

## EDucation

Measuring dental students' and dental hygiene students' perceptions of eating disorders and their management

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— INSIDE —



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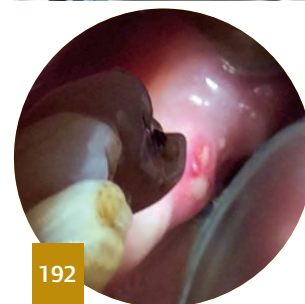
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Dr Jane Renehan

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References: 1. Baysan A et al. Caries Res 2001;35:41-46. 2. Ekstrand et al. Caries Res 2013;47:391-8. 3. Schirrmeyer JF et al. Am J Dent 2007;20, 212-216. 4. Ekstrand et al. 2008 Gerod 2008; 25:67-75.

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



Dr Ciara Scott  
Honorary Editor

## Re-evaluating our future

Articles in this edition of the *Journal* reflect on the significant changes and re-evaluations occurring in dentistry and dental education.

In a small graveyard overlooking Lady's Island in Wexford, a headstone reads: "Here lies dentist Doyle, filling his last cavity". This has always amused me, but on a recent cycle there, I also reflected on how much 'being a dentist' has changed over the decades. This pandemic has delivered a paradigm shift in how we do things in many aspects of our lives. It is also becoming clear that many new ways of working are not temporary. The pandemic has simply accelerated the inevitable shift in how we work, live, shop and access services, including healthcare.

Recent correspondence in *The Lancet*<sup>1</sup> encouraged the dental profession to see the pandemic as an opportunity to rethink how we deliver operative and preventive dentistry. The members' news in this issue brings you the findings from the recent IDA survey, which reports that members have significantly reduced their patient numbers to comply with the new demands and additional precautions. Since returning to clinical practice, many of us have felt busier doing less, and this has a significant impact on access to dental care and to the cost of providing treatment. With access to services at a low and reported hospital waiting times at an all-time high, we may feel like we lack the resources to reinvent the wheel, but the stakes have never been higher for levelling the demand for treatment with the need for preventive approaches.

### Back to school

Dental educators have not had time to ponder while rapidly restructuring the remote delivery of teaching, assessments and examinations to allow the continuation of the curriculum and the graduation of the classes of 2020. We congratulate all the dentists who have recently joined the Register under such challenging circumstances and the new cohort of students who will start to study dentistry in the coming weeks. I thank the Deans of our Dental Schools, Christine McCreary and Brian O'Connell, and the Dean of the Faculty of Dentistry RCSI, Albert Leung, for taking the time to share some of the ways they have adapted the delivery of non-clinical and clinical teaching to allow the continued education of dental students.

We are all also adapting how we learn. While many of us attend conferences for CPD, we often learn just as much from informal conversations with our colleagues and the trade at these events. Elaine Hughes has also shared her perspective on how the IDA is continuing to support members in this issue. I

also thank the trade who continue to keep us informed through the *Journal*. The Dental Council is currently updating our Code of Conduct and in this issue, Raj Rattan from Dental Protection shares his perspective on the proposed changes to discretionary indemnity.

### Continuing to care for our patients

We are all familiar with the risk of osteonecrosis from some medications. Many patients in the at-risk group have already coped with a significant diagnosis and medical treatment, and may have a limited appetite for more hospital visits to manage this type of complication. In this issue, Brendan Fanning reports a case where this complication was successfully diagnosed and managed conservatively in a general dental practice setting with agreement from the oncologist and patient. Our second case report addresses the benefits of long-term dental management of a patient with cyclic neutropenia. In our third paper, Maeve Cush and her co-authors describe their valuable research study to understand dental and dental hygiene students' perceptions of eating disorders and of the local support services available for this vulnerable patient group. Their findings highlight the students' interest in learning more to understand and support patients. We all seek to care for our patients and understand the medical or psychological issues they may be facing, but it is also not uncommon for healthcare professionals to sometimes avoid some of these very sensitive issues during visits, perhaps out of fear that we will say the wrong thing or overemphasise the problem.

With this in mind, I am delighted that Dr Angela Mazzone from the Anti-Bullying Centre has shared her expertise in the clinical feature in this issue. Angela offers advice on understanding and approaching the issue of bullying related to dental appearance in children, and outlines some of the support services available for both victims and healthcare professionals.

I hope that you enjoy this issue. We hope to be back in print for the next issue and intend to include a readers' survey. Your opinion matters in how we continue to use our *Journal* and share good quality content with our readers.

### Reference

1. **Watt, R.G.** Covid-19 is an opportunity for reform in dentistry. *Lancet* 2020; 396 (10249): 462. Available from: [https://doi.org/10.1016/S0140-6736\(20\)31529-4](https://doi.org/10.1016/S0140-6736(20)31529-4).



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Prof. Leo Stassen  
IDA President



## Where is dentistry going in Ireland?

Dentistry is at a crossroads and we need to fight for what is right.

The summer is nearly over and here we are getting ready (we hope) for the school rush, back to work, days getting shorter, nights longer, and the cold and what is going to happen with Covid-19, access to PPE, the Programme for Government, the National Oral Health Policy, the medical card/PRSI schemes, independent dental practice, HSE dentistry, CPD, and the Dental Council.

Some vision is required for dentistry to deal with all the above problems. The Association has been working on that vision for some time, dealing as clearly and consistently as it can as problems arise, recognising its strengths and the possibilities as well as recognising what we cannot do. The Board and staff have been very strong, hard working and resilient. As President I hear your accusations, understand the frustrations, and the anger we all face. United as dentists, we have a chance of achieving something but divided we will be destroyed. My Presidency focused on trying to bring dentistry together.

### Covid-19

Dentistry has dramatically altered and mainly from a behavioural (how we do things) point of view. The Association advice on practice, managing the environment, appropriate use of PPE and dental care remains sound and safe advice. We needed to change, and we did. We are incredibly grateful to the Quality and Patient Safety Committee and in particular Drs Eamon Croke and Gerald O'Connor for their trojan work in keeping dentistry going.

Some things have become clearer. Hand washing, social distancing, masks in community areas, sneeze hygiene, avoiding crowds, contact tracing and some form of lockdown when cases occur does work. Covid-19 immunity does occur but very much less than initially thought and seems to only last for months, not forever – almost the same as the other coronaviruses. Vaccination will be available earlier than we figured but its distribution will be slow and unfortunately too costly for many countries. Testing has got easier, more available and quicker but there are far too many false negatives (poor sensitivity) and false positives (poor specificity), so the real test remains clinical acumen (temperature, upper respiratory tract symptoms, loss of smell/taste, travel abroad, and contacts), suspicion, a precautionary approach and a negative test (if possible and available). Same old advice – take care and stay safe.

### CPD

This has and is likely to stay changed for some time. Your *Journal*, webinars, online CPD, how-to-do-it seminars, and small groups are the future. We will lose out on the personal connectivity. We will win on the national availability of speakers. The CPD Committee and Regional Committees are working hard on this and there are great opportunities. “Do what you can, with what you have, where you are.” – Theodore Roosevelt (1858-1919).

### Dentistry and the State

The Programme for Government, the National Oral Health Policy, the medical card/PRSI schemes, independent dental practice, and HSE dentistry: what can

we do? Dentistry is not really included in the Programme for Government and the National Oral Health Policy remains the Department of Health's (DoH) vision for the future. The medical card and PRSI schemes are in serious trouble and as of yet there are no Government plans to open discussions. There are difficult conversations ahead. The Association is and has always been willing to have an open, constructive, listening and reflective conversation but instead of the DoH and the Chief Dental Officer getting on and trying to do something, it is always somebody else's responsibility/problem, and nothing happens. Maybe we are at fault for not getting our message across more clearly. We were promised PPE for dentists by a former Minister for Health – then “this did not happen, that did not happen, wrong instructions, HSE has not done this, misunderstandings in their communications” and here we are – no basic PPE to help us look after medical card/PRSI (i.e., State) patients. There is a serious problem building up for our public patients. “Ninety-nine percent of failures come from people who make excuses.” – George Washington (1732-1799).

So let's not make excuses and start trying to resolve the problems. The Association will keep doing its best, keep trying and keep listening to our members for what is needed. “Try and fail, but don't fail to try.” – John Quincy Adams (1767-1848).

Personally, I fear for the medical card/PRSI schemes and the lack of discussions on the future of public/Government-supported dentistry. The National Oral Health Policy produced by academics, most without a real understanding for what was needed for the implementation of its advice at the coal face in dentistry, is history. If the plan was going to have any chance of success, its chances are seriously damaged because of Covid-19. The difficult conversations need to commence with the one aim of producing sound oral and dental health for the Irish population in a viable and sustainable manner.

The Association is not questioning the National Oral Health Group's motives but do worry about the wisdom of its proposals. I may sound like a dog with a bone but unless we stand up for what we believe is reasonable, sensible, possible in the best interests of oral and dental health and also financially viable, we will have let the whole of dentistry down for the next 10-15 years. “It's easier to do a job right, than to explain why you didn't.” – Martin Van Buren (1782-1862).

### Au revoir

This is my last message for the *JIDA* as President. I want to thank you all for being so patient with me as Editor and now as President, for your support. I would like to thank Fionnuala O'Brien who was my Editorial PA for all the great help and advice she gave me, Think Media for their support and invaluable help, the Board of Directors (Management Committee), Council for all their hard work, time, support and help, and all Association staff in particular Fintan Hourihan, Elaine Hughes, Roisín Farrelly, Aoife Kavanagh and Liz Dodd for their commitment to all members and to the President of your organisation. Nothing would have been possible without them. Good luck and keep it up for the future of dentistry, our future. Thanks and *au revoir*.





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## HSE Seminar and branch ASMs

The Management Committee has regrettably decided to cancel the annual HSE Seminar for 2020. All Branch Annual Scientific Meetings are also cancelled. We hope to be back in 2021 with these face-to-face events.

## Young dentists' day

The third dedicated day for new graduates/young dentists will take place virtually for 2020, on Friday, October 9. Full details and programme will be announced soon. This is an event not to be missed by any young dentist, or for those who have graduated in the last six to eight years.



## Mouth Cancer Awareness Day 2020



Mouth Cancer Awareness Day will take place on Wednesday, September 16, 2020. This year we are not asking dentists to carry out free mouth cancer exams on patients. Instead, this year's campaign will focus on patients over 60 years of age, and will take place online and via social media. A full revamp of the Mouth Cancer Awareness Day website has taken place and you can see it on [www.mouthcancer.ie](http://www.mouthcancer.ie).

## CPD autumn-winter 2020

Covid-19 has seen the majority of CPD now being delivered online via Zoom seminars and live Q&As. All of these webinars are available on the members' section of the IDA website for members to view at a suitable time.

