspicion of malignancy constitutes an urgent referral. Conditions such as recurrent aphthous ulceration or burning mouth syndrome do not. These latter patients are seen on an 'as soon as possible' basis. The use of the non-specific term 'lesion', without any further descriptive element, is impossible to assess, e.g., "the patient has a lesion on his tongue". Size, shape, consistency, colour, ulceration and induration should be mentioned. If the patient has an ulcer or other lesion related to sharp dentures or teeth, this trauma should be eliminated and the patient reviewed. If there is no improvement at that stage then a referral to secondary care is warranted. If the patient is under the care of another consultant, the request that the referral is for a second opinion must be made clear.

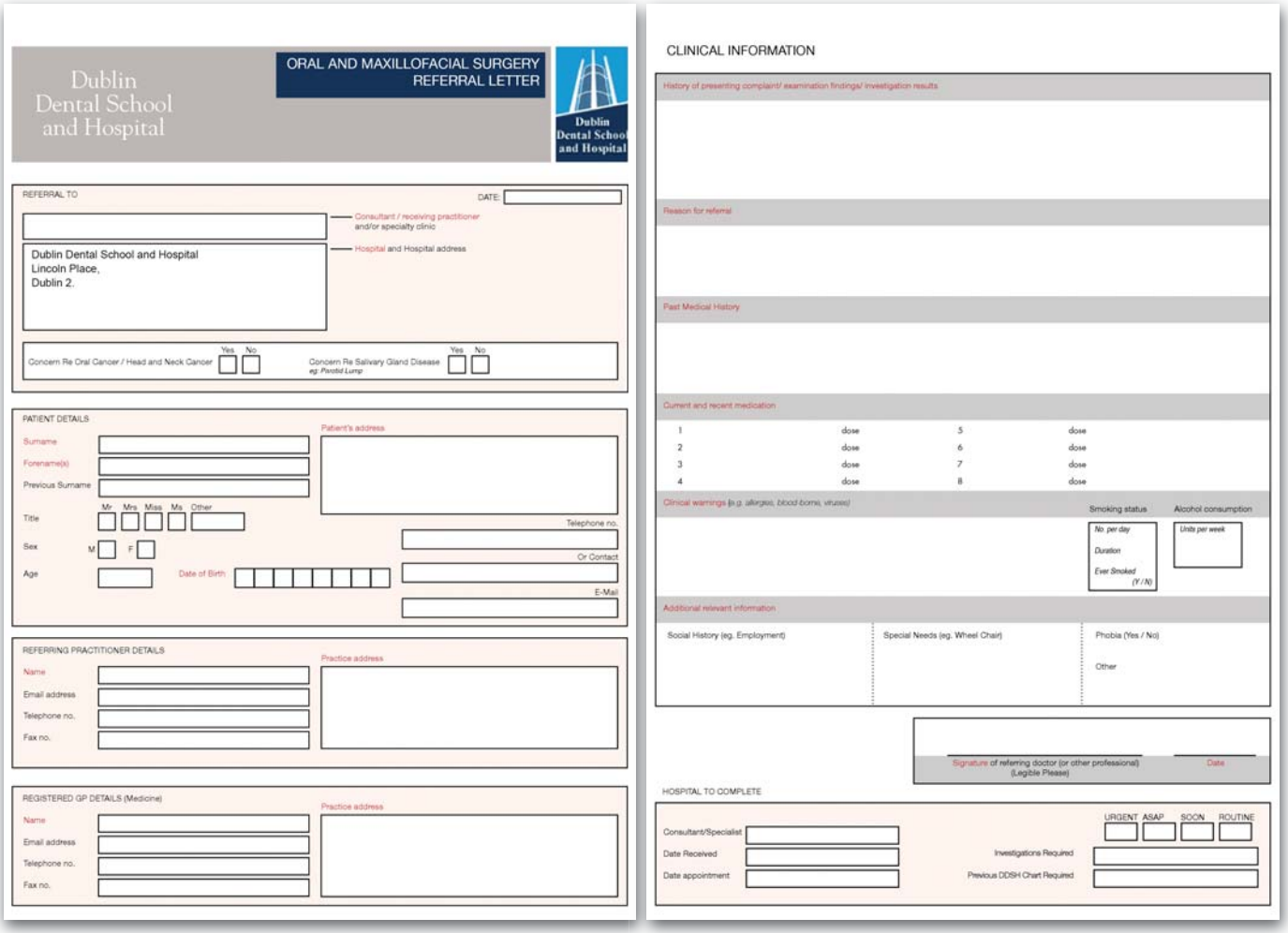


FIGURE 1: Pro forma referral letter.

High quality referral in theory may make it possible to book patients for assessment and treatment in the same session for certain simple procedures. This is one concrete way of reducing waiting times and improving patient outcomes.

Recommendations

The results of this audit have been used as an educational tool for students and clinicians, and it is planned to implement a referral pro forma for referring practitioners. One strategy that has been tried in another department in the Hospital, is to return poor referral letters with the request that they be resubmitted with the rquired information. However, this action is not supported by senior clinicians in oral and maxillofacial surgery and oral medicine in case an important referral is missed. The important issue is two-way feedback eliciting an improvement in referral letters. It is planned to re-audit in one year. Finally, the use of a custom-designed pro forma, such as ours (**Figure 1**), is recommended. It may be possible to roll out this pro forma as a universal Dublin Dental School and Hospital referral document. It is planned that the pro forma be downloadable from the DDSH and IDA websites.

References

1. http://www.sign/ac.uk/guidelines/fulltext/31/index.html.
2. **Zakrzewska, J.M.** Referral letters – how to improve them. *Br Dent J* 1995; 178 (5): 180-182. PMID: 7702954.
3. **Burke, T., Freeman, R.** Referrals. *Dent Update* 2007; 34 (6): 338-339. PMID: 17784582 [PubMed – indexed for MEDLINE]
4. **Scully, C., Porter, S.R.** Referrals in oral medicine. *Dent Update* 2007; 34 (6): 340-342, 345-346, 348-350. PMID: 17784583 [PubMed – indexed for MEDLINE]

PEER-REVIEWED

Factors influencing the provision of removable partial dentures by dentists in Ireland

Précis

As the number of partially dentate patients increases, it is important to determine factors that influence acceptance of removable partial dentures (RPDs). This study illustrates current trends in the provision of RPDs in Ireland, and factors that influence clinical practice in the management of partially dentate patients.

Abstract

Factors influencing clinical treatment of partially dentate patients are varied, and there is a need to identify factors influencing success in the provision of removable partial dentures. The aim of this study was to assess the attitudes of general dental practitioners (GDPs) in Ireland towards tooth replacement and use of RPDs, in partially dentate older adults. The sample frame was the Register of Dentists in Ireland; data were also collected from a sample of dentists practising under NHS regulations in Northern Ireland. Validated questionnaires were sent to all dentists on the Register of Dentists in the Republic of Ireland, and dentists working under NHS regulations registered with the Central Services Agency in Northern Ireland. Content of the questionnaire included details of the dentist themselves, their dental practice and the profile of partial denture provision. They were also asked to give their views on factors influencing the success or failure of an RPD, the process of providing RPDs and their attitudes to RPD provision. A total of 1,143 responses were received, a response rate of 45%. A mean number of 61 RPDs per annum were provided, with 75% of dentures provided being acrylic based. Respondents indicate their belief that cobalt-chromium based dentures had a longer prognosis than acrylic dentures, but less than half (46%) claim to design the frameworks themselves. Patients' attitudes are considered influential in the success of RPD provision, and their influence on appearance is considered the most important factor influencing success. The most important factors influencing failure are: the patient not requesting a denture; an RPD restoring unbounded saddles; and, lower RPDs. Although considered important, approximately 60% of the sample do not routinely organise follow-up appointments for patients provided with RPDs. The fee structures in the DTSS and DTBS are considered a barrier to quality in the provision of partial dentures.

Professor Finbarr Allen BDS PhD MSc FDS (Rest Dent) RCPS, FFDRCSI
Professor/Consultant in Prosthodontics & Oral Rehabilitation
Cork Dental School and Hospital
Wilton
Cork

Address for correspondence:
Professor Finbarr Allen
Cork Dental School and Hospital
Wilton
Cork
Tel: 00 353 21 490 1186
Fax: 00 353 21 490 1193
Email: f.allen@ucc.ie

Journal of the Irish Dental Association 2010; 56 (5): 224-229

Introduction

Removable partial dentures (RPDs) are a simple method for replacing teeth for patients missing some or all of their natural teeth. From a professional perspective, potential benefits of partial dentures include: a) adjacent and opposing natural teeth are prevented from drifting; b) the burden of occlusal loading on remaining natural teeth is reduced; and, c) oral comfort and function is enhanced. However, whether this is essential has been questioned by some researchers, who suggest that older adults have different functional needs to young patients and therefore do not need a complete dentition. Furthermore, the World Health Organisation (WHO) suggested that a goal for oral health in the year 2000 should be that adults retain for life a healthy, functioning dentition of at least 20 teeth and not require an oral prosthesis to replace missing teeth.[1] Kayser and co-workers have proposed the shortened dental arch concept as a strategy for maintaining a functional rather than a complete dentition in older adults.[2] Using this approach, treatment goals are limited to maintaining key teeth for

function and appearance purposes. The rationale is that treatment can be simplified and directed at the patient's particular needs. In a six-year longitudinal study, Witter *et al* compared patients provided with RPDs and partially dentate patients managed using the shortened dental arch approach.[3,4] They found that this approach worked well in carefully selected patients and that removable partial dentures did not appear to significantly improve oral function or comfort. From an epidemiological point of view, many studies indicate that patients are willing to accept posterior spaces and don't seek treatment to replace missing molar teeth.[5,6] What remains unclear is whether this is because tooth spaces are acceptable, or perhaps more acceptable than the alternative of having a partial denture. In an analysis of data from a survey of oral health of older adults in the United Kingdom, Steele *et al*[7] assessed the importance of tooth loss on oral health-related quality of life. Having controlled for confounding factors such as gender, age and denture wearing, they concluded that having 20 or more teeth was an important predictor of satisfaction with oral health. This analysis is consistent with findings reported from the cohort study of Witter and colleagues.

Until now, there has been a lack of research that explores the reasons for provision of RPDs and patient acceptance of RPDs. A number of reports, including observational and cohort studies, indicate that patients provided with partial dentures discard them or wear them on an occasional basis.[8-11] Irrespective of an intended benefit to appearance and function, a number of studies have indicated poor patient acceptance of RPDs, with findings of some 30-50% of patients never or only occasionally wearing their denture commonly reported. Further, cross-sectional studies and longitudinal clinical trials have reported an increased incidence of caries and periodontal breakdown when RPDs are worn.[12,13] Evidence from national surveys suggests a significant divergence between clinical intent and treatment outcome as measured by the prevalence of use of RPDs. This, together with their potential to generate an additional long-term treatment need, represents a considerable potential waste of resource. The reasons for this discrepancy are unclear but may reflect the attitudes and expectations of patients, the clinical knowledge and technique of dentists, or administrative and financial restrictions. If these are identified accurately, practical guidelines can be developed to target RPD treatment more effectively.

Information regarding the outcome of treatment to provide RPDs to partially dentate adults in Ireland is currently lacking, and little is known about the effectiveness of tooth replacement strategies employed by dentists in the Republic of Ireland. Furthermore, the influence of the different healthcare funding mechanisms on treatment-seeking behaviour of middle-aged and elderly adults in Ireland is also unclear. Data from the 2001/'02 adult oral health survey in Ireland showed that 56% of adults over the age of 65 years need some kind of treatment to replace missing teeth.[14] Although this information is based on objective data collection criteria, it gives an indication of the potential scale of treatment need for adult patients in the Republic of Ireland. While many adults have missing teeth, not all will necessarily seek treatment to replace them or use removable prostheses provided for them. As with the UK, this may represent a considerable waste of resources if subjective treatment need is not accurately identified. To date, this research question has not been addressed in the Republic of Ireland.

The aim of the present study was to assess attitudes of GDPs towards tooth replacement and use of RPDs in partially dentate older adults.

The objectives of the study were to:

- determine the factors that shape provision of RPDs in the Republic of Ireland; and,
- determine whether provision of treatment by dentists and demand for RPDs is influenced by the different healthcare systems in the Republic of Ireland, particularly the DTSS and DTBS schemes.

Methods

Ethical approval for the study was granted by the Clinical Research Ethics Committee of the Cork Teaching Hospitals. The sampling frame was the Register of Dentists in Ireland. Each dentist on the register was sent a questionnaire seeking their views on RPDs. The questionnaire was a modified version of that previously validated for use in the UK by the author and co-workers.[15] The questionnaire was derived from interviews with dentists, and contained five themes, namely:

- current practice and provision of RPDs;
- factors influencing the success or failure of an RPD;
- the process of providing RPDs;
- attitudes to RPD provision; and,
- details about the characteristics of the practitioner and their practice.

Current practice and provision of RPDs

GDPs were asked to estimate their prescription rates for both acrylic and cobalt-chrome RPDs during the previous year (2007).

Factors influencing the success or failure of an RPD

GDPs were asked to indicate how likely a list of factors were to result in the success or failure of an RPD, including dental factors, patient factors, design and aftercare. Each factor was scored from -5 to +5 with -5 indicating increased chance of failure and +5 indicating increased chance of success. Success was defined as a denture that is stable and comfortable and the patient is able to wear it all day.

The process of providing RPDs

Four case studies were provided that GDPs might come across in practice. They were asked to rate on a five-point scale (ranging from 1 = no influence to 5 = very strong influence) the influence of 11 factors on their decision to prescribe an RPD. The 11 factors covered issues of dental status, function, patient preference, patient age, cost, published evidence and availability of alternative treatments.

Attitudes to RPD provision

GDPs were asked to indicate the extent to which they agreed or disagreed with a series of statements about RPDs, including issues of cost, DTBS/DTSS fee structure, GDP experience, training, job satisfaction, dental status, material used and patient preference.

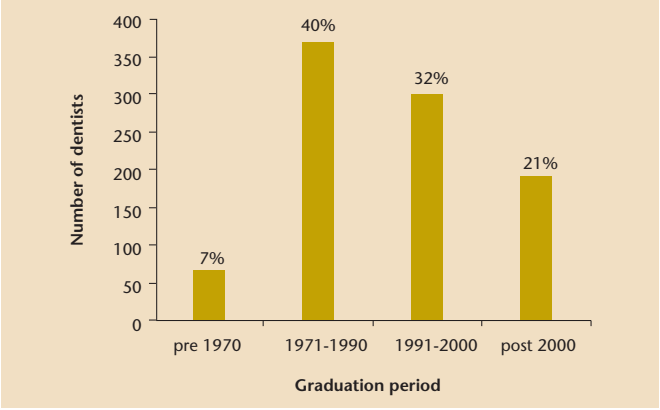


FIGURE 1: Distribution of respondents by time since graduation.

Table 1: Percentage of very low, low, medium and high providers of RPDs per annum, by country.

Number of RPDs provided per annum	Republic of Ireland	Northern Ireland
<10	13%	6%
10-49	31%	37%
50-99	18%	21%
>100	18%	24%
No answer	20%	12%
Differences not statistically significant (p=0.185, Chi-square test)		

Table 2: Proportion (%) of dentists providing <50 and >50 acrylic and cobalt-chromium-based RPDs, by country.

	Acrylic dentures*		Cobalt-chromium dentures**	
	RoI	NI	RoI	NI
<50 per annum	14	3	68	58
>50 per annum	86	97	32	42
	*p=0.005, Chi-square		**p=0.14, Chi-square	

Table 3: Factors that dentists believe influence the success of RPDs.

Factor influences success	Mean (SD) score
RPD has high aesthetic value to the patient	4.07 (1.41)
Advice is given about the care of remaining teeth	3.22 (1.50)
Time is made available to make minor adjustments	3.19 (1.47)
Saddles of RPD are bounded	3.09 (1.56)
RPD has high functional value to the patient	3.05 (1.64)
Advice is given about how to adjust to wearing an RPD	3.01 (1.45)

Details about the characteristics of the practitioner and their practice

Demographic details, including gender, number of years since graduation as a dentist, postgraduate training and type of practice were also collected.

Questionnaires were sent to the address given on the Register of Dentists, and a cover note was sent with the questionnaire outlining the purpose of the study and assuring confidentiality of responses. They were asked to complete the questionnaire as completely as possible, and to return it in the enclosed pre-paid envelope. A period of four weeks was allowed for a response, after which two follow-up mailings were made to get a response from all non-responders.

For the purpose of comparison, dentists working in the National Health Service (NHS) in Northern Ireland were also included. The sampling frame was the register of dentists held by the Central Services Agency (CSA) in Northern Ireland. This is a list of dentists contracted to provide dental care under NHS regulations in Northern Ireland. The UK version of the questionnaire was used for this group, and the same method for handling non-responders was employed.

Data entry screens were designed in Microsoft Excel. All data were double entered by trained personnel (Data Entry Bureau). The data were transferred to SAS for entry validation and discrepancies were resolved with reference to the returned questionnaires. All data were subject to consistency checks and cleaned as appropriate.

Data were analysed descriptively, and frequency distributions are reported. Chi-squared tests were used when comparing categorical data.

Results

There were 817 responses from dentists resident in the Republic of Ireland, with 326 respondents from Northern Ireland, giving a total of 1,143 responses. The overall response rate was 45%. The gender breakdown was 61% male to 39% female.

The distribution of respondents by time since graduation is shown in **Figure 1**. This shows that respondents had a broad range of clinical experience. The number of RPDs provided by respondents ranged from 2-651, with a mean number of 61 RPDs provided per annum. Some 75% of RPDs provided were acrylic based. A comparison of prescribing profiles is shown in **Table 1**. This table shows the breakdown by very low (<10), low (<50), medium (50-100) and high (>100) providers of partial dentures provided annually by category, i.e., fewer than 10 per annum, greater than 100 per annum, etc. There were no significant differences between the number of RPDs provided annually in the Republic of Ireland and Northern Ireland.

In terms of proportions of acrylic/cobalt-chromium based dentures provided, **Table 2** shows the breakdown into percentage of dentists providing <50 and >50 acrylic and cobalt-chromium based RPDs per year, by country. These data indicate that the proportion of dentists providing >50 acrylic-based RPDs is larger in Northern Ireland.

Dentists believe that the average lifespan of an acrylic-based RPD is 5.7 years, whereas a cobalt-chromium based denture has an average lifespan of 10.6 years. In terms of designing cobalt-chromium based frameworks, 46% claim to design the frameworks themselves while 22% delegate this task to a dental technician.

Concerning follow-up/review of patients, only 40% of respondents routinely arrange post-treatment review appointments. The remaining GDPs advised patients to make a review appointment only if they experienced problems with their RPD. Approximately 10% of respondents refer their RPD patients to a dental hygienist for oral

Table 4: Factors that dentists believe influence the failure of RPDs.

Factor influences failure	Mean score (SD)
Patient did not ask for an RPD	-3.19 (1.56)
Includes unbounded saddles	-2.20 (1.82)
RPD replaces teeth in lower jaw	-1.93 (1.99)

Table 5: Factors influencing the decision to provide RPDs, ranked in order of importance.

Factor	Mean (SD) influence
The patient's desire not to have an RPD	4.25 (0.11)
The dental status of adjacent teeth	4.00 (0.14)
The likely prognosis for remaining natural teeth	3.91 (0.05)
Tooth loss due to dental neglect	3.81 (0.05)
The potential for an RPD to improve function	3.59 (0.48)
My judgment about whether the patient can cope with the more expensive preparatory work for alternative treatment options	3.55 (0.09)
The financial aspects of the treatment	3.54 (0.04)
The time since loss of teeth	3.40 (0.16)
Your confidence in providing other possible treatment options	3.27 (0.03)
The age of the patient	3.03 (0.08)
The published evidence about RPDs	2.71 (0.07)

Table 6: Statements with which dentists agreed.