These will continue for autumn/winter, in particular all branch meetings. On a positive note, all of these branch meetings will now be available to all members, offering more choice to IDA members.

The IDA is, however, delighted to announce that we will continue to provide certain live practical/hands-on courses during autumn/winter.

On Saturday, September 12, Dr Seamus Sharkey will deliver a hands-on 'Prep design' course in Fota Island. Numbers will be strictly limited and all physical distancing

guidelines will be adhered to. Full details will be sent to members.

The IDA will also continue with CPR/BLS courses regionally, provided by Safe Hands. Safe Hands has recorded a very worthwhile webinar on medical emergencies, which is available on the website. All members are encouraged to view it; however, the webinar in itself will not suffice to fulfil your CPD requirements in this subject. The full-day practical course is needed for this.

### Dates and venues:

- Saturday, October 3 – Radisson Blu, Dublin Airport
- Saturday, November 7 – Rochestown Hotel, Cork



## Dental Protection discount for IDA members



Dental Protection reminds IDA members that the company offers them an 11.5% discount on subscription fees. This partnership reflects the collaboration between the IDA and Dental Protection in terms of the dental complaints service, joint representation of members on probity and disciplinary matters, and in public advocacy campaigns.

This discount with Dental Protection can save over €700 per annum for most dentists in general practice and is worth even more to dentists in specialist or limited practice. Having received several queries from members recently about this discount, Dental Protection is pleased to confirm that this benefit for IDA members remains in place.

To get your discount, contact the Dental Protection membership team on 1800 509 411 and quote your IDA membership number.

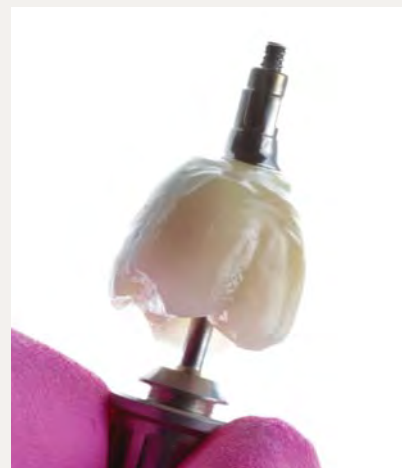
## Quiz

Submitted by Dr Ambrish Roshan.

### Questions

1. What type of implant restoration is this?
2. What are the main advantages of this type of implant prosthesis?
3. What are the main disadvantages of this type of implant prosthesis?

Answers on page 202.



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# Guidance means accuracy: A randomized clinical trial on freehand versus guided dental implantation

Varga, E., Antal, M., Major, L., Kiscsatari, R., Braunitzer, G., Piffko, J.

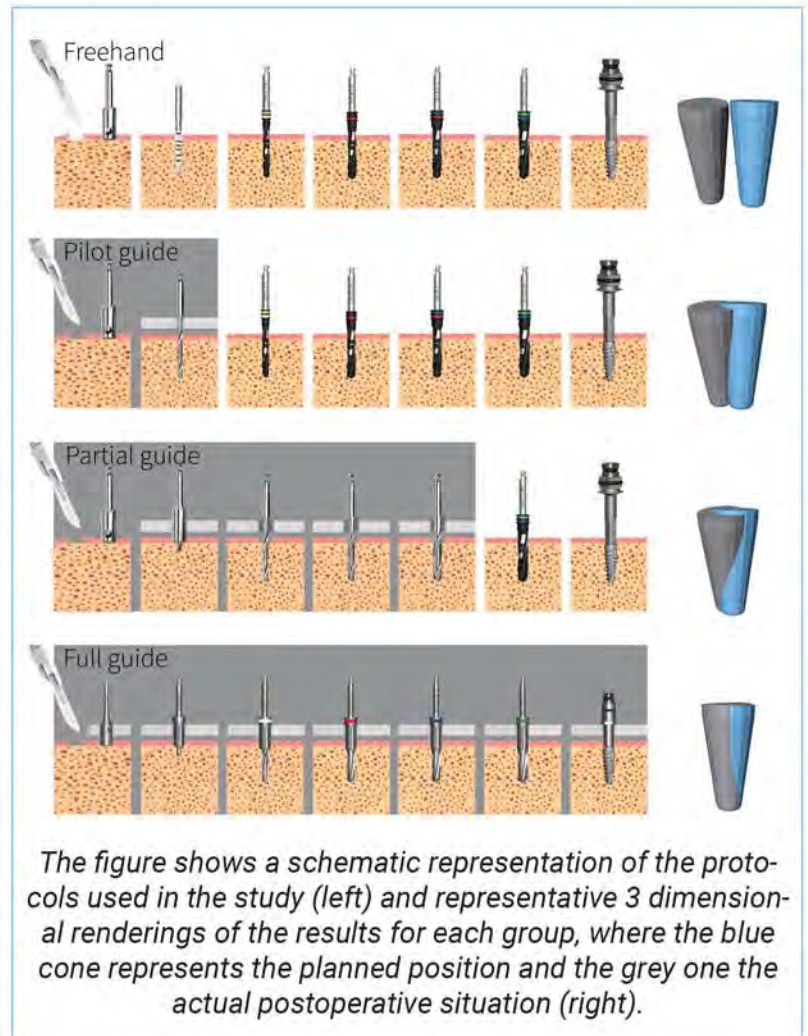
A randomized clinical trial was conducted at the Department of Oral and Maxillofacial Surgery, University of Szeged to

*- Compare the three known static guided surgery protocols (pilot, partial, and full) with each other and with freehand surgery in terms of accuracy, under the same conditions.-*

Two hundred and seven implants of the same brand and type were placed in 101 partially edentulous volunteers in need of implantation in the mandible, maxilla or both. All cases were digitally planned in SMART Guide (dicomLAB Dental Ltd., Hungary), and the comparison of the planned and actual implant positions was performed using a medical image analysis software with dedicated algorithms. The primary outcome variable was angular deviation (AD, degrees). The secondary outcome variables were coronal global deviation (CGD, mm), apical global deviation (AGD, mm), and voxel overlap (VO, %).

*AD showed stepwise improvement in significant steps as the amount of guidance increased.*

The highest mean AD ( $7.03^\circ \pm 3.44$ ) was obtained by freehand surgery and the lowest by fully guided surgery ( $3.04^\circ \pm 1.51$ ). As for the secondary outcome variables,



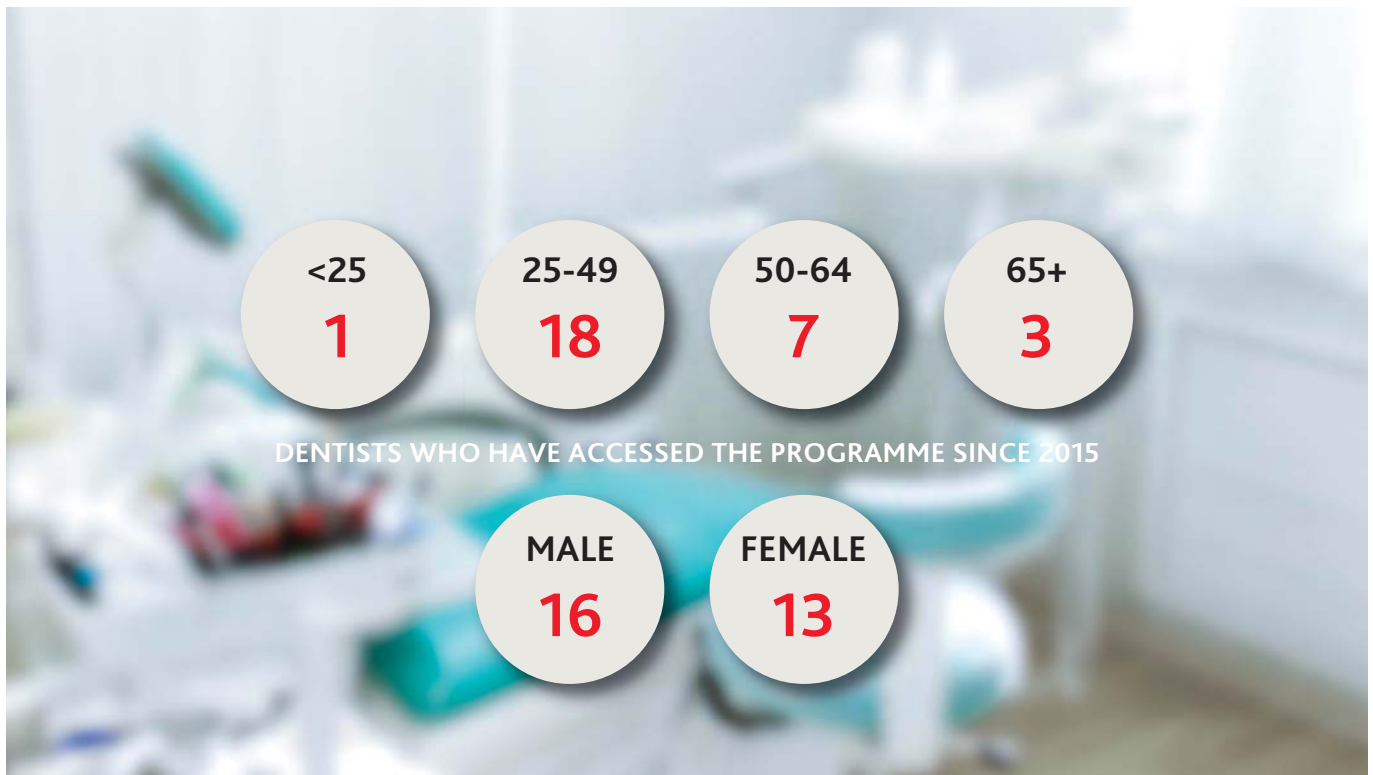
all guided protocols turned out to be significantly superior to freehand surgery, but they were not always significantly different from each other. In conclusion, any degree of guidance yields better results than freehand surgery and increasing the level of guidance increases accuracy.

Open access full article:  
*Clinical Oral Implants Research 2020 May;31(5):417-430.*

For further information on SMART Guide please visit:

[WWW.SCDLAB.IE](http://WWW.SCDLAB.IE)

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## Dentists continue to avail of practitioner support programme

Six dentists sought assistance from the Practitioner Health Matters Programme (PHMP) during 2019, according to figures contained in the Programme's Annual Report. There were 78 new presentations to the PHMP in total, comprised of doctors, dentists and pharmacists.

The PHMP was launched in September 2015 and provides appropriate care and support for health professionals in Ireland who may have mental health issues such as stress, anxiety or burnout, or who may have a substance misuse problem. To date, the service has supported 245 practitioner patients across the medical, dental and pharmacy professions, including 29 dentists.