Statement	% GDPs agreed
My experience in practice has influenced the patients I select for RPDs	92%
The gross DTSS/DTBS fee (after deductions for laboratory costs) for RPDs is a disincentive to providing cobalt-chrome RPDs	82%
I would like to be able to provide more cobalt-chrome RPDs on the DTSS/DTBS	77%
I would never have an RPD myself	62%

Table 7: Statements with which dentists disagreed.

Statement	% GDPs disagreed
It is perfectly feasible to achieve a high quality cobalt-chrome RPD within the current DTSS/DTBS fee structures	86%
The current DTSS/DTBS fee structure for RPDs is a fair reflection of the work involved in providing an acrylic RPD	83%
In general, patients prefer an RPD to a bridge	78%
Most RPDs end up being left in the drawer	65%

hygiene instruction and maintenance, whereas the remaining 90% of respondents provide oral hygiene instruction themselves.

When considering factors influencing the success of RPDs, patients' perceptions on the importance of a denture in restoring appearance was considered the most important factor. Restoration of function, though important, was considered less influential. These data are shown in **Table 3**, and are based on the measurement scale:

Increased chance of failure					No influence					Increased chance of success
-5	-4	-3	-2	-1	0	1	2	3	4	5

In terms of factors influencing failure of RPDs, **Table 4** indicates the factors that dentists believe most likely to result in patients not wearing an RPD. The data show that patients' wishes are the most important factor influencing this.

A summary table indicating the factors that influence dentists to provide RPDs is shown in **Table 5**. These data indicate that patients' wishes are the most important factor influencing the decision whether or not to provide an RPD. Factors related to dental status are considered important, as are financial aspects. Intriguingly in an era of evidence-based dental care, published evidence about RPDs is very moderately influential in decisions about RPD provision.

When asked to indicate which statements they agreed and disagreed with, the highest prevalence of agreement related to the influence of previous experience and fees for treatment (**Table 6**).

Statements with which dentists generally disagreed are shown in **Table 7**. These data indicate that dentists consider the fee structure for RPDs to be a barrier to quality provision of care.

Discussion

This study is the first of its kind in the Republic of Ireland to investigate factors influencing prescription of RPDs. The response rate of 45%, while lower than ideal, is reasonable for a study of this kind, and the demographic characteristics of the respondents suggest that the results can be generalised. This is a trade-off in using the entire Register of Dentists as a sampling frame in the Republic of Ireland. This database includes dentists living overseas or on temporary registration arrangements,expected that a significant number of individuals on the Register might not respond. However, the respondents came from a wide geographical range, and represented broadly a wide category of periods since time of graduation. Secondary analysis indicated that the characteristics of non-responders were not that different to responders, and it is not therefore likely that a significant response bias has occurred.

A further important consideration in this regard was the process used to develop the study questionnaire. This instrument was grounded in the outcomes of qualitative interviews with GDPs, and its content validity is, therefore, appropriate for administration to GDPs.

The focus of this paper was to describe dentists' attitudes and practice in providing RPDs. Overall, it is clear that the provision of RPDs continues to be primarily patient led. The most important factors reported as influencing both the GDP's decision to provide an RPD and its subsequent success were patient desire to have a partial denture and aesthetic value associated with having an RPD. This supports previous findings and endorses the view that patients are unlikely to wear an RPD in the absence of self-perceived need. Active participation of patients in the treatment decision-making process is seen as influential in treatment outcome, specifically in

relation to patient satisfaction.[16-18] Interestingly, in the present study patient desire to have an RPD was reported by dentists as the most important factor in providing an RPD regardless of any other individual case factor.

However, the decision-making process is also influenced by a number of factors including time, previous experience in providing RPDs, cost and the fee structure available for providing RPDs. This may be a reflection of financial considerations or demands of patients in socio-economically deprived areas. Kronstrom *et al*[19,20] have reported that decision-making is influenced by gender of the dentist, and by whether they work in the private sector or in the public service. They indicate that fixed prosthodontics are far less used in a public healthcare setting in Sweden, which is probably a reflection of the influence of financial resources available to pay for oral healthcare.

Consistent with the literature, the majority of respondents in the present study supported the view that success would be positively influenced if the dentist designed the RPD. Only half of all dentists reported designing their own RPD in practice, again possibly associated with the difficulty of resolving time and cost. This is less than previous studies have reported. This is of concern, especially if it is felt that success is likely to be influenced by who designs the denture. A further issue is the high prevalence of acrylic-based dentures provided, despite the fact that 77% of respondents would like to provide more cobalt-chromium-based dentures. This may be a reflection of the fee scales provided for RPDs. Another influence could be the relative lack of technical support for making cast cobalt-chromium frameworks in the Republic of Ireland, as reported previously by Lynch and Allen.[21]

Clearly the present study highlights that for some dentists there is a divergence between knowledge and practice. This inconsistency is most apparent in decisions regarding material used, level of follow-up and responsibility for design, all of which GDPs directly associated with success of the RPD and involve greater practitioner time and cost. Interestingly, published evidence in the scientific literature was not widely regarded as influential in the decision-making process for prescribing RPDs. In an era of emphasis on evidence-based decision making, the reasons for this warrant further investigation.

Cost and the DTBS/DTSS fee structure (NHS fees in Northern Ireland) were also key themes to emerge as important factors in the decision-making process when providing an RPD. These fee structures were not seen to be a fair reflection of the work involved. In the UK study reported by Allen *et al*[20] respondents reported the current NHS guide as " … highly unrealistic unless the practice is prepared to go bankrupt", "laughable", "a joke" and " … similar to donating to charity". When asked about specific materials, respondents who were currently most likely to provide an acrylic RPD were more likely to say they would prefer to provide more cobalt-chrome on the NHS. Indeed, 91% of GDPs believed that using cobalt-chrome would to some degree improve the chance of success of an RPD. However, the majority of GDPs agreed, regardless of prescribing practice, that the gross NHS fee for an RPD is not feasible and in fact is a disincentive to providing cobalt-chrome RPDs. A number of dentists suggested that within the NHS fee guidelines, it is impossible to balance quality, time needed and profit when providing a cobalt-chrome RPD. Similarly, while the majority of GDPs reported that aftercare improves the chance of success of the RPD, many GDPs in practice did not follow their own beliefs and failed to routinely arrange a review appointment with patients or refer patients to a hygienist. In the present study, respondents from the Republic of Ireland offered a slightly different emphasis on this. While generally agreeing that the fees provided by the DTSS/DTBS schemes were not adequate, there was also a sense that RPDs are seen as a cheap alternative to the preferred option of fixed prosthodontics (i.e., fixed bridgework or implants). This is shown in free comments made by respondents such as " … limited finances rule out other treatments … ". Potentially, there may be an equity issue for Medical Card holders, as they are only offered acrylic-based dentures, " … in the case of medical card holders there is no other treatment option … ".

Overall, the findings reported in this study are quite similar to the UK study reported by Allen *et al.*[15] There is a greater prevalence of acrylic denture provision in the UK, but there were no other major differences noted between dentists in the Republic of Ireland and the UK. RPDs are seen to have a role in the management of partially dentate patients in both countries. However, some clear patterns emerge. Patient attitude to aesthetics appears to be a major influence in the success of RPDs, particularly in the upper jaw. Fee structures are an apparent disincentive to RPD provision in both countries. Finally, best practice in relation to routine patient follow-up and designing RPDs appears to be somewhat less than ideal.

Acknowledgements

Financial support for this research was provided by the Department of Health and Children. The author would like to thank the following people for their contribution:

Dr Margaret Shannon, Department of Health & Children

Dr Michael Cronin, Department of Statistics, UCC, for statistical advice

Mary Cronin and Sarah Meaney, Department of Public Health and Epidemiology, UCC, for collecting data for qualitative phase of the study

Louise Murray for preparing and distributing questionnaires

Data Entry Bureau, Listowel, Co. Kerry, for data entry and cleaning

Dr Nick Jepson and Dr Ruth Graham, Newcastle University, UK, for advice provided on study design

References

1. **World Health Organisation.** A review of current recommendations for the organisation and administration of community oral health services in Northern and Western Europe. Copenhagen: WHO regional office for Europe, 1982.
2. **Käyser, A.F.** Shortened dental arches and oral function. *J Oral Rehabil* 1981; 8: 457-462.
3. **Witter, D.J., De Haan, A.F.J., Käyser, A.F., Van Rossum, G.M.J.M.** A 6-year follow-up study of oral function in shortened dental arches. Part I: occlusal stability. *J Oral Rehabil* 1994; 21: 113-125.
4. **Witter, D.J., De Haan, A.F.J., Käyser, A.F., Van Rossum, G.M.J.M.** A 6-

year follow-up study of oral function in shortened dental arches. Part II: craniomandibular dysfunction and oral comfort. *J Oral Rehabil* 1994; 21: 353-366.