Dr Íde Delargy, Medical Director of the Programme, commented: "When practitioners become unwell or are struggling, particularly with a mental health or substance misuse issue, they often find it difficult to seek help in the usual way. Some may not wish to access occupational health services or their own GP and this can lead to attempts to self-manage their problems, which can sometimes include self-prescribing. There is a perceived shame and stigma to being unwell and this can often lead to practitioners delaying seeking help.

"A key element of the PHMP service is confidentiality. The design of the service and legal agreements we have with the Medical Council, the Pharmaceutical Society and the Dental Council allow us to deliver the service without the requirement to immediately report. Advice, treatment and therapy is provided in a strictly confidential and non-judgmental way with a team that is experienced in dealing with doctors, dentists and pharmacists".

Of the 78 professionals who sought help from the programme in 2019, 51% were female and 49% male, and the majority (56) were aged 25-49 years. Presenting problems included substance misuse, depression, anxiety and burnout.

### Referral

Any practitioner can self-refer to the programme, or be referred by a concerned third party. Telephone or confidential email contact is encouraged in the first instance and a timely appointment will then be offered. Following an initial assessment with the medical director, a treatment plan will then be agreed. A range of interventions will be offered, which may include consultant psychiatric assessment, psychotherapy, addiction counselling, financial advice, or personal and career coaching. Some practitioners may require hospitalisation but this is a rare occurrence.

Said Dr Delargy: "There is now a body of first-hand experience of the pressures and stresses some professionals are experiencing. We can hear their stories and help them to recover. However, this is not enough. The PHMP will endeavour to influence change within the culture of our healthcare system, leading to one that is more humane and genuinely values its healthcare workers. The cost of not improving the system at both an individual and a service level is simply too great".

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1. Barnett ML. The rationale for the daily use of an antimicrobial mouthrinse. JADA 2006; 137: 16S-21S

2. Araujo MWB et al. Meta-analysis of the effect of an essential oil-containing mouthrinse on gingivitis and plaque. JADA 2015; 146(8): 610-622  
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**References:** 1. Merry A, et al. AFT-MX-1, a prospective parallel group, double-blind comparison of the analgesic effect of a combination of paracetamol and ibuprofen, paracetamol alone, or ibuprofen alone in patients with post-operative pain. Department of Anaesthesiology, University of Auckland, New Zealand 2008. \*compared with the same daily dose of standard paracetamol or ibuprofen alone.

**Easolief Duo 500 mg/150 mg film-coated tablets** Each tablet contains paracetamol 500 mg and ibuprofen 150 mg. **Presentation:** A white, capsule shaped tablet with breakline on one side and plain on the other side. **Indications:** Short-term symptomatic treatment of mild to moderate pain. **Dosage: Adults/elderly:** The usual dosage is one to two tablets taken every six hours up to a maximum of six tablets in 24 hours. **Children:** Easolief Duo is contraindicated in children under 18 years. **Contraindications:** Severe heart failure, known hypersensitivity to paracetamol, ibuprofen, other NSAIDs or to any of the excipients, active alcoholism, asthma, urticaria, or allergic-type reactions after taking acetylsalicylic acid or other NSAIDs, history of gastrointestinal bleeding or perforation related to previous NSAID therapy, active or history of recurrent peptic ulceration/haemorrhage, severe hepatic failure or severe renal failure, cerebrovascular or other active bleeding, blood-formation disturbances, during the third trimester of pregnancy. **Warnings and precautions:** This medicine is for short term use and is not recommended for use beyond 3 days. Clinical studies suggest that use of ibuprofen, particularly at a high dose may be associated with a small increased risk of arterial thrombotic events. Patients with uncontrolled hypertension, congestive heart failure, established ischaemic heart disease, peripheral arterial disease and/or cerebrovascular disease should only be treated with ibuprofen after careful consideration and high doses should be avoided. Careful consideration should be exercised before initiating long-term treatment of patients with risk factors for cardiovascular events. The use of paracetamol at higher than recommended doses can lead to hepatotoxicity, hepatic failure and death. Patients with impaired liver function or a history of liver disease or who are on long term ibuprofen or paracetamol therapy should have hepatic function monitored at regular intervals. Severe hepatic reactions, including jaundice and cases of fatal hepatitis, though rare, have been reported with ibuprofen. Paracetamol can be used in patients with chronic renal disease without dosage adjustment. There is minimal risk of paracetamol toxicity in patients with moderate to severe renal failure. Caution should be used when initiating treatment with ibuprofen in patients with dehydration. The use of an ACE

inhibiting drug, an anti-inflammatory drug and thiazide diuretic at the same time increases the risk of renal impairment. Blood dyscrasias have been rarely reported. Patients on long-term therapy with ibuprofen should have regular haematological monitoring. Like other NSAIDs, ibuprofen can inhibit platelet aggregation. GI bleeding, ulceration or perforation, which can be fatal, has been reported with all NSAIDs at anytime during treatment. Combination therapy with protective agents (e.g. misoprostol or proton pump inhibitors) should be considered. Use with concomitant NSAIDs including cyclooxygenase-2 selective inhibitors should be avoided. NSAIDs may lead to onset of new hypertension or worsening of pre-existing hypertension and patients taking antihypertensive medicines with NSAIDs may have an impaired anti-hypertensive response. Fluid retention and oedema have been observed in some patients taking NSAIDs. NSAIDs may very rarely cause serious cutaneous adverse events such as exfoliative dermatitis, toxic epidermal necrolysis and Stevens-Johnson syndrome. Products containing ibuprofen should not be administered to patients with acetylsalicylic acid sensitive asthma and should be used with caution in patients with pre-existing asthma. Adverse ophthalmological effects have been observed with NSAIDs. For products containing ibuprofen aseptic meningitis has been reported only rarely. NSAIDs may mask symptoms of infection and fever. **Interactions:** Warfarin, medicines to treat epilepsy, chloramphenicol, probenecid, zidovudine, medicines used to treat tuberculosis such as isoniazid, acetylsalicylic acid, other NSAIDs, medicines to treat high blood pressure or other heart conditions, diuretics, lithium, methotrexate, corticosteroids. Refer to summary of product characteristics for other interactions. **Fertility, pregnancy and lactation:** Easolief Duo is contraindicated during the third trimester of pregnancy. **Driving and operation of machinery:** Dizziness, drowsiness, fatigue and visual disturbances are possible after taking NSAIDs. If affected patients should not drive or operate machinery. **Undesirable effects:** Dizziness, headache, nervousness, tinnitus, oedema, fluid retention, abdominal pain, diarrhoea, dyspepsia, nausea, stomach discomfort, vomiting, flatulence, constipation, slight gastrointestinal blood loss, rash, pruritus, alanine aminotransferase increased, gamma-glutamyltransferase increased, abnormal liver function tests, blood creatinine increased and blood urea increased. Refer to Summary of Product Characteristics for other adverse effects. **Pack size:** 24 tablets. **Marketing authorisation holder:** Clonmel Healthcare Ltd., Clonmel, Co. Tipperary. Marketing authorisation number: PA0126/294/1. Medicinal product not subject to medical prescription. For retail sale through pharmacy only. A copy of the summary of product characteristics is available upon request. **Date prepared:** October 2019. 2019/ADV/EAS/117H.



# Learning through Covid-19

Like every other sector of society, those involved in dental education in Ireland have had to adapt to the enormous changes wrought by Covid-19.

## Supporting dentists in crisis

The Irish Dental Association runs an extensive programme of CPD throughout the year. When the lockdown happened in March, the Association's flagship Annual Conference was the first casualty. With dentistry in crisis as practices closed to all but emergency care, Assistant CEO Elaine Hughes feels the decision to cancel all CPD initially was the right one: "CPD wasn't a massive priority for people; they were in survival mode".

The decision also gave the Association breathing space to reconfigure its CPD to address the new issues dentists were facing. Elaine says that timing, and striking the right balance of content, were vital: "Our members wanted to hear about what had been put in place by the Government, HR issues – all the practical stuff. We had to get the mix right as regards clinical and practical advice, support and help".

In the chaos immediately following the lockdown, dentists rightly felt cast adrift, and looked to their representative organisation for support and information: "While it wasn't up to us to decide on policy or on whether or not dental practices could open or close, it was up to the IDA to interpret what the powers that be, i.e., NPHET and the Department, were saying, and then to see how dentists were going to need help".

One of the first online offerings after the lockdown addressed these practical concerns: "It was a clinical 'getting back to work' webinar and was very well received. That webinar was basically an A to Z walk through of the dental surgery, and how things are going to look now that Covid-19 is here and how dental practices can get back to treatment, so it was an absolute must for members to have as a resource".

### Ann-Marie Hardiman

Ann-Marie is managing editor with Think Media, with an interest in further education and CPD.



Reconfigured waiting area in the DDUH.

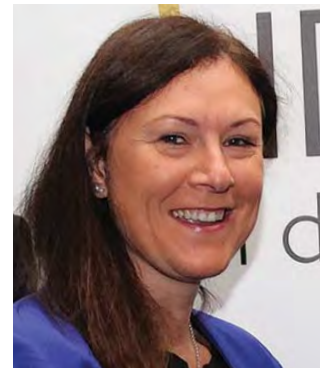
The IDA is planning more of this type of practical CPD, and Elaine also wants to look at offering support to dentists in terms of their health and well-being: "Now that they're back, many dentists have told us that they're finding it very physically challenging. As an organisation, we want to help dentists through this".

The big positive from the online CPD offering is that all IDA members can access it, and also that all webinars/educational pieces are available at any stage on the members' section of the website to view at a convenient time for the member.

As well as their educational function, branch meetings and CPD also serve as vital social and networking outlets, so the Association looked at ways to fill that gap: "We have run live Q&As where dentists have the opportunity to hear from a panel of other dentists on a topic. Those have proven to be very valuable, because it's the nearest thing that we have to a branch meeting for that opportunity to chat".

Elaine says that the IDA also plans to return to face-to-face CPD in the autumn and winter, albeit in a reduced fashion: "We will continue to run hands-on courses and physical courses for members around the country, with the proper precautions and adhering to the guidelines. Dates and venues will be announced soon. Education and learning is a very important part of what the IDA does and a very important service to members. We will be continuing to do it".

Elaine praises the members of the IDA's Quality and Patient Safety and CPD Committees and has a particular word of thanks to Dr Maurice Fitzgerald, Dublin for all his technical support and advice: "It has been great working with the two committees to come up with practical solutions to all of the different issues and problems that we've had over these last months".



Elaine Hughes  
Assistant CEO, IDA.

**New ways of working**

After the initial shock of the lockdown, Dublin Dental University Hospital (DDUH) undertook what Dean of the School Prof. Brian O’Connell calls a “a really rapid education in putting stuff online”.