5. **Liedberg, B., Norlen, P., Owall, B.** Teeth, tooth spaces and prosthetic appliances in elderly men in Malmo, Sweden. *Comm Dent Oral Epidemiol* 1991; 19: 164-168.
6. **Steele, J.G., Walls, A.W.G., Ayatollahi, S.M., Murray, J.J.** Major clinical findings from a dental survey of elderly people in three different English communities. *Brit Dent J* 1996; 180: 17-23.
7. **Steele, J.G., Ayatollahi, S.M., Walls, A.G.W., Murray, J.J.** Clinical factors related to reported satisfaction with oral function amongst dentate older adults in England. *Comm Dent Oral Epidemiol* 1997; 25: 143-149.
8. **Jepson, N.J.A., Thomason, J.M., Steele, J.G.** The influence of denture design on patient acceptance of partial dentures. *Brit Dent J* 1995; 178: 296-300.
9. **Van Waas, M., Meeuwissen, J., Meeuwissen, R., Kayser, A., Kalk, W., Van't Hof, M.** Relationship between wearing a removable partial denture and satisfaction in the elderly. *Comm Dent Oral Epidemiol* 1994; 22: 315-318.
10. **Hummel, S.K., Wilson, M.A., Marker, V.A., Nunn, M.E.** Quality of removable partial dentures worn by the adult US population. *J Prosthet Dent* 2002; 88: 37-43.
11. **Frank, R.P., Milgrom, P., Leroux, B.G., Hawkins, N.R.** Treatment outcomes with mandibular removable partial dentures: a population-based study of patient satisfaction. *J Prosthet Dent* 1998; 80: 36-45.
12. **Berg, E.** Periodontal problems associated with the use of distal extension removable partial dentures – a matter of construction? *J Oral Rehabil* 1985; 12: 369-379.
13. **Drake, C.W., Beck, J.D.** The oral status of elderly removable partial denture wearers. J Oral Rehabil 1993; 20: 53-60.
14. **Whelton, H., O'Mullane, D., Crowley, E., Woods, N., Kelleher, V., Guiney, H., *et al.*** *Oral Health of Irish Adults 2000-02*. Department of Health and Children. Brinswick Press Ltd. Final Report April 2007.
15. **Allen P.F., Jepson N.J.A., Doughty J., Bond, S.** Attitudes and practice in the provision of removable partial Dentures. *Brit Dent J* 2008; 204 (1): E2. Epub June 15, 2007.
16. **Narby, B., Krosntrom, M., Soderfeldt, B., Palmqvist, S.** Prosthodontics and the patient: what is oral rehabilitation need? Conceptual analysis of need and demand for prosthodontic treatment. Part 1: a conceptual analysis. *Int J Prosthodont* 2005; 18: 75-79.
17. **Rich, B., Goldstein, G.R.** New paradigms in prosthodontic treatment planning. A literature review. *J Prosthet Dent* 2002; 88: 208-14.
18. **Leles, C.R., Martins, R.R., Silva, E.T., Nunes, M.F.** Discriminant analysis of patients' reasons for choosing or refusing treatments for partial edentulism. *J Oral Rehabil 2009*; 36: 909-915.
19. **Kronstrom, M., Palmqvist, S., Soderfeldt, B.** Prosthodontic decision making among general dentists in Sweden. II: The choice between fixed and removable partial dentures. *Int J Prosthodont* 1999; 12: 527-533.
20. **Kronstrom, M., Palmqvist, S., Soderfeldt, B.** Dentist-related factors influencing the amount of prosthodontic treatment provided. *Comm Dent Oral Epidemio*l 2000; 28: 185-194.
21. **Lynch, C.D., Allen, P.F.** Prescription of removable partial dentures in Irish dental practice. *Int J Prosthodont* 2003; 16: 362-364.

ABSTRACTS

Ten-year results after connective tissue grafts and guided tissue regeneration for root coverage.

Nickles, K., Ratka-Krüger, P., Neukranz, E., Raetzke, P., Eickholz, P.

Background
This study clinically evaluates the 10-year results of connective tissue graft (CTG) and guided tissue regeneration (GTR) therapies using bioabsorbable barriers for root coverage (i.e., the reduction of recession depth).

Methods
In 15 patients, 38 Miller Class I and II recessions were treated. Recession defects received a CTG or GTR by random assignment. At baseline (immediately prior to surgery) and six and 120 +/- 12 months after surgery, clinical parameters were obtained.

Results
Nine patients, who contributed 24 recession defects, were available for re-examination at 120 +/- 12 months. Six and 120 +/- 12 months after receiving a CTG, statistically significant ($p<0.05$) root coverage was observed compared to baseline root coverage (six months: 3.07 +/- 1.74mm; 120 +/- 12 months: 2.07 +/- 1.89mm). The GTR therapy resulted in statistically significant root coverage compared to baseline root coverage only after six months (2.28 +/- 1.77mm; $p<0.05$). Both groups experienced a statistically significant loss of coverage from six to 120 +/- 12 months (CTG: -1.0 +/- 0.78mm; GTR: -2.03 +/- 2.24mm). At 120 +/- 12 months after CTG surgery, the stability of root coverage was statistically significantly better than 120 +/- 12 months after GTR surgery ($p=0.002$). The CTG caused more post-surgical discomfort ($p<0.05$), but it resulted in a better treatment outcome ($p<0.05$) than GTR as perceived by patients.

Conclusion
The long-term stability of root coverage (i.e., the reduction of recession depth) and aesthetic results perceived by patients were significantly better 10 years after CTG surgery, statistically, than after GTR surgery using bioabsorbable barriers.

Journal of Periodontology 2010; 81 (6): 827-836.

Influence of bisphosphonates in orthodontic therapy: systematic review

Iglesias-Linares, A., Yáñez-Vico, R-M., Solano-Reina, E., Torres-Lagares, D., González Moles, M.A.

Objective
The objective of this paper was to analyse the effects of bisphosphonates and their influence on orthodontic therapy.

Data/sources
The literature was systematically reviewed using the PubMed/Medline, Scopus, Ebsco Host, Scirus and Cochrane databases up to December 31, 2008.

Study selection
Articles were independently selected by two different researchers based on previously established inclusion and exclusion criteria, finding a good concordance (kappa index of 0.862). The methodological quality of the reviewed papers was assessed. The search strategy identified 205 titles. Thirteen articles were selected after application of the inclusion/exclusion criteria, and only one of these had a high methodological quality. Bisphosphonate applications in orthodontic therapy were divided between two main groups: tooth movement and skeletal relapse.

Conclusions
Topical or systemic application of bisphosphonates decreases orthodontic tooth movement, and reduces orthodontic tooth movement relapse and skeletal relapse after maxillary expansion or mandibular distraction and similar procedures. Further longer-term studies are required to assess possible adverse effects after bisphosphonate treatment for these purposes.

Journal of Dentistry 2010; 38 (8): 603-611.

Bacteraemia following dental implants placement

Piñeiro, A., Tomás, I., Blanco, J., Álvarez, M., Seoane, J., Diz, P.

Objective
To investigate the prevalence, duration and aetiology of bacteraemias following the placement of implants, as well as the prophylactic efficacy of a chlorhexidine digluconate (CHX) mouth rinse.

Material and methods
Fifty patients undergoing implant placement were randomly distributed into two groups:

- control group: 30 patients with no prophylactic intervention before surgery; and,
- CHX group: 20 patients who performed a 0.2% CHX mouth rinse before surgery.

Blood samples were collected at baseline, at 30 seconds after the insertion of implants and at 15 minutes after completion of the suturing of the mucoperiosteal flap. Samples were processed in the Bactec 9240, and the subculture and further identification of the isolates were performed using conventional microbiological techniques.

Results
The prevalence of bacteraemias was 2% at baseline. In the control group, the prevalence of bacteraemias was 6.7% at 30 seconds and

3.3% at 15 minutes, but no statistically significant differences were achieved compared with the baseline percentage. In the CHX group, there were no positive cultures from blood samples obtained at 30 seconds or at 15 minutes.

Conclusions

Implant placement via a mucoperiosteal flap does not carry a significant risk of developing bacteraemias. The use of antibiotic prophylaxis for the prevention of focal infections such as bacterial endocarditis in 'at-risk' patients undergoing dental implants is therefore questionable. Although its efficacy has not been confirmed statistically, we recommend a 0.2% CHX mouth rinse before treatment, as proposed previously by the British Society for Antimicrobial Chemotherapy.

Clinical Oral Implants Research 2010; 21 (9): 913–918.

Medication in elderly people: its influence on salivary pattern, and signs and symptoms of dry mouth

Coelho Leal, S., Bittar, J., Portugal, A., Falcão, D.P., Faber, J., Zanotta. P.

Objective

To compare stimulated and non-stimulated salivary flow, pH, buffering capacity and presence of signs and symptoms of hyposialie and xerostomia in elderly patients with senile dementia using medication and healthy elderly subjects not using medication.

Methods

Forty individuals (mean age: 68.5 years) were divided into two groups, according to the use (G1) or non-use (G2) of medication and the presence (G1) or absence (G2) of senile dementia. Data with reference to the general health condition, use of medication and the patient's complaints were collected while taking a medical history. Clinical examination identified signs associated with hyposialie and xerostomia. Stimulated and non-stimulated saliva flow, pH and buffering capacity were verified.

Results

The stimulated saliva flow in both groups was below normal parameters. The drugs used by individuals in G1 showed xerostomic potential. Individuals with a higher consumption of xerostomic medication presented with dry and cracked lips. A significant negative relationship was found between drugs consumption and the buffering capacity ($p<0.001$), and the resting saliva flow rate ($p=0.002$).

Conclusion

The use of medication increases the chance that an elderly person may present with signs related to xerostomia and alterations in stimulated saliva flow and buffering capacity.

Gerodontology 2010; 27 (2): 129-133.

QUIZ

Submitted by Dr Joanne Mawhinney.

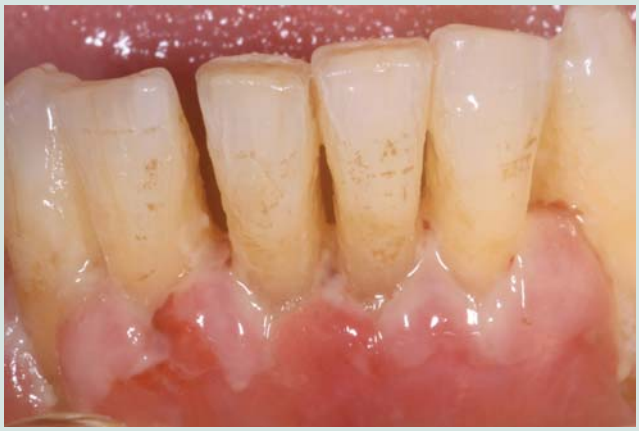


Figure 1: Labial gingivae – Patient A.

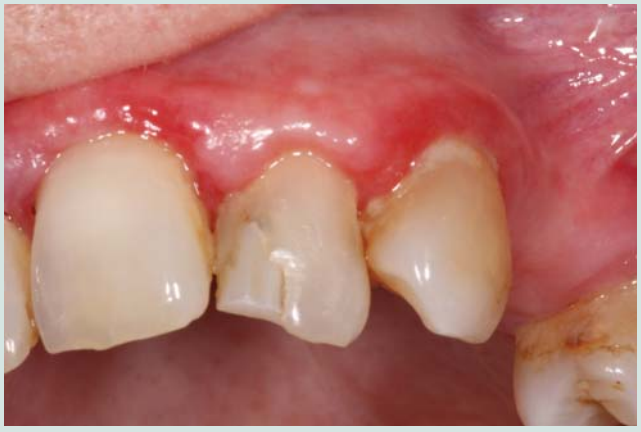


Figure 2: Labial gingivae – Patient B.