As a dental hospital with an Accident and Emergency Department, the DDUH never actually closed, maintaining an emergency service throughout. Brian says this has been very helpful in allowing them to test out new ways of working and reconfiguring the building before the return of undergraduate students. Changes have included increased signage to help patient flow, increased ventilation, automatic temperature monitoring at the entrances, and a whole raft of other processes.

Third, fourth and fifth years will return on August 24, with second years back the following week, and first years at the end of September. While classroom teaching will stay online for the foreseeable future, all students will have practical sessions from the beginning: “We have the capacity to bring back second to fifth years, who will be working in clinics and labs. Trinity wants all students to have some face-to-face learning, so even first years will be doing anatomy, chemistry, physics to some degree face to face. But we will not have people hanging around or able to socialise and mix informally like they were before. They’ll come in for their clinic and then they will leave”.

Brian is very aware of the impact on staff and students of the lockdown, and



*Prof. Brian O’Connell, Dean, Dublin Dental University Hospital (DDUH).*



*Dr Christine McCreary, Dean and Head of School, Cork University Dental School and Hospital.*

praises the way students used online resources to maintain a sense of community. Indeed, he notes that many online lectures had 100% attendance, which was very encouraging for staff who were concerned about their students: “It was good to see people online and know that they’re working away and keeping focused”.

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He also acknowledges his staff, who were often balancing work pressures with home schooling their children, or caring for relatives: “The staff have been great; people really stepped up. All of the dental students graduated on time. Everybody who was in final year got finished and either has graduated or is about to graduate, so there’s some satisfaction in that”.

For the future, Brian sees maintaining standards while complying with safety measures as paramount: “The important thing is that students should and will graduate with the same core skills and abilities that they had before, but probably with a greater appreciation of working in a pandemic situation. We answer to the university for quality and to the regulator, the Dental Council, so all the way through this we’re documenting that the students have had equivalent training and assessments. All of that goes on in the background so that the stakeholders are clear that we are delivering the same quality education as before, and the students as they graduate, be it in nursing, hygiene, dentistry, or technology, are fit to go out and practise and work with the public in the way they would have before. We’ve learned some good things, probably some things we’ll keep doing in the future”.

### Planning for the future

At Cork University Dental School and Hospital, the first priority was moving classes online and getting students through their exams and assessments. Once the academic year was over, the priority moved to preparing for students’ return, and for Dean and Head of School Dr Christine McCreary this carried the added complication of a building that is old and unfit for purpose. This led the School to take a somewhat radical approach: “We took a decision quite early on that we would frontload all our didactic material in years one, two and three, and deliver that completely online. That was not a popular decision with the university, but it’s one that I’m delighted we took because I don’t think the concept of a meaningful face-to-face engagement with these students is a realistic option. The fifth years are back online, starting the didactic component



*Like all healthcare settings, increased use of PPE is a fact of life for dental schools.*

of their final year. First, second and third years will have teaching online until January, when they will return to campus”.

Space and procedures are also being reconfigured as far as possible to conform with safety requirements: “We’re looking at high-volume suction, rubber dam use, fallow time between aerosol-generating procedures,

### ADVERTORIAL

## A FOCUS ON PREVENTION

The World Health Organisation’s Global Oral Health Programme has outlined strategies for oral disease prevention and health promotion. Some of the key objectives are to reduce the burden and disability of oral disease and to promote healthy lifestyles and reduce risk factors to oral health.

The National Oral Health Policy, *Smile agus Sláinte*, has an emphasis on the prevention of oral diseases, stabilising and reversing early dental decay. The primary goal of the Policy is to provide the supports to enable every individual to achieve their personal best oral health.

Methods of preventing oral diseases include supporting positive health behaviours such as regular and effective oral hygiene, reducing the amount and frequency of sugar intake, counselling in relation to the negative effects of tobacco use and excessive

alcohol consumption. Chewing sugar-free gum can play a role in these positive health behaviours. Keeping our mouths healthy has never been so important. In June this year, UK researchers Sampson, Kamona & Sampson reported on the potential link between bacterial load and the COVID-19 virus. They suggest that maintaining or improving oral hygiene when infected with the COVID-19 virus, in order to reduce the bacterial load in the mouth, may play a role in reducing the risk of complications such as pneumonia, acute respiratory distress syndrome and sepsis. This was particularly relevant for people with diabetes, hypertension or cardiovascular disease.

We need to consider novel ways of getting these health messages to our patients as we learn to live in a post-pandemic environment. The public has embraced the concept of online interactions during the lockdown, there was never a better time to consider the use of tele-dentistry. Many of the non-treatment elements of dentistry such as medical, social and dental history taking, health counselling



and providing instructions on practical skills such as toothbrushing can all be carried out remotely. With the use of smartphones good quality images can allow diagnoses. This will allow better use of the face to face appointment and reduce travel and costs for patients.

*Dr Catherine Waldron*

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- Isabel Olegário, Kirsten FitzGerald and Cal McCarthy** How to send photos of your child’s teeth to your dentist



Automatic temperature monitoring has been installed at the entrances to the DDUH.

telephone triage and screening. At the minute we're still going to two-metre social distancing in corridors, but our corridors are not two metres wide, so we have to have a one-way system. We're doing risk assessments in each clinical area and having experts in to advise us on what's the best we can do with the space available".

The other major challenge facing the Cork School is that they are in advanced planning stages for a new School building, and now have to decide what changes can and should be made: "We just finished the design phase of that and we have planned a polyclinic. We've been in discussions with our adviser and they are advising us not to alter anything too much because I don't think you can plan a dental education facility that doesn't use a polyclinic set-up. Unless you have an unlimited budget, and can have a supervisor in every room, it's just not going to be feasible. I don't think we can plan a building that's going to be operational for 50 or 60 years just because of Covid-19, and that's been a very interesting debate for us".

That debate feeds into the wider debate on dental education in a post-Covid-19 world. Christine is optimistic that things will not always be this way: "I think it has made us aware of the potential that is always out there. We've learnt a lot from it. Do I think five years from now we're going to be very much different to where we are now? We might use more teledentistry, telemedicine. We might do more remote consultations, but dentistry is a profession where regardless of digital dentistry, regardless of anything else, we're quite a long way from robots doing the stuff that humans do in people's mouths. I'm old enough to remember when HIV first came on the scene and that was going to be the end of everything. And, you know, it wasn't. Now this is obviously a different agent, but the principle, I think, remains the same".



Prof. Albert Leung, Dean of the Faculty of Dentistry, RCSI.

### The global perspective

Prof. Albert Leung is Dean of the Faculty of Dentistry, RCSI, and a Professor of Dental Education at King's College in London. Based primarily in London, he had no idea when he returned from a visit to Dublin in March that his role would be carried out virtually thereafter. The RCSI's first priority was to figure out how to carry out examinations that were due to take place. The Faculty carries out over 1,000 postgraduate assessments every year, with candidates from all over the world, so a huge amount of work went into ensuring that formats and learning outcomes could be adapted, while complying with regulatory requirements, and without compromising standards. With help from the College's Faculty of Medicine, just over two weeks later, the first remote examination took place. Albert explains: "That examination was conducted 3,000 miles away in Qatar. We had local proctoring. We had video monitoring through Zoom so that we could see everybody, and candidates practised social distancing and wore masks. We had examiners in Scotland and Ireland who we connected to Qatar. The candidates were quarantined, with the trainers in different rooms. That was a proud moment because it was the first ever postgraduate exam conducted like this in the whole RCSI".

Since those first exams, the Faculty has not rested on its laurels: "In the first exams, there were many moving parts and a lot of things could go wrong. They didn't go wrong, but there was a huge amount of effort involved to make sure of that. We have made modifications to our initial approach so that there are fewer moving parts, fewer things can go wrong, and the candidate's experience can be improved".

The College's lectures have also moved online, and are recorded in the lecturer's home, edited and uploaded within 24 hours.

For the future, Prof. Leung foresees a mixture of face-to-face and online education becoming the norm, at least in the short to medium term: "I think that there are certain values of face-to-face teaching and assessment. A patient is an individual. Ultimately, can you treat an individual well? If you can, how do you actually do that? Can we test candidates in this particular environment in a way that is close to what they practice? I'm contacting the software providers to see whether or how some aspect of these online examinations can be more interactive, in which clinical scenarios can be tested online. I don't know whether it will happen or not, but we're trying".

He is full of praise for his colleagues around the world: "I am very grateful for all my colleagues, the entire team, for the splendid work that they have done. We have been very lucky in that in the Faculty Board and other colleagues we have huge amounts of expertise in different arenas and different parts of the world. The feedback from the candidates was very useful as well. They pointed out things that we didn't notice, and we made changes accordingly".

The Faculty has also endeavoured to lead international debate on the future of dental education, hosting a webinar in July entitled 'Back to School in the time of Covid-19: an international perspective', which attracted over 600 participants, including Deans and Directors of Education from ten dental schools.



## Fast and affordable x-tra fil and Futurabond U

According to VOCO, rapid treatment is often needed – and yet the quality and price must also be right. With its light-curing, posterior tooth, bulk fill restorative material x-tra fil, and its universal bonding agent Futurabond U, VOCO states that it offers an ideal combination that guarantees basic treatment at the best price/performance ratio, and in a timely manner. The company states this solution is also a proven alternative to amalgam fillings.

### x-tra fil

VOCO states that this restorative material was especially conceived for therapy in the posterior region (classes I and II) as well as for core build-ups. Thanks to the option of applying increment thicknesses of up to 4mm in a single work step, as well as the short curing time of only 10 seconds, both patient and dentist benefit from a very short chair time. Thus, x-tra fil is especially well-suited for treatment of non-compliant patients.



Aside from its fast and easy handling, the company states that x-tra fil also stands out with its high depth of cure and low shrinkage. Furthermore, the product's high translucency produces a chameleon-like shade adaptation to the surrounding tooth substance, meaning the patient obtains not only a long-lasting and unrestricted masticatory load-bearing result, but also an aesthetic one.

### Futurabond U

Total basic treatment is optimally rounded off in combination with the dual-curing universal adhesive Futurabond U. In addition to its practical handling in a hygienic SingleDose, VOCO states that Futurabond U also offers an outstanding range of application options. Whether self-etch, selective-etch or total-etch, the company states that Futurabond U allows practitioners to freely select how they wish to condition the dental hard tissue, depending on the individual clinical situation and their personal work preferences. Thus, Futurabond U covers such a broad spectrum of applications that no additional bonding system is required in practice.

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## JADE Air Purifier from Quintess

Quintess Denta is offering the JADE Air Purifier from Surgically Clean Air through its new sister company, Surgically Clean Air UK and Ireland. The company states that Surgically Clean Air's JADE Air Purifier is a medical-grade air system that is one of the most advanced on the market. According to Quintess, the reported benefits of the JADE Air Purifier include:

- Decreases pollutants: the exclusive six stages of technology not only filter the air but also sterilise it. It diminishes everything that is in the air – bio-aerosols, odours, gasses, disinfectants, particulates, moulds, viruses, bacteria and fungus. Quintess states that it also re-energises the air to combat fatigue and to give the air a 'lighter' feel.
- Increases comfort: Headaches, fatigue, itchy eyes, dry skin, coughing, sneezing, and the need for inhalers are all ways polluted air can cause discomfort and inconvenience. Quintess states the JADE Air Purifier eliminates the causes of these problems.
- Increases productivity: Studies show that removing pollutants can increase productivity by up to 16%.
- Decreases absenteeism: Person-to-person virus spread is a significant problem in dental practices given that windows do not open and bio-aerosols from every patient are mixed in the air.
- Improves morale: Your staff will greatly appreciate not only the noticeably fresher air but the fact you care so much about their health and comfort. Current and prospective patients and clients will be impressed.
- Reduces patient anxiety: The odours present in most dental practices can be a major source of patient anxiety. Quintess states the JADE Air Purifier can make those odours – and that anxiety – go away.

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## You don't need a wealth manager!



Richard Collins.

According to Dentawealth, saying that you don't need a wealth manager's advice sounds pretty strange, doesn't it? For some areas of financial planning, it is true; anybody can buy an off-the-shelf pension and think they are sorted for life. However, Dentawealth states that with a bit of time and effort you can make some vast differences to your future to create the financial independence to retire early.

The company suggests some issues to consider:

1. Make a will. Everyone should consider having a will. It sounds pretty morbid to think about death and what happens when you're gone, but it is so important. Don't think you need one? Have a quick search on the laws of intestacy, and you'll see why it's so important. If you have made a will, when was the last time you looked at it?
2. Have fixed income in your portfolios. The bank deposit rates are terrible – close to 0%. There are returns available associated with the Government that guarantee 8% returns for the long term. The even better news is that they are asset backed. You can, of course, use the funds on offer with no fixed return rate. This will push out your retirement date.
3. The day will come when you sell your practice. At this point, you could face

a tax bill unless of course you plan the criteria required to extract the goodwill value of your practice tax free up to €750,000.

Dentawealth states that these three points show why you need a wealth manager. Contact Dentawealth to discuss how financial independence is attainable on 01-458 4327, or by emailing [info@dentawealth.ie](mailto:info@dentawealth.ie).

## Henry Schein Ireland launches extra-oral suction unit

According to Henry Schein Ireland, the OPTIMA EOS 350 device effectively captures droplets and airborne aerosols produced from dental treatments while ensuring patient comfort.

Henry Schein Ireland has announced that it will co-operate with B.A. International to distribute the OPTIMA EOS 350 extra-oral suction unit. According to the company, the device is designed for dental practices to effectively capture droplets and airborne aerosols from treatments. As an extra-oral suction unit, the device will help to ensure patient comfort during usage.

Henry Schein states that the OPTIMA EOS 350 unit has a triple layer HEPA H14 filter, which traps 99.995% of particles that are  $\geq 0.3$   $\mu$ m. The double UVC lamps positioned before the HEPA filter inactivate virus and bacteria that are trapped by the filter. Through its Intelligent Airflow Dynamics, the exhaust air is released from a rear-mounted air vent at the top of the system to prevent blow-up of any dust particles or contaminants from floor surfaces.\*

"Infection control has become more crucial to dental professionals than ever before. We at Henry Schein are committed to continuously extend the company's solutions portfolio to provide the practical solutions to our customers. Therefore, we are happy to add the OPTIMA EOS 350 extra-oral suction unit to our portfolio of air management and air suction devices," said Davide Fazione, Vice President, Equipment and Service of Henry Schein's EMEA Dental Group.

According to the company, other features of the OPTIMA EOS 350 are:

- intelligent control panel with digital indicator and adjustable power levels;
- easy to disinfect and with an auto HEPA filter replacement reminder;
- optimised height for easy handling and lightweight design for easy moving between surgeries using ergonomically placed pull handles;
- airtight casing – prevents contaminants from escaping and reduces noise; and,
- quiet operation at 58db (air-conditioning volume) and silent wheels with minimal noise.

For more information, please visit [www.henryschein.ie](http://www.henryschein.ie).

\*Source: B.A. International.





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## Bullying related to dental appearance: suggestions for dental professionals



In the past three decades, research around the phenomenon of bullying has considerably increased. Although there is no consensus regarding the definition of bullying, scholars agree that bullying is intentional, in that it is the expression of a systematic abusive behaviour, intended to harm the target physically and/or psychologically.<sup>1</sup>

Bullying typically occurs repeatedly, over the course of weeks, months and even years, and it is characterised by an imbalance of power between the perpetrator and the target. The negative impact on the target in terms of mental health and well-being could persist even several years after the abusive behaviour has come to an end.<sup>2</sup>

Beyond the physical forms of abuse, bullying involves verbal abuse in the form of teasing, threats and name-calling. Relational bullying involves excluding and spreading rumours about the target, with the aim of damaging their reputation. In recent years, a new form of bullying has emerged, 'cyberbullying', which occurs through technological devices.<sup>3</sup> Examples of cyberbullying involve threatening and abusive text messages, exclusion from chats, and nasty posts

and pictures, which might be shared with a large audience with the goal of humiliating the target.

### Dental appearance and bullying

Children who are perceived as 'different' from the norm in terms of their physical appearance are at a greater risk of being bullied.<sup>4</sup> Dental appearance plays a key role in facial attractiveness and might be one of the factors associated with bullying victimisation.<sup>5</sup> Research has shown that children with dental health problems (e.g., space between the teeth, dental caries, missing teeth, issues with the shape or colour of teeth, or prominent front teeth) are more likely to be bullied, compared to their peers with no dental health issues.<sup>5</sup> Worryingly, children with dental problems who are bullied show a poor quality of life, in terms of mental health and psychosocial well-being.<sup>5</sup>

Although a strong link between children's dental appearance and bullying victimisation has been shown in previous research, it should not be concluded that the motives of bullying lie in dental appearance. Such an approach would oversimplify the issue of bullying and would, in turn, result in a process of victim blaming, neglecting the responsibility of those who perpetrate the bullying. In addition, this approach does not consider the complexity of bullying and the associated socio-contextual factors. More specifically, bullying is a group phenomenon, in which peers, family and the school system play a key role.<sup>6</sup> Peers might reinforce the bullying directly, by laughing when bullying happens, or indirectly, by ignoring the abusive episodes, which could be framed as a silent way to condone the bullying. The school might not be able to put adequate prevention and intervention measures in place, or might fail to acknowledge that some subtle behaviours constitute bullying (e.g., social exclusion). Adults might show false myths;<sup>7</sup> for instance, they might believe that bullying is just a normal part of childhood, which in turn translates into a failure to address the bullying.

### Practical implications: suggestions for dentists and orthodontists

Dental professionals might be confronted with young patients being bullied at school who demand dental or orthodontic treatment as the solution, or who refuse dental treatment (e.g., unaesthetic braces) due to the fear of being



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further discriminated against and bullied by their peers. This can be particularly challenging for dental professionals, who may avoid addressing the issue directly because they feel unprepared to deal with the bullying. However, there are things that dental team members can do to educate themselves and to assist these children.

### Participation in anti-bullying training

Dental professionals can undertake training in relation to the bullying of children with dental health problems. Participation in awareness-raising programmes helps to increase knowledge regarding the features and forms of bullying, and provides information about the best strategies to address this problem. More information on anti-bullying resources and training can be found at <https://antibullyingcentre.ie/>.

### Asking questions

It is paramount to keep the communication with young patients open. Dental professionals might ask questions about whether the school has been informed in relation to the bullying and whether children are receiving any support from the school. Children might be unwilling to disclose the identity of their peers involved in bullying; therefore, inquiring about other peers should be avoided. Children need to trust adults before being able to share any relevant information. In other words, the disclosure process should be gradual.

### Empathy

Children might be reluctant to report their victimisation experiences, as they might believe that adults are not interested in taking action. In addition, they might lack confidence in adults' ability to stop the bullying.<sup>8</sup> Showing empathic concern helps children to share their experience and trust adults. Empathy is an intellectual ability enabling us to understand others' experience and feelings, and to show a corresponding emotional reaction.<sup>9</sup> Active listening, namely, paying attention and trying to understand the other's experience, is a prerequisite for empathy. If a child reports that he/she is bullied at school, it is crucial that they are believed and reassured that a system of support will be put in place. Parents should be encouraged to contact the school and speak to the principal and teachers, in order to address the problem.

### Manage children and parents' expectations

Children and their parents may have an expectation that dental treatment is the solution to the problem of bullying victimisation. Although dental or orthodontic treatment can contribute to the young patients' self-esteem, children can still experience bullying while wearing appliances.<sup>10</sup> It is advisable for dental professionals to be positive about the benefits of dental treatment. However, they will also need to explain that dental treatment does not constitute a solution to the problem of bullying. Bullying has a systemic nature; thus, simply ameliorating children's dental appearance will not help to tackle this phenomenon. In order to effectively combat bullying, it is paramount to raise awareness about this social problem among both children and the school staff. Effective solutions should be planned in co-operation with the school, and with the help of anti-bullying experts.

### Collaboration with anti-bullying experts

Enhancing the collaboration between dental professionals and anti-bullying experts is warranted. Dental professionals should be provided with screening

**Table 1: Suggestions for dental professionals regarding how to address bullying in children with dental appearance problems.**

▶ Participate in anti-bullying awareness-raising programmes.
▶ Keep the communication with the child open.
▶ Listen empathically.
▶ Encourage parents to contact the school.
▶ Refer children and their families to anti-bullying experts.
▶ Advise them to seek psychological support, especially when signs of distress are evident.

instruments (e.g., child self-report questionnaires) that will help to identify the bullied children. Children reporting high scores in terms of bullying victimisation should be referred to anti-bullying experts and counsellors.

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### Further reading

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- Rivers, I., Duncan, N., Besag, V.E.** *Bullying. A Handbook for Educators and Parents*. Rowman and Littlefield Education, 2009.

### Web-based resources

- National Anti-Bullying Research and Resource Centre free resources: <https://antibullyingcentre.ie/free-resources>
- National Anti-Bullying Website: <https://tacklebullying.ie>

## Double indemnity

A new Dental Council proposal would take away a dentist's right to choose discretionary indemnity.

Dental professionals in Ireland will be concerned to hear that the Dental Council is consulting on proposals that would require them and their business to hold a policy of insurance, removing dental professionals' ability to choose discretionary indemnity, without any apparent reason or explanation for the proposed change.