These patients presented with painful bleeding gingivae. Also noted on clinical examination were white striated regions on the buccal mucosae.

Questions

1. What is the most likely clinical diagnosis?
2. How should these cases be managed?

Answers on page 238

Partnership agreements

DAVID PHELAN reminds dentists in business together of the need for a formal partnership agreement.

Any time two or more people carry on business together with a view to making a profit and without forming a company, a partnership exists. To that extent, it is the default form of business model for businesses involving more than one owner.

The Dentists Act 1985 imposes a restriction on dentists practising dentistry through the medium of a company. While there has been discussion about lifting this restriction (as has happened in the UK), the statutory prohibition is still in place here, so where two or more dentists wish to practise together, they are effectively required to use the vehicle of a partnership to carry on their business.

It is crucial therefore to understand the nature of a partnership. It is also important to understand that you may be deemed by a court to be in a partnership, even if you think you are not. If you have not formalised the relationship by way of a written agreement, that is where trouble can begin.

Need for a written partnership agreement

The law in this area dates back to The Partnership Act 1890. This Act implies certain terms into partnership agreements, unless the partners have agreed otherwise in writing. Therefore, if a partnership is deemed to be in existence and there is no written agreement in place, the implied terms of the 1890 Act will apply. This is not an advisable state of affairs as many of the terms of the 1890 Act are not suitable in a modern context. For example, under the 1890 Act:

- any one partner may dissolve the partnership unilaterally without reason;
- there is no right to expel a partner. Thus, no matter how unprofessional a partner may be in the running of a dental practice, in the absence of a written partnership agreement providing for expulsion, the only option would be to dissolve the partnership entirely; and,
- there is no power for a partner to retire, and if a partner dies, the firm will automatically dissolve.

To avoid the rights and restrictions of the 1890 Act being implied into your relationship with your partners, it is essential to have a written partnership agreement in place. If you are either about to enter into partnership with others, or are already carrying on business with others but without a written partnership agreement, it is advisable to arrange to have a written agreement put in place as soon as possible. Discuss between yourselves at the outset what you see as the key issues. Having done that, you can use the IDA's pro-forma Partnership Agreement, which is available to members. Alternatively, you might decide to consult a solicitor, who will take your information and assist with the drawing up of an appropriate partnership agreement. Likely key issues will be division of profits and losses, the responsibility for the management of the practice between the partners, annual leave, payment of tax and expenses, grounds for expulsion of a partner and voluntary exit mechanisms for partners.

Partnership property

Issues regarding what is or is not partnership property can often arise in partnerships. It is important at the outset to decide which property is partnership property and which property instead belongs to individual partners. The 1890 Act presumes that property used in the partnership is partnership property and that property bought with partnership funds is partnership property.

Structure of a partnership

The model of how a partnership operates in practice has been refined in many other professions, particularly among solicitors and accountants. A review of the way in which partnerships are structured in other professions identifies the following:

Generally, smaller partnerships (for example two to six partners) are relatively straightforward, in that the written partnership agreement identifies who the partners are and often provides that the partners share profits and losses, obligations and entitlements equally. While the partnership agreement can provide for some division of responsibility for management of the partnership between the individual partners, ultimately, each partner is usually a full co-owner of the business and shares equally in the ups and downs of business with all of the other partners.

For larger partnerships, a 'two-tier' partnership structure can sometimes be seen. A common approach to a two-tier partnership is:

1. The first 'tier' partner is a full equity partner; that is, one of the owners of the business, who shares in the profits and losses and obligations and entitlements with the other equity partners.

2. The second 'tier' is a 'salaried partner'. That term is in fact something of a contradiction in terms since a salaried partner is not usually a 'partner' but is technically an employee of the practice. A salaried partner is a person who operates in the middle rank of professional partnerships, between equity partners and salaried employees. He or she is held out externally as a partner of the firm, but receives a set salary like other employees. For those outside the firm, the salaried partner is to all intents and purposes a partner of the firm. However, internally, the salaried partner usually has limited rights, for example he or she is unlikely to have the right to vote at partners' meetings, to dissolve the firm or to be involved in other significant decisions of the firm.

It is important to note that a salaried partner is liable to third parties who understood the salaried partner to be a full partner of the firm. For that reason, it is often the case that a salaried partner will be given an indemnity from the equity partners in respect of any potential liability to third parties.

It is important for full equity partners of a business to understand that appointing a salaried partner is generally perceived within a practice as a statement that the relevant person is suitable material for a full equity partnership in due course. In appointing a salaried partner, there need not be any specific commitment to make the person a full equity partner at any stage in the future, but generally it can give rise in due course to an expectation that the person will become a full equity partner at some stage.

Similar partnership models or particular aspects of such models could be used among dentists in partnerships of sufficient size. Again it is a case of documenting carefully the parties' intentions.

Conclusion

The key issue is to avoid uncertainty in the legal relationships you have with your partners. Taking the trouble to put a partnership agreement in place to regulate the relationships you have with your partners can save a huge amount of time and hassle at a later stage.

David Phelan *is a partner at Hayes Solicitors and is Head of the Commercial and Business Law Team.*

Non-verbal communication

SUE BOYNTON continues Dental Protection's series of articles with some advice on communicating with patients.

Imagine saying to a teenager as they leave the house, 'Enjoy college today!' and receiving the reply, 'Yeah, right'.

Now that could mean 'yes I'll enjoy it that's right'– or alternatively, and more commonly in some households, it means the exact opposite. The meaning of the words is altered by the tone of voice and/or the body language.

Many people will have received a text or an email from a friend and misinterpreted its content. This is often because we don't have the context for the communication; we're missing the non-verbal cues, body language or intonation.

Non-verbal communication is important

In dentistry we communicate all the time, with our teams and to our patients. We all have different degrees of skill in non-verbal communication. We can even send very definite messages to others without saying anything.

Think of a time when a colleague has arrived at work – before they've even spoken you know what sort of mood they're in. You have subconsciously interpreted their non-verbal communication.

Patients can do the same thing when they visit the dental surgery. A patient can quickly pick up on the atmosphere in the practice. If it's a happy team where everyone communicates well and listens when someone speaks, then the patient feels that their communication is more likely to be valued and as a result they feel able to communicate effectively with the team. This is important because many studies have demonstrated a close correlation between the ability of healthcare professionals to communicate effectively and the likelihood of them facing complaints or being sued.

Different applications

Non-verbal communication is one of the key aspects of communication and can be used in a number of ways, such as:

- to reinforce or repeat a verbal message, e.g., pointing at a specific tooth while explaining a treatment plan;
- to complement the verbal message, e.g., a nod can reinforce a positive message; and,
- to contradict a message the individual is trying to convey, e.g., agreeing but subconsciously shaking the head.

Communication is not just about choosing the right words to say, and saying them in the right order, and in the right way. Equally important are:

- the ability to listen effectively, without interrupting;
- the ability to control our body language;
- being able to interpret the body language of others;
- making sure that both parties properly understand what is being said; and,
- trying to form an understanding of the underlying feelings of the other person.

Listening

When we are listening to someone, our own body language can be very revealing. We can also learn a lot by observing the body language of the people that we are speaking to.

Effective listening is a skill that can be learned. Many people have a tendency to 'half listen', their attention drifting in and out of a conversation. A person's willingness and ability to listen will be a reflection partly of their underlying personality, partly of the subject matter and the other demands on the person at that time, and partly of their communication skills.

Active listening is a specific, structured way of listening and responding to others, where the listener's attention is focused heavily on the speaker. The benefits of this approach are not simply that more of the message is reaching the listener; equally important is the fact that the

speaker can see that the other person is really listening, and is actively engaged in the conversation. It therefore has a particular importance in consultations between patients and clinicians.

If a clinician can convey to a patient that they are not only hearing and understanding the words that the patient is saying, but also that they understand the patient's feelings, the quality of the interaction will be significantly enhanced.

It is helpful therefore to demonstrate that the listener has understood and is interested in what's being said. This kind of active listening can be by way of good eye contact, a nod of the head, and responses such as 'Ah,' or 'I understand what you mean'. You can also summarise what has been said to demonstrate your understanding or invite expansion with an open-ended question, e.g., 'Can you tell me more about that?' All of these responses can help to facilitate the communication process.

In addition, if we align what we want to say with the tone, posture and gestures that we use then communication will be much more effective. This is called congruence – sending the same message on verbal and non-verbal levels. Past experience has shown that if the message is not congruent because the body language does not match the verbal statement, then human nature is such that the listener will disregard the verbal communication and focus on the non-verbal message that is being received.

For example, if a patient says, 'Yes, I'm happy with the crown' while frowning or grimacing, we automatically know they are not happy. This is where teamwork is essential, as it is often the dental surgery assistant or receptionist who picks up these types of non-verbal clues. Courses on communication are available and they can be helpful in developing the skills of the team. The ability to listen effectively and to communicate well is one of the most powerful ways to build and strengthen the rapport we have with our patients. Many studies have shown that rapport ranks very highly on the list of what patients want most from healthcare professionals.

Conclusion

Establishing rapport with a patient can help to maximise patient satisfaction and strengthen the professional relationships, improve treatment outcomes, reduce the frequency of claims and complaints, and assist dental team members in resolving dissatisfaction and complaints quickly and easily when they do arise.

Sue Boynton LLM BDS. *Before working for Dental Protection as a dento-legal adviser, Sue worked in the Community Dental Services for five years and in general dental practice for over 17 years. Sue is DPL's Deputy Lead for members in Ireland. She is an NLP Master Practitioner and a trained mentor.*

Initial Medical Services

Dental Hazardous Waste Services

A safer environment in our experts hands

Initial Medical Services has been in operation for over ten years and is the largest provider of specialised dental hazardous waste services to dental practitioners in Ireland.

We specialise in the packaging, collection and treatment of clinical, chemical, pharmaceutical, and bio-hazardous waste, which requires controlled disposal due to its infectious, biological, chemical or sharp attributes.

We are a fully permitted, licenced company offering a nationwide service. All our service technicians use a sophisticated waste tracking system, providing a fully traceable service from point of collection through to point of treatment.

Segregation guidelines

YELLOW BAG

* All blood-stained or contaminated items including:
- Dressing
- Swabs
- Bandages
- Personal protective equipment (gowns, aprons, gloves)
- Max Weight 12 kg

NO SHARPS, LIQUIDS OR HARD OBJECTS

YELLOW 30/60 LITRE RIGID BIN (with purple lid)

- Small quantities of residual medicines or pharmaceuticals left over after administration to patients
- Out of date pharmaceuticals

NO SHARPS, OR FREE LIQUIDS

YELLOW SHARPS BIN (with blue or red lid)

- Needles
- Syringes
- Scalpels
- Blood stained or contaminated glass

NO FREE LIQUIDS

AMALGAM SEPARATION

- Traps, collects and recovers amalgam particles from Dental waste water
- Recovers 98% Amalgam from entering water system

Conformance with Article 4 of the Waste Directive (75/442/EEC) waste.

AMALGAM WASTE

- Waste amalgam
- Matrix bands
- Amalgam-contaminated metals

AMALGAM CAPSULES

- Used Capsules
- Dappen Dishes
- Carrier Tips
- Mercury- contaminated plastics
- Lead Foils

SLUDGE DRUM

- Aspirated waste filters
- Used collector cups
- Transport of mercury contaminated products

TOOTHBOX

- Extracted teeth – containing amalgam

X-RAY CHEMICALS

- Fixer
- Developer

MISCELLANEOUS EQUIPMENT

- Mercury suppressant spray
- Biohazard disposal kit
- Mercury spill kit
- Pedal bin for safe storage of clinical waste bags

PLEASE NOTE

- Bags must not be used for sharp or breakable items or for liquids
- Do not over fill bags or bins
- Yellow bags must be securely closed with cable tie when 2/3 full
- Bins must be securely closed when 2/3 full or at manufacturer's fill line
- All containers are UN approved, each have their own weight restrictions which must be complied with
- Label all Healthcare Risk Waste appropriately prior to collection
- For waste not specified above please refer to www.initialmedical.ie

CONTACT DETAILS

Initial Medical Services
(Formerly Healthcare Waste Management Services®)
The Royal Mews
10 Dublin Street
Carlow
T: 059 9134811
F: 059 9134812
E: info@initialmedical.ie
W: www.initialmedical.ie

Please note: we provide services for the safe/compliant storage, collection and treatment of all hazardous waste produced by a dental practice.

Amalgam waste disposal

DR TOM FEENEY summarises current policy with regard to the disposal of mercury from amalgam.

Over the past decade, the mercury (Hg) released into the environment as a result of dental amalgam use and disposal, and the potential consequences (risks) for human and environmental health, have received increased attention. Although numerous publications are available describing one or more aspects of this issue, a comprehensive EU-wide assessment of the human health and environmental risks of the mercury used in dental amalgam is not available. This type of risk assessment requires, in addition to extensive general information on the effects on humans and (various) environmental species, more detailed information on possible region-specific differences in the use, release and fate of mercury originating from dental amalgam. This includes detailed quantitative information on the use and release pattern in all EU27 countries, possible country-specific abatement measures, and differences in the fate of mercury in region-specific municipal wastewater treatment and sludge application practices.

Mercury occurs naturally in the environment in different chemical forms. Elemental mercury is the form used in dental amalgams. Forms more commonly found in nature are inorganic mercury and organic mercury. Natural events (e.g., weathering of rocks) and human activities (e.g., fuel and waste combustion and, to a lesser extent, use and disposal of dental amalgams) can cause releases of these different forms of mercury into the environment.

The main environmental concern relates to methylmercury, an organic form of mercury, because it can accumulate in organisms. Levels of methylmercury increase along the food chain and with age. Some of the mercury released by the use of dental amalgams will be converted into methylmercury. Although estimates are available of the amounts of mercury released by the use and disposal of dental amalgams in the European Union, it is not possible to say what proportion of the risk associated with organic mercury present in the environment is due to releases from amalgam.

EU position

The Commission is now considerably less concerned about the direct health risks of dental amalgam, but is focusing more on the environmental impact of mercury associated with dentistry.

The EU Mercury Strategy is currently under review and the Commission intends to have this review completed by the end of 2010 with proposals for any necessary changes published by the end of the year. The Commission has appointed a company called Bio-intelligence Services (BIO-IS) to conduct the research for the review. The Commission hosted a meeting of stakeholders and interested parties on June 18, 2010, and feedback from the meeting will be taken into consideration in the final report, which is expected in autumn 2010. The Commission will then progress to propose any changes to the Mercury Strategy by the end of the year.

The Commission admits that there is a tremendous lobby to ban mercury from remaining uses, in particular dental amalgam, which – following the elimination of mercury in the chlor-alkali industry – has risen to the top of the list in volume of use. The Commission is aware that the high standards of oral health in some countries are due to the very effective and well-funded prevention programmes. The Nordic/Scandinavian countries are examples, where amalgam is no longer used and the need for fillings is very low.

The general opinion is that, in terms of the continuing use of amalgam, the status quo is not an option. However, the effects of a worldwide ban would be catastrophic in many countries and so the preferred option is a phasing down approach. This would be a fairly long-term process, as it would require further dental restorative material development to find a true replacement for amalgam and an increase in preventive activity to reduce dental caries. During this process there would need to be an improvement in the management of waste dental amalgam to show the profession's commitment to environmental principles.

FDI position

Dental staff should be trained to take appropriate measures to minimise the amount of waste and adopt best management practices for ensuring that all generated waste is properly disposed of in accordance with applicable environmental legislation. Dental offices should collect, store safely and forward for recycling as much of the amalgam waste as possible, regardless of whether or not it has been in contact with a patient. Such waste includes used amalgam capsules, excess amalgam that is not used in placing a restoration and amalgam waste retained in chair-side traps, vacuum pump filters and amalgam separators. Extracted teeth restored with amalgam can also be recycled with other types of amalgam waste. If amalgam separators are to be installed in the dental clinic, they should comply with ISO 11143.

CED position

The dental profession takes seriously the environmental impact of its members' activities and emphasises that the professional has an obligation to work within the legal framework governing mercury-

containing products. The CED calls on Member States to ensure the full implementation and enforcement of EU waste laws, and fully supports examination into whether this is happening. In most Member States amalgam separators are used and in many they are obligatory. Amalgam separators are an effective way of reducing harmful waste and remove a further 95% from the dental units' existing filtration systems, resulting in a total capture of 99%, so preventing waste amalgam from entering the waste stream.

The CED also encourages national dental associations to share best practice on waste management and to support their members regarding compliance with waste management obligations.

IDA Best Practice Statement

1. Amalgam capsules should be stored in special UN-approved labelled containers. Spent capsules can be stored in the 2L surgery container, which includes a mercury suppressant sponge. When the container is full it can be decanted into a larger 6L container – this may be stored in a central location away from the surgery for space saving purposes. Always ensure that the lid is kept securely sealed.
2. Waste amalgam/amalgam sludge from suction units should be stored in special UN containers with a vapour suppressant. The sponge is impregnated with a suppressing agent so it is not necessary to add any solutions.
3. Always ensure that the lid is kept securely sealed.
4. Amalgam filters on suction units need to be disposed of by a licensed group.
5. Extracted teeth with amalgam fillings should be placed in special containers with a fixative to preserve dental tissue and prevent odour.

All the above containers should have tear strip lids, inner seals and mercury vapour suppressants and should ultimately be processed for mercury recovery.

Dental practice requirements:

1. Have a practice waste plan, including staff training to ensure correct segregation and handling of waste.
2. Have suitable UN-approved containers, suitably labelled.
3. Arrange safe storage prior to collection and ensure that members of the public cannot access the storage site.
4. Arrange for safe transport and collection of the waste and subsequent disposal. The practice must have a dangerous goods safety adviser and some waste management companies offer dentists access to their dangerous goods safety adviser as an additional service, which removes the onus from the dentist to have their own adviser.
5. Keep good records of waste disposal and retain transfer notes. C1 forms must be retained for three years. A C1 form (consignment document) is required by law when transporting hazardous waste from one facility/location to another within Ireland. It is the dentist's responsibility to ensure that the company that he/she uses to remove hazardous waste from the practice (including contractors who pay for waste amalgam and waste metal) complies with the following:
   - waste collection permit from the local authority;
   - access to licensed disposal sites and export incineration routes as approved by the EPA;
   - dedicated vehicles with Hazchem-trained personnel;
   - appropriate public liability and employers liability insurances; and,
   - dangerous goods safety adviser.

Amalgam separators

Amalgam separators are required by law in 18 of the 28 European countries that took part in a recent CED survey. In most cases (18/21), this applies to all units/premises and not just newly installed/equipped premises. The EU standard for amalgam separators is EN 11143, which was withdrawn and re-launched in 2008.

In 14 countries over 99% of practices have separators installed. A further five countries reported that 80-99% of practices have them installed. In most countries where separators are not legally required, they are recommended by professional associations, government, environmental agencies or manufacturers.

Amalgam separators are not required by law in Ireland. However, this situation may change and in any event the use of amalgam separators is clearly best practice. The IDA has started a tendering process for the contract to retrofit practice waste systems, and hopes to shortly be able to offer members the opportunity to have amalgam separators fitted at a group discounted rate.

Quiz answers *(questions on page 231)*

Submitted by Dr Joanne Mawhinney.

1. What is the most likely clinical diagnosis?

These patients were diagnosed with desquamative gingivitis, a manifestation of several different disorders including, most commonly, oral lichen planus. Typically, the gingivae appear smooth and erythematous with desquamation and erosion. Localised lesions can precede more widespread involvement of the gingivae. Discomfort and profuse bleeding can impair the patient's oral hygiene practices, resulting in copious plaque and calculus accumulation. As a result, they may be at an increased risk of periodontal disease.