Since the first dentists joined in 1892, Dental Protection has provided discretionary indemnity to dental professionals and continues to do so as it is highly valued by members and provides very effective, flexible and reliable protection against cases and claims.

While dentistry has evolved during this time, the core purpose of the organisation has remained largely the same. Members of Dental Protection are part of a clinician-led, mutual organisation that is focused on their interests, and our default position is to always consider how we can help.

One of the real strengths of discretionary indemnity is that it enables the organisation to be flexible in making decisions that best support members. This has been more important than ever for dentists who have been hit hard by the Covid-19 pandemic.

### Help in challenging times

Dentists are facing significant financial pressures and have returned to practice in unsettling and challenging circumstances – working in different ways, worrying about their health and that of their families, patients, colleagues and employees, and facing a backlog of patients with problems potentially due to the delay in treatment. There are also no guarantees about what the short-, medium- and long-term implications of the virus will be.

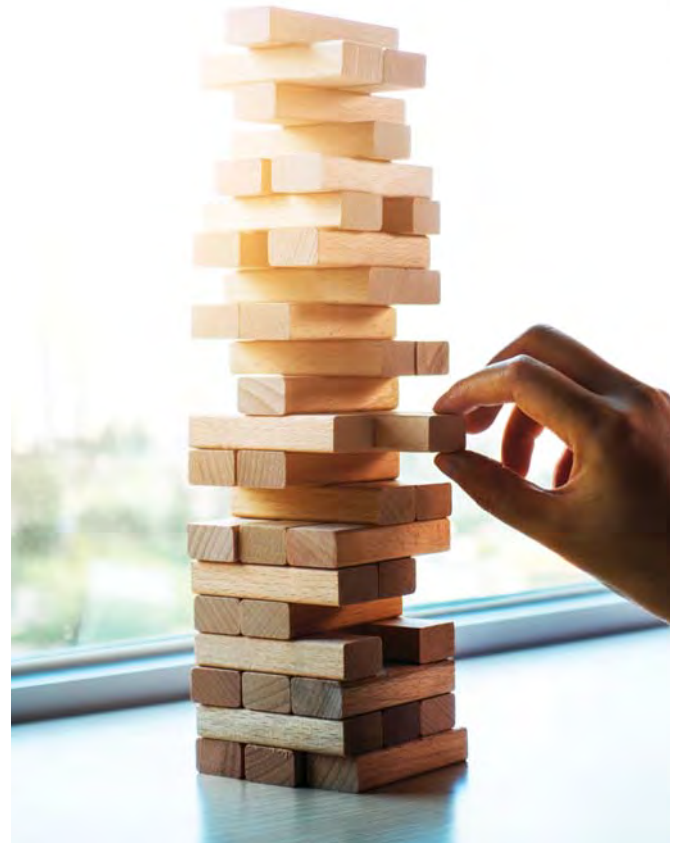
To help dental professionals dealing with financial challenges, Dental Protection has been able to pay the equivalent of two months' subscription fees back to members, as well as enabling them to adapt their membership on an ongoing basis to reflect the changing level of work they are doing.

We have also adapted the support we provide to dentists having to work in different ways while continuing with our risk prevention workshops and webinars. For example, we have extended assistance to members who have only been able to provide remote consultations where this had not previously formed part of their normal scope of practice.

#### Dr Raj Rattan

MBE BDS MFGDP(UK) PgDip MDE FFGDP(UK) FICD

Raj is Dental Director of Dental Protection



In addition, to support members during this difficult time, we extended our counselling service for those dentists experiencing work-related stress due to the crisis. The service is provided through a third-party partner and is completely confidential.

### Time for a rethink

It is unlikely that insurance companies, due to the contractual restrictions in place that form their relationship with dentists, could be anywhere near as supportive or flexible. There will be policy limits and exclusions that dentists will have to carefully consider before purchasing a policy. This is why, with the near future for dentistry looking uncertain, now would be the worst possible time to make it compulsory for dental professionals to change the type of protection they have in place.

Dental Protection is not dogmatic about the relative benefits of discretionary indemnity and insurance. Both have their strengths and we believe that the current open market provides the best of both worlds to dental professionals. Dental Protection is urging the Dental Council to rethink its proposal – which takes away the right to choose discretionary indemnity – and retain the current open market. We believe dentists should be able to continue to choose for themselves the type of protection that works best for them, making an informed decision after considering the pros and cons of insurance policies versus traditional discretionary indemnity. We are confident that the majority of the profession in Ireland will agree.



# MEMBERS' NEWS



Coronavirus  
COVID-19

## Crunching the Covid numbers

A recent survey of IDA members highlights the significant challenges dentists face in the wake of Covid-19, and the implications for dentistry as a profession, and for the oral health of the nation.

A recent IDA member survey, which was carried out in July and is presented exclusively in the *Journal of the Irish Dental Association*, shows the enormous changes wrought by the Covid-19 pandemic on dental practice in Ireland. With almost 600 respondents from across independent private practice and the

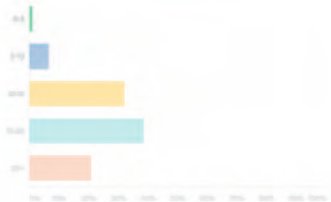
urgently with dentists regarding the Dental Treatment Services Scheme (DTSS), which provides dental care to medical card patients. This scheme has long been regarded as unfit for purpose, but the impact of Covid-19 is making the scheme unworkable for many dentists. The IDA is warning that increasing numbers of dentists are serving notice of their intention to resign from the Scheme, which has enormous implications for vulnerable patient groups.

### Return to work

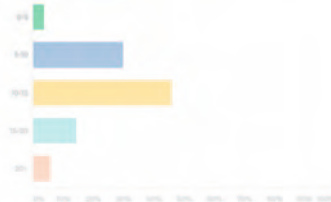
The survey results show that, like many other professions, the last few months have been extremely difficult for dentists. Most closed their practices in March to all but emergency cases, and while dentists began to reopen in May, only 25% have fully resumed their practice. Indeed, 16% have resumed less than 50% of their practice.

The impact on patient care is clear. Prior to the shutdown, the vast majority of dentists saw more than 10 patients per day, with only 8% seeing fewer than 10. Since reopening, the number of dentists seeing 10 patients or fewer per day has jumped to almost 34%, while the number seeing more than 15 patients has fallen from almost 50% to 20%. This is clearly the case that the majority of

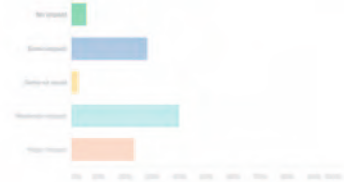
Q3  
On average, how many dental appointments per day did you see prior to the pandemic restrictions?



Q4  
On average, how many dental appointments are you currently seeing daily?



Q5  
How do you believe these new changes in behaviour (social distancing, decreased footfall, and need to wait in their car) will impact on our capacity to deal with the oral health of our Irish Population?



Anne points out the facts behind the figures in the new reality of how dentists are having to organise their practices: “We don’t use our waiting rooms the same way. We’ve changed the workflow between our waiting rooms and our surgeries. We’re making sure that we have space between appointments to be able to be very detailed in our infection control processes, and that has had a knock-on effect on the number of patients that people see during the day. There’s also the issue of the stress of providing care where you’re making sure that you have the right protective wear on for the right treatments, and that you’ve got every detail and that you’re running to time. All of this puts huge pressure on staff”.

#### Patient health

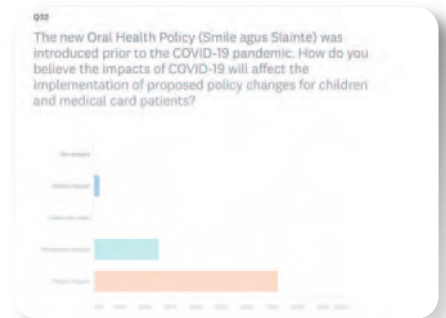
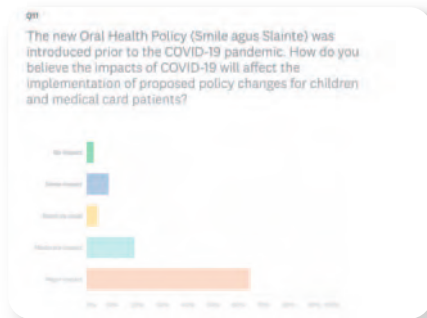
The impact of Covid-19 on the oral health of the general population is a

changes would impact on the implementation of the new oral health policy, Smile agus Sláinte, which was launched in April 2019, that number jumps to almost 85%.

The IDA has long argued that Smile agus Sláinte is not workable in its current form, and that, in contrast to the approach taken prior to the publication of the policy, a process of consultation between dentists and the Department is essential to find a way forward.

Says Anne O’Neill: “The DTSS has long been identified by the Association as being unfit for purpose. The new model proposed in the policy relies even more heavily on contracted care, and I have great concerns that the profession has lost trust. The impact of Covid, as well as that lack of trust, means that trying to implement the proposed model within Smile agus Sláinte has significant implications for the oral health of the general population, and we are





number is now a shocking 0%, with the vast majority now seeing fewer than 10 patients per day (82%). This has of course contributed to significantly increased waiting times for non-emergency appointments, which now average 101 days.

Anne O'Neill acknowledges that this redeployment is necessary, but is concerned at its knock-on effects: "It's a necessary evil, but the impact for oral health will be seen. Not necessarily today or tomorrow because the emergency service is there, but what happens for the structured care, the preventive care, if the resources aren't there to provide it at the moment?"

Dentists also identified serious issues in referring patients for treatment under general anaesthetic (GA), with almost 70% saying that they had identified or referred a patient for treatment under GA since the commencement of COVID-19, but only 22% saying that they have knowledge of how to impact

96% predicting a moderate or major impact. This rises to almost 98% of dentists who believe that the pandemic will have a moderate or major impact on the roll-out of Smile agus Sláinte. Again, this is a clear signal to the Department of Health that a fundamental rethink is needed, particularly regarding the proposals around dental care for children.

#### Role of the IDA

Both groups of dentists were asked what services or activities they would like the Association to prioritise during this challenging period. While dentists praised the Association's webinars and other CPD, they are anxious that the Association continue and increase its advocacy on behalf of the profession. Both public and private dentists also flagged serious concerns about the IDA's role in the implementation of the Department of Health's proposals for a new

## Have you registered for Healthmail yet?

IDA members can now register for Healthmail.



Following extensive lobbying and discussions by the Association, IDA members are now able to sign up to Healthmail, with over 300 members already having applied. Healthmail secure clinical email is a service that allows healthcare providers to send and receive clinical patient information in a secure manner. The IDA has partnered with Healthmail and will provide a verification service for IDA members, which will speed up their application. We would encourage all members who have yet to register for a Healthmail account to do so. Please note, there can only be one email set up per dental practice.