2. How should these cases be managed?

Management includes oral hygiene instruction and periodontal treatment as indicated by clinical examination, with regular maintenance. Diagnosis and treatment of the underlying mucocutaneous condition requires a specialist oral medicine practitioner. Regular monitoring is essential due to the potential for malignant transformation in oral lichen planus.

Reference

Lo Russo, et al. Diagnostic pathways and clinical significance of desquamative gingivitis. *J Periodontol* 2008; 79: 4-24.

Classified advert procedure

Please read these instructions prior to sending an advertisement. On the right are the charges for placing an advertisement for both members and non-members. Advertisements will only be accepted in writing via fax, letter or email (fionnuala@irishdentalassoc.ie). Non-members must pre-pay for advertisements, which must arrive no later than November 5, 2010, by cheque made payable to the Irish Dental Association. If a box number is required, please indicate this at the end of the ad (replies to box number X). Classified ads placed in the Journal are also published on our website www.dentist.ie for 12 weeks.

Advert size	Members	Non-members
up to 25 words	€75	€150
26 to 40 words	€90	€180

Non-members must send in a cheque in advance with their advert. The maximum number of words for classified ads is 40.

Only if the advert is in excess of 40 words, then please contact:
Think Media
The Malthouse, 537 North Circular Road, Dublin 1.
Tel: 01-856 1166 Fax: 01-856 1169 Email: paul@thinkmedia.ie

Please note that all classified adverts MUST come under one of the following headings:
Positions Wanted
Positions Vacant
Practices for Sale/To Let
Practices Wanted
Unwanted/Second Hand Equipment for Sale

Classified adverts must not be of a commercial nature. All commercial adverts must be display advertisements, and these can arranged by contacting Paul O'Grady at Think Media, Tel: 01 856 1166.

POSITIONS WANTED

Approachable, capable, enthusiastic, hardworking dentist with outstanding academic qualifications is looking for a part-time associate position or locum work in the greater Dublin area and surrounding counties. Very sociable and great team player. Immediate start possible. Tel: 086-776 3757, or Email: madeleyew@hotmail.co.uk.

Friendly, high quality, conscientious, experienced dentist working in nearly all fields of dentistry except orthodontics is looking for full-time or part-time associate position or locum work in Dublin area and surrounding counties. Immediate start possible. Tel: 087-160 6038, or Email: Superzahn.elh@gmx.de.

POSITIONS VACANT

Part-time associate wanted for well-established private practice off Grafton Street, Dublin 2. Computerised, digital radiographs, full support. Experience required. Send your CV to dpgal@eircom.net.

Avalon Medical is recruiting full- and part-time associate dentists to work in modern mixed practices in England and Wales. Excellent monthly remuneration with full relocation packages available. Tel: 0044-1935-385935, Mob: 0044-776-0163323, Email: Miriam@avalon-consulting.co.uk, or log on to www.avalonmedical.co.uk.

Associate dentists required to join our busy practices in Drogheda, Wexford and Galway City. Excellent conditions. Immediate start possible. Email: Emmet@smiles.ie.

Experienced part-time associate required to join well-established practices in west Dublin area, from mid October. Excellent facilities, conditions and support staff. Principal is a certified Cerec trainer. Email: gbglass@mac.com.

Enthusiastic, experienced associate dentist required for a position in a busy dental practice in the Rochestown area, Cork. Please Tel: 087-784 5355.

Full-time associate position – Edinburgh, Scotland. We are looking for a full-time associate to join our new practice in Edinburgh. NHS/private/brand new surgeries – digital, fully computerised, hygienist. Able to do interview in Dublin around September 24. Tel: 0044-131-3325510, or Email: stockbridgedental@yahoo.com.

Dental associate required for busy dental practice, Mullingar region. Modern, computerised, three-surgery practice, digital OPG, excellent support staff. Tel: 044-966 1777, or Email: info@dentistsireland.com to set up interview.

Dental associate required for busy Dublin northside dental practice. Long-established, fully computerised, digital OPG, hygienist. Associate must be proficient and experienced. Send CV to info@dentistsireland.com.

Experienced part-time associate required to join Cork practice from mid October. Computerised, digital radiography, Cerec, hygienist, full support. Please send CV to claire.rath@smilesandmore.ie.

Associate required for six months maternity cover in busy thriving practice in Co. Tipperary. Modern fully equipped surgery, OPG, hygienist and excellent support team. Starting January 2011. Replies by Email please to themallpractice@eircom.net.

New Belfast specialist practice – state-of-the-art private referral practice requires additional specialists for a multi-disciplinary clinic. Referral base already established. Relocating to a fully refurbished Victorian building with lecture facilities. Please Tel: 0044-7917355555.

Dental technician required, mainly skilled at cosmetic ceramic work, but some experience with acrylic work essential. Send CV to info@dentistsireland.com.

Part-time sessions available for experienced and enthusiastic hygienist in Limerick City Centre practice, preference given to those capable of administering block and with EXACT computer software experience. Please Tel: 087-657 1043.

Full-time hygienist required. Must be experienced and friendly. Email: bdswicklow@eircom.net.

AAAAARRRRGHHH! My excellent dental nurse wants to leave me, move cross-country, and be with her husband in Meath. She's cheerful, kind,

CLASSIFIED

capable, honest, hardworking, enthusiastic, responsible, experienced, fully qualified and now looking for work, commutable from Navan. Tel: 087-905 4645, or Email: orthodontics@ireland.com.

Dental nurse required – Kilkenny. Qualified and experienced dental surgery assistant required full-time/part-time in Kilkenny. Must be willing to work late sessions and Saturdays. Email CV and cover letter to jacquelineclune1@gmail.com.

Dental nurse/receptionist required. Full-time position located in Dublin 4. Experience required. Please contact Emma, Tel: 086-331 9950, and send CV to meehan.e@gmail.com.

Dental nurse required (full-time) immediately for busy northside dental practice 15 minutes from city centre. Tel: 01-838 9966, or Email: info@dentisitsireland.com to set up interview.

DSA required – Carlow. Qualified and experienced dental surgery assistant required full-time in Carlow but part-time may be possible. Must be willing to work late sessions and Saturdays. Tel: 087-299 8930, or Email CV to: montgomeryhousedc@gmail.com.

Qualified and experienced dental surgery assistant required full-time for new practice in Terenure. Shared reception duties. Part-time considered. Email CV and cover letter to info@elitedental.ie.

Qualified and experienced dental surgery assistant required full-time for well-established private practice off Grafton Street, Dublin 2. Computerised, digital radiographs, some shared reception/admin duties. Please forward CV to dpgal@eircom.net.

Experienced capable DSA required for private Dublin practice, located just off the M50 in South Dublin. Minimum two years experience. Tel: 01-294 5122, or Email: tfoley@iol.ie.

Qualified dental surgery assistant required to cover oral surgery sessions in specialist practice in Dunshaughlin, Co. Meath. Please forward CV to: sjw0404@gmail.com.

Part-time receptionist required for busy Dundrum dental practice. Applicant must be flexible on times; nursing experience an advantage. Please Email CV to 1dundrumdentalsurgery@eircom.net.

PRACTICES FOR SALE/TO LET

For sale/to let. Dental surgery in Ennis, Co. Clare. 500-1,100 sq. ft. with the option to extend. Customer and staff private parking also available. Tel: 087-227 1430, or Email: pat@cfsirl.com.

For sale – 27-year lease on rooms in excellent position in banking district of Wexford Town. Would suit specialist. Has been a dental surgery for 35 years. Tel: 087-228 6166.

South West Dublin – two/three surgeries, fully equipped. Busy, long established, community-based practice. Large passing trade. Fully computerised. OPG/hygienist. Strong new patient numbers. Excellent figures 2010. Large potential to expand hours and service. Tel: 086-807 5273, or Email: niall@innovativedental.com.

Room available in a very busy dental practice in a modern medical centre in Dublin Northwest on a seasonal basis. Ideal for periodontist, endodontist, etc. For details please contact Elizabeth, Email: eoreilly@touchstone.ie.

Rooms to let – Belarmine Plaza Shopping Centre, Stepaside. Rooms available in new multidisciplinary medical centre. Free parking. Residential area/shopping centre with 1,200 homes. Tel: 087-948 4021, or Email: j.vazbeck@lph.ie.

Rooms available for experienced orthodontist. New state-of-the-art dental practice in Cork City. Fully equipped digital surgery. Excellent support team. Reply by Email please to lindaryan001@gmail.com.

PRACTICES WANTED

Dental practice sought for purchase in South Dublin area. Two-surgery practice preferred. Especially interested in a good practice where principal dentist is considering retiring in the next few years. Please reply in confidence to: irishdentist@hotmail.com.

Practice wanted within one hour of Dublin. Ideally two-surgery practice. Confidentiality assured. Email: dentist020510@hotmail.co.uk.

Practices wanted nationwide. Investment/sales considered. Two to three surgeries minimum. Good turnover. Low medical card. Cash available. Speed essential. Tel: 087-099 4928, or Email: dentalireland@gmail.com.

EQUIPMENT FOR SALE

For sale. Brand new delivery unit for syringe (handpiece) suction. See www.Boydindustries.com for model CSU-356. Contact Michael, Tel: 087-065 4620.

For sale. 1. Cranex 2.5+ OPG with Durr Developer. 2. Wall-mounting Belmont delivery system with fibreoptic lights. 3. Four W&H Topair 795 high speed handpieces. Contact Ciaran, Tel: 086-833 7318, or Email: ciaranallendental@eircom.net.

Diary of events

A round-up of national and international events for dental professionals.

OCTOBER 2010

Munster Branch, IDA – Scientific Meeting
October 6 Maryborough House Hotel, Cork
Speakers: Dr Michael Hartnett, Ms Mairead Cashman and Dr Seamus Sharkey.

IDA Public Dental Surgeons Seminar
October 6-8 Clarion Hotel, Sligo
For further information contact Dario in IDA House, Tel: 01-295 0072.

IDA North Eastern Branch Meeting
October 7 Nuremore Hotel Carrickmacross, 8.00pm
Speaker is Dr Tom Canning on 'Problem Solving in Prosthodontics'.

Metropolitan Branch, IDA – Scientific Meeting
October 14 Hilton Hotel, Dublin 2
Speaker is Professor Bob Cronin on 'Diagnosis and restoration of the severely worn dentition'.

EFAAD – the European Federation for the Advancement of Anesthesia in Dentistry – Annual Meeting
October 14-15 The Royal and Ermitage Resort, Evian-Les Bains, France
For further information, see www.efaad2010.squarespace.com.

Munster Branch, IDA – Scientific Meeting
October 18 Maryborough House Hotel, Cork
Speakers: Dr Barry Lynch, Dr Pat O'Driscoll and Dr Mary O'Dea.

Irish Endodontic Society Meeting
October 21 Small lecture theatre, Dublin Dental Hospital
Meeting begins at 7.00pm. Speaker is Dr Nick Wright, specialist endodontist.

Faculty of Dentistry, Royal College of Surgeons in Ireland – In Practice
October 28-29 Royal College of Surgeons, St Stephen's Green, Dublin 2.
12 CPE Points. Register today online at www.fodasmrcsi.ie.

NOVEMBER 2010

FTI 2010 – The 2nd Future Trends in Implantology International Dental Conference
November 11-13 Florence, Italy
For further information, see www.ftidental.com.

Munster Branch, IDA – Annual Scientific Conference
November 12 Fota Ireland Hotel & Spa, Co. Cork
For further information contact Dr Eamonn Murphy, Tel: 021-429 4590.

CEA Dental – San Diego Dental Convention
November 12-13 Marina Village Conference Centre, San Diego, CA.
For further information, see www.ceadental.com.

Munster Branch, IDA – Annual Scientific Meeting
November 12 Fota Island Hotel and Spa, Co. Cork
For further information contact Catherine Nevin from the Postgraduate Medical and Dental Board, Tel: 021-490 1294, or Email: c.nevin@ucc.ie.

Metropolitan Branch, IDA – Scientific Meeting
November 18 Hilton Hotel, Dublin 2
Speakers: Dr Dermot Kavanagh on 'FAQs: five ortho questions dentists ask', and Dr Ed Cotter on 'Repairs, Relines, Remounts, Reappraisal – all the daily Rs'.

Irish Society for Disability and Oral Health (ISDH) – 'The A-Z of Oral Conditions of Children'
November 18 Dublin Dental Hospital and School
7.00pm-8.00pm. For further information contact Adrianne, Tel: 087-798 7240, Email: a.dolan@o2.ie, or log on to www.isdh.ie.

Orthodontic Society of Ireland Meeting – Damon Symposium
November 19-20 Four Seasons Hotel, Dublin
Speaker is Dr Alan Bagden.

DIARY OF EVENTS

DECEMBER 2011

Munster Branch, IDA – Scientific Meeting
December 7 Maryborough House Hotel, Cork
Speaker is Dr Ray Dookun, President, British Academy of Dental Sleep Medicine, on 'Snoring and sleep apnoea'.

JANUARY 2011

Munster Branch, IDA – Scientific Meeting
January 17 Maryborough House Hotel, Cork
Speaker is Dr Tim Newton on 'Psychology and dentistry'.

Metropolitan Branch, IDA – Scientific Meeting
January 20 Hilton Hotel, Dublin 2
Speakers: Professor Stephan Renvert on 'Peri implantitis – the new dilemma', and Dr Pat Cleary on 'Endodontics saves teeth'.

FEBRUARY 2011

AEEDC Dubai 2011
February 1-3 Dubai International Convention & Exhibition Centre
For further information, see aeedc@index.ae.

Metropolitan Branch, IDA – Annual Scientific Day
February 18 Hilton Hotel, Dublin 2
Speakers: Professor Robin Seymour on 'Oral health and systemic diseases: where are we now?'; Professor St John Crean on 'Recognising medical conditions in the dental patient'; Dr Paul McEvoy on 'Problem solving with CadCam ceramics'; Dr Garry Heavey on 'Marketing – the most effective bang for your buck'; and, Dr Ashley Latter on 'Ethical sales and communication'.

Munster Branch, IDA – Scientific Meeting
February 22 Maryborough House Hotel, Cork
Speaker is Prof. John Whitworth on 'The wise man built his house … concrete foundations and soggy bottoms in endodontics'.

MARCH 2011

Metropolitan Branch, IDA – Scientific Meeting
March 24 Hilton Hotel, Dublin 2
Speakers: Dr Jason Owens on 'Location, location location – site consideration in implant placement', and Dr Raphael Bellamy on '100% – X the challenge of endodontic success'.

APRIL 2011

Orthodontic Society of Ireland – Meeting
April 15-16 K Club, Co. Kildare
Speaker is Dr Hugo De Clerck. See www.orthodontics.ie for more details.

MAY 2011

IDA Annual Conference 2011
May 11-14 Slieve Russell Hotel and Country Club, Ballyconnell, Co. Cavan
For further information contact IDA House, Tel: 01-295 0072.

OCTOBER 2012

21st Congress of the International Association for Disability and Oral Health
October 17-20 Sydney, Australia
For further information, see www.iadh2012.com.

Colgate Total
Fluoride Toothpaste

Clinically proven 12-hour antibacterial protection

- Unique triclosan and copolymer formulation retains triclosan on soft and hard tissues to hinder plaque recolonisation
- Clinically proven to significantly reduce bacteria for 12 hours[2,3]

Evidence-Based toothpaste Recommend it to your patients

1 Loesche WJ. Dental Caries: A Treatable Infection. Springfield, Illinois: Charles Thomas; 1982:64-66. 2 Amornchat C, Kraivaphan P, Triratana T. Mahidol Dent J. 2004;24:103-111. 3 Kruger IJ, Murphy CM, Sullivan RJ. Demonstration of the sustained effect of Colgate Total by confocal microscopy. Poster presented at: American Association for Dental Research; March 7-10, 2001; Chicago, IL. Abstract 1031.

Trade name of medicinal product: Colgate Total Toothpaste. **Active ingredients:** Triclosan 0.3% w/w, Sodium Fluoride 0.32% w/w (1450ppm F) **Indications:** To reduce dental caries, improve gingival health and reduce the progression of periodontitis. **Dosage and administration:** Brush the teeth for one minute twice daily. Children under 7, use a pea-sized amount. If using fluoride supplements, consult your Dentist. **Contraindications:** None Known. Individuals with known sensitivities should consult with their dentist before using. **Special warnings and special precautions for use:** Children under 7, use a pea-sized amount. If using fluoride supplements, consult your Dentist. **Interactions with other medicines:** None known. It is important to note that as for any fluoride containing toothpaste in children under systemic fluoride therapy, it is important to evaluate the total exposure to fluoride (fluorosis). **Undesirable effects:** None known. **Legal classification:** GSL. **Product authorisation number:** PA320/5/1. **Product authorisation holder:** Colgate-Palmolive (U.K.) Ltd, Guildford Business Park, Middleton Road, Guildford, Surrey GU2 8JZ. **Recommended retail price:** €1.59 (50ml tube), €2.59 (100ml tube). **Date of revision of text:** August 2009.

Colgate

YOUR PARTNER IN ORAL HEALTH

Colgate Customer Care Team: 01 403 9800

www.colgate.ie

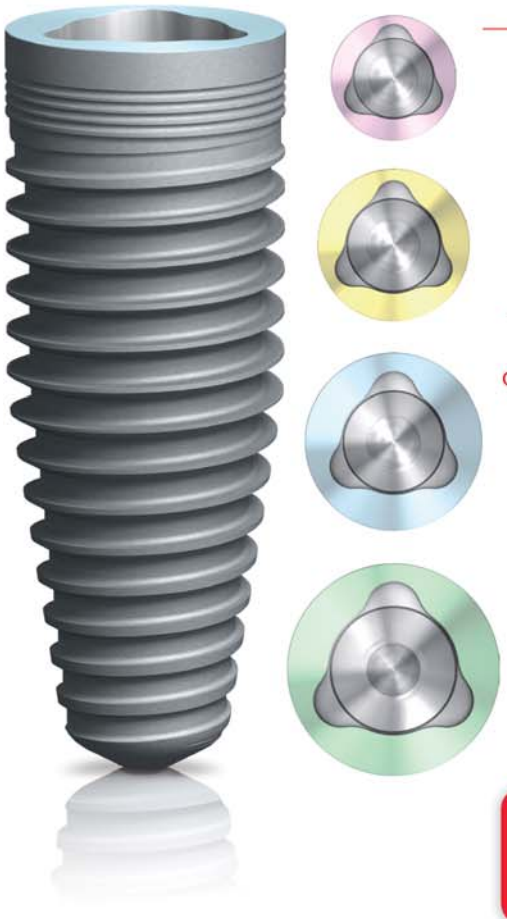
NobelReplace™

The world's most used implant system.*

Internal tri-channel connection for accurate and secure prosthetic restorations.

TiUnite® surface and Groovy™ to enhance osseointegration.

Implant design that replicates the shape of natural tooth roots.



Color-coded system for accurate and fast component identification and ease of use.

Color-coding: step-by-step drilling protocol for predictable surgical procedures.

NEW Now also available in 11.5 mm length

* Source: Millennium Research Group

Versatility, ease-of-use and predictability have made NobelReplace Tapered the most widely used implant design in the world.* NobelReplace Tapered is a general use, two-piece implant system that performs both in soft and hard bone, one- and two-stage surgical procedures, while consistently delivering optimal initial stability.

NobelReplace Tapered is a system that grows to meet the surgical and restorative needs of clinicians and their patients – from single-tooth restorations to more advanced multi-unit solutions. Whether clinicians are just starting or are experienced implant users, they will benefit from a system that is unique in flexibility and breadth of application.

Nobel Biocare is the world leader in innovative and evidence-based dental solutions.
For more information, contact us at + 44 (0) 208756 3300 (UK), 1800 677306 (Ireland) or visit our website

www.nobelbiocare.com

Nobel Biocare UK LTD, Telephone: + 44 (0) 208756 3300. Fax: + 44 (0) 208 573 6740, **Ireland,** Telephone: 1800 677306. Fax: 1800 677307