### Using Healthmail

Healthmail is a secure system and will be provided to all members who have registered for a Healthmail account.

### Hospital to dental practice:

- ▶ notification of therapy on patient.

### How does it work?

Healthmail is configured to be easy to use and to improve electronic communications for the benefit of patients and clinicians. Healthmail works within a private bounded network with a defined set of connected agencies.

### Registration

When registering for a Healthmail account, Healthmail will provide a verification service for IDA members, which will speed up their application.



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<sup>1</sup> Tiba A et al., Journal of American Dental Association, 144(10), 1182-1183, 2013.

<sup>2</sup> based on sales figures



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# Determining dental students' and dental hygiene students' perceptions of eating disorders and their management

## Précis

There is a need for development within the dental curriculum to improve the teaching and training regarding the diagnosis and management of eating disorders.

## Abstract

**Statement of the problem:** Pathological tooth surface loss (TSL) is an increasing challenge for dental healthcare professionals (DHCPs). Patients with eating disorders (EDs) may present with TSL and future DHCPs should be aware of the medical, dental and general management of patients with EDs who may present with TSL.

**Purpose of the study:** Determine perceptions of undergraduate students at Cork University Dental School and Hospital (CUDSH) regarding their training and the management of eating disorders.

**Methods:** A questionnaire was distributed to final year dental (FYD; n=47) and dental hygiene (FYDH; n=14) students approaching the end of their studies at University College Cork.

**Results:** A response rate of 40% for FYD (n=19) and 86% for FYDH (n=12) students showed no obvious trends differentiating between perceptions of FYDs and FYDHs. The perceived confidence of students in managing patients with EDs varied widely. A number of respondents perceived inadequate training in relation to oral manifestations (32%) and dental management (16%) of patients with EDs. In relation to the medical management (90%), personality traits (71%) and psychological needs (81%), students perceived a requirement for further training. A total of 77% of respondents were unaware of local support services available to ED patients, with 94% also unaware of Eating Disorder Centre Cork (EDCC).

**Conclusion:** There is a need for improvement within the dental curricula in education regarding patients with EDs, specifically their comprehensive management by DHCPs and surrounding services.

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## Introduction

Eating disorders (EDs) can be described as “a group of psychopathological disorders affecting patient relationship with food and his/her own body, which manifest through disorders or chaotic eating behaviour”.<sup>1,2</sup> The most common types of EDs are listed in **Table 1**.<sup>3</sup>

**Table 1: Common eating disorders.**

Common types of eating disorders	Summary of subtype
<b>Anorexia nervosa (AN)</b>	<ul style="list-style-type: none"> <li>▶ Persistent restriction of energy intake (food) leading to a person becoming significantly underweight</li> <li>▶ Intense fear of gaining weight or of becoming fat</li> <li>▶ Undue influence of body shape and weight on self-evaluation</li> </ul>
<b>Bulimia nervosa (BN)</b>	<ul style="list-style-type: none"> <li>▶ Repeated episodes of binge eating</li> <li>▶ A sense of a lack of control over eating during the episode</li> <li>▶ Inappropriate compensatory behaviours aimed at preventing weight gain</li> <li>▶ Self-evaluation is unduly influenced by body shape and weight</li> </ul>
<b>Binge eating disorder (BED)</b>	<ul style="list-style-type: none"> <li>▶ Repeated episodes of binge eating</li> <li>▶ A sense of a lack of control over eating during the episode</li> </ul>

Potential effects of these disorders can be severe. The mortality rate associated with anorexia nervosa for females aged 15 to 24 years is 12 times higher than the rate of all other causes of death in this group.<sup>4,5</sup>

EDs can have severe consequences for patients’ oral health, such as lesions of the mucosa, periodontium and dentition, and symptoms such as xerostomia and oral pain.<sup>2,6,7</sup> Early detection and intervention are important for the treatment and recovery of patients with EDs to avoid or minimise oral health sequelae.<sup>8-10</sup>

Research has identified the lack of educational training pertaining to the oral and physical manifestations of EDs, skills in patient approach, and knowledge of referral agencies as a barrier to ED-specific comprehensive care among practising dentists.<sup>4</sup> Limited literature exists regarding dental practitioners’ attitudes towards the management skills in approaching the ED patient and patient referral to the appropriate services. Previous studies have indicated that although dental and dental hygiene educational programmes include these health issues within their curricula, more dental hygiene students reported inclusion in comparison to dental students.<sup>11</sup>

## Aim

The purpose of this study was to identify the knowledge and awareness of final year dental (FYD) and dental hygiene (FYDH) students regarding the appropriate management of a patient with an ED and the resources available. The study aimed to identify if there are weaknesses in the curricula for dental students and dental hygiene students in relation to ED management.

## Method

An electronic survey was distributed to FYD and FYDH students to assess their self-efficacy and ability to appropriately manage an individual with an ED in a dental setting.

## Recruitment

Ethical approval was granted from the Social Research Ethics Committee, University College Cork (UCC). FYD and FYDH students were invited to participate in an online survey to determine their knowledge and awareness of, and confidence regarding, patients who have been diagnosed with an ED. The survey was sent to the UCC emails of all FYD (n=45) and FYDH (n=14) students.

## Data collection

The questionnaire was distributed in May 2017 via UCC Blackboard Learn, an academic website used to access lecture notes and online discussions. Students were reminded to complete the questionnaire by their class representative.

## Data analysis

Results were analysed on a Microsoft Excel spreadsheet. Each response was entered and answers were collated.

## Results – overview

The response rate was 31 from a total of 59 (52.5%). Nineteen out of a total of 45 FYD students (42%) responded and 12 from 14 FYDH students (86%). There was no data collected on the gender or nationality of responders. The response rate of this study was higher than that of the McDermott (2016) study, which investigated a similar topic in a similar location (36.5%).<sup>12</sup> A 2007 study by DeBate *et al.* had a response rate of 46%.<sup>4</sup> The questionnaire was categorised into four main themes: confidence; training; awareness of EDs; and, onward referral knowledge. For the appropriate questions, a five-point Likert scale was used. The scores correlated to:

- 1 – Very little
- 2 – Little
- 3 – Average
- 4 – Good
- 5 – A great deal

With questions regarding confidence, scores correlated to:

- 1 – Not at all confident
- 2 – Not confident
- 3 – Average
- 4 – Fairly confident
- 5 – Extremely confident

### Main theme 1: Confidence

**Q.** How would you rate your confidence in discussing a suspected eating disorder with the patient?

Only 5% of dental students felt that they were “extremely confident” discussing an ED with a patient, 16% felt they were “fairly confident”, and 47% gave their confidence an “average” value. Some 26% felt “not confident”, and 5% “not at all” confident.

Dental hygiene student results showed that 8% were “extremely confident” approaching a patient suspected to have an ED, 25% were “fairly confident”, and 33% gave their confidence an “average” value. The remaining 34% were split evenly between “not confident” and “not at all confident”.

### Main theme 2: Training

**Q.** In relation to your teaching/training at dental school about patients with



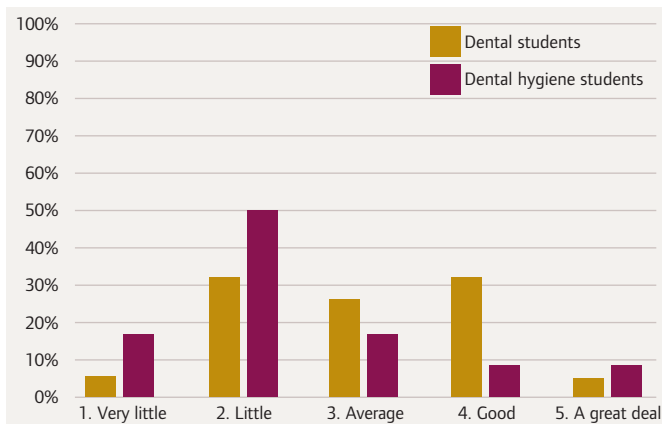


FIGURE 1: Response distribution to the question: "In relation to your teaching at dental school about patients with eating disorders, how much did you learn about their personality traits?"

eating disorders, how much did you learn about their personality traits, dental management, medical management, psychological needs and oral manifestations?

A total of 5% of FYD students felt that they were given "a great deal" of teaching/training about the personality traits of patients with EDs. Some 32% felt that the teaching/training provided a "good" level, 26% thought this aspect of their training was "average", and 32% thought they received "little" training. A total of 5% felt that the course provided "very little" training.

Some 16% of FYDH students felt that the teaching/training provided on personality traits of ED patients was "good" or equal to "a great deal". Some 17% thought this training was average, 50% thought it was equivalent to "little" and 17% to "very little" (Figure 1).

With regard to dental management of patients with EDs, 11% of dental students reported that they learned "a great deal". A majority of 53% felt they learned a "good" amount, 32% "average" and only 5% "little". No dental student participants felt that they were taught "very little" regarding the dental management of patients with EDs.

Results from FYDH students showed that 8% felt they learned "a great deal" on the dental management of EDs, 17% thought they learned a "good" amount, and 42% "average". The remaining 34% was split evenly between a value of "little" and "very little".

None of the dental students that participated in the survey felt that they learned "a great deal" about the medical management of EDs. Only 5% felt that they learned a "good" amount, 42% felt that their teaching/training was "average", 37% felt it was "little", and 11% scored it as "very little".

A total of 24% of dental hygiene students responded that their teaching/training during dental school, on medical management, was worth a value of "a great deal", "good" or "average" (8% allocated to each value). Some 42% gave their teaching/training on this topic a value of "little", and 33% scored it "very little".

None of the dental students who participated in the survey felt that they learned a great deal regarding the psychological needs of patients with EDs. A total of 21% felt that they had learned a "good" amount, 26% gave their teaching/training on the psychological needs of eating ED a score of "average", 42% thought this aspect of their training was "little", and 11% scored it "very little".

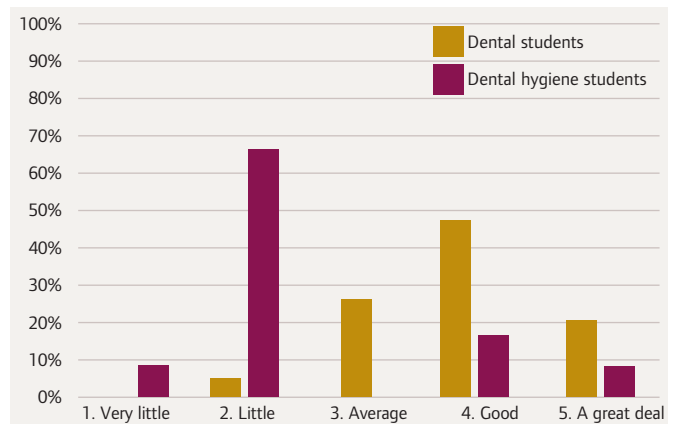


FIGURE 2: Response distribution to the question: "In relation to your teaching/training at dental school about patients with eating disorders, how much did you learn about their oral manifestations?"

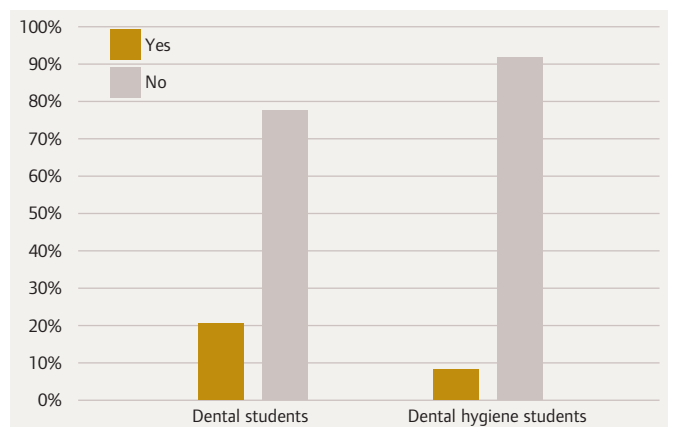


FIGURE 3: Response distribution to the question: "Have you personally managed a patient with a known or suspected eating disorder whilst you have been a student?"

A total of 8% of dental hygiene students felt that their training with regard to the psychological needs of patients with EDs ranged from "very good" to "average", 50% felt the teaching they received was "little", and 25% felt it was "very little".

Figure 2 summarises results regarding teaching of ED oral manifestations.

**Q.** Have you personally managed a patient with a known or suspected eating disorder while you have been a student?

The majority of FYD and FYDH students (79% and 92%, respectively) had not experienced managing a patient with a known or suspected ED (Figure 3).

**Sub theme:** Do you feel that more training is required for you to be confident in diagnosing patients with eating disorders?

The majority of dental students (53%) thought more training is required, while just under half (47%) felt the opposite.

The vast majority of the dental hygiene students, however, indicated that more training is required for them to be confident in diagnosing ED patients. Only 17% felt that additional training was not needed.

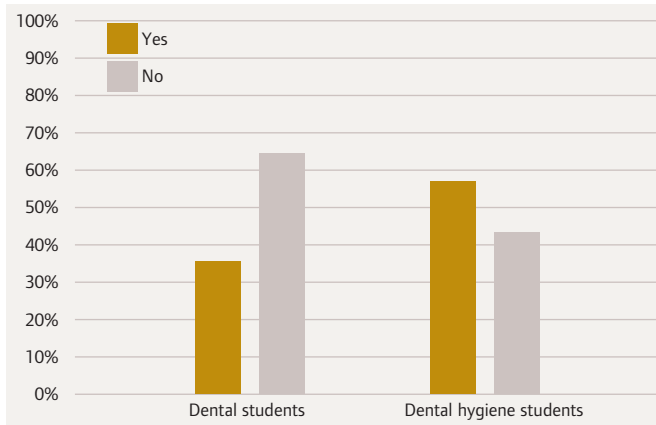


FIGURE 4: Response distribution to the question “Do you feel that more training is required for you to be confident in treating patients with eating disorders?”

**Q.** Do you feel that more training is required for you to be confident in treating patients with eating disorders?

The results to this question were opposing between the cohorts. Results from the dental students illustrated that 37% felt more training was required in order to feel confident treating patients with EDs, and 63% felt more training was unnecessary.

In contrast, 58% of dental hygiene students felt that more training in this topic was necessary, and 42% felt the opposite (Figure 4).

### Main theme 3: Awareness

**Q.** How would you rate your awareness of the prevalence of eating disorders in the general population?

Results from FYD students showed that 69% felt that their awareness of EDs was either “good” or “average”. The final third of participants were distributed evenly between “a great deal”, “little” and “very little” (11% for each).

Results from FYDH students stated that only 8% felt that their awareness of the prevalence of EDs in the general population was “a great deal”. One-quarter of participants rated their awareness as “good”, and a further 25% as “average”. Some 42% rated their awareness as “little”, with no participants rating their awareness as “very little”.

### Main theme 4: Onward referral knowledge

**Q.** If you were the first clinician to identify a potential eating disorder patient, are you aware of the support services available to them?

The majority of both dental and dental hygiene students (79% and 75%, respectively) were not aware of the local support services available.

**Q.** Have you heard of Eating Disorder Centre Cork?

None of the dental students had heard of Eating Disorder Centre Cork (EDCC), and 83% of dental hygiene students were also unaware of the Centre.

**Q.** As a clinician, do you know whether you could refer a patient to Eating Disorder Centre Cork?

Results from both cohorts surveyed indicated that very few students (only 5% of dental students and 8% of dental hygiene students) knew whether they could or could not refer a patient to EDCC.

Table 2: Resources on eating disorders for dental health professionals.

Educational resources	Website
<b>Eating Disorder Centre Cork</b>	
▶ Website for general info	<a href="http://eatingdisordercentrecork.ie/">http://eatingdisordercentrecork.ie/</a>
▶ Patient information leaflet	<a href="https://www.ucc.ie/en/media/academic/dentalschool/documents/patientinfoleaflets/EatingDisordersandOralHealthPatientInformation.pdf">https://www.ucc.ie/en/media/academic/dentalschool/documents/patientinfoleaflets/EatingDisordersandOralHealthPatientInformation.pdf</a>
<b>BodyWhys</b>	
▶ Website for general info	<a href="https://www.bodywhys.ie/">https://www.bodywhys.ie/</a>
▶ Dental resource PDF	<a href="https://www.bodywhys.ie/wp-content/uploads/2018/01/BW-Dentist-A5-FINAL.pdf">https://www.bodywhys.ie/wp-content/uploads/2018/01/BW-Dentist-A5-FINAL.pdf</a>
<b>SlainteCare</b>	
▶ Action Plan 2019	<a href="https://assets.gov.ie/22606/4e13c790cf31463491c2e878212e3c29.pdf">https://assets.gov.ie/22606/4e13c790cf31463491c2e878212e3c29.pdf</a>
<b>Health Service Executive (HSE)</b>	
▶ Summary of eating disorders	<a href="https://www2.hse.ie/conditions/mental-health/eating-disorders.html">https://www2.hse.ie/conditions/mental-health/eating-disorders.html</a>
▶ Making every contact count (encouraging healthy eating)	<a href="https://www.hse.ie/eng/about/who/healthwellbeing/making-every-contact-count/making-every-contact-count-framework.pdf">https://www.hse.ie/eng/about/who/healthwellbeing/making-every-contact-count/making-every-contact-count-framework.pdf</a>
▶ Model of care	<a href="https://www.hse.ie/eng/services/list/4/mental-health-services/national-clinical-programme-for-eating-disorders/ed-moc.pdf">https://www.hse.ie/eng/services/list/4/mental-health-services/national-clinical-programme-for-eating-disorders/ed-moc.pdf</a>
▶ A Vision for Change 2006	<a href="https://www.hse.ie/eng/services/publications/mentalhealth/mental-health---a-vision-for-change.pdf">https://www.hse.ie/eng/services/publications/mentalhealth/mental-health---a-vision-for-change.pdf</a>

### Discussion

The results highlight the need for improved ED teaching to DHCPs. Dental professionals can play a fundamental role in identifying oral manifestations of an ED;<sup>2</sup> thus, their awareness of EDs is essential along with correct management. This study indicated that dental students and dental hygiene students had average or little awareness of the prevalence of EDs, respectively. Previous studies have identified a lack of educational training pertaining to the oral and physical manifestations of EDs, skills in patient approach and knowledge of referral services.<sup>5</sup>

Although greater attention has been paid in more recent years to including ED training within dental school curricula, the emphasis has only been on improving identification of oral manifestations of the disorder. At best, future DHCPs are being trained to identify oral and systemic health connections, but inadequate training continues on the ED patient approach and patient management. Surprisingly, the majority of dental students perceived that they did not require further training to feel confident treating patients with EDs, and approximately half felt the same regarding diagnosing patients with an ED. These results are unexpected, as when asked about their training, the general consensus was that knowledge of EDs was unsatisfactory. This mismatch in the results could be due to final-year students feeling overwhelmed with workload during the exam season when the questionnaire was answered.

Students must be aware of the severity of EDs, the professional and legal responsibility they have in identifying a patient with an ED, and their liability to appropriately refer patients.



These results indicate that FYDH students gave lower values to the amount of teaching/training provided in their dental hygiene curricula, across all ED-related topics. To almost every question, the majority of the dental hygiene participants scored their learning at a value of 2 (signifying little teaching/training on the topic). An exception to this trend was when asked about dental management of ED patients. Dental hygiene participants gave higher frequency to a score of 3 (signifying an average amount of teaching/training). This suggests again that all aspects of the teaching on EDs provided by dental and dental hygiene schools requires improvement. The majority of FYDH students felt that more training is necessary. These results were the opposite of those seen from the dental students, but seem to indicate a positive outlook from the dental hygiene students as to a willingness to continue learning.

### Limitations

This study included a small participant pool with a relatively low response rate. The study was non randomised, which could have introduced bias as students were aware that a fellow dental student was collecting the data.

### Conclusion

Knowledge gained from this study will serve as a foundation for the development of an effective curriculum in this area. Dentists and dental hygienists should ensure that they promote patient-centred care and are aware of the educational resources and referral pathways available to professionals and their patients. **Table 2** summarises a number of educational resources, which may be useful to DHCPs.

### Acknowledgements

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### CPD questions

To claim CPD points, go to the MEMBERS' SECTION of [www.dentist.ie](http://www.dentist.ie) and answer the following questions:



CPD

- |   |   |   |
|---|---|---|
| <p>1. The mortality rate associated with anorexia nervosa for females aged 15-24 years old is _____ times higher than the rate of all other causes of death:</p> <p><input type="radio"/> A: 4</p> <p><input type="radio"/> B: 8</p> <p><input type="radio"/> C: 12</p> | <p>2. With regard to the dental management of patients with eating disorders, what percentage of dental students felt they learned a "great deal"?</p> <p><input type="radio"/> A: 5%</p> <p><input type="radio"/> B: 11%</p> <p><input type="radio"/> C: 15%</p> | <p>3. What percentage of dental students thought more training is required to increase their confidence in diagnosing patients with eating disorders?</p> <p><input type="radio"/> A: 47%</p> <p><input type="radio"/> B: 50%</p> <p><input type="radio"/> C: 53%</p> |
|---|---|---|

# Case report of a spontaneous occurrence of MRONJ

## Abstract

This is a case report of a patient with bone cancer who developed medicine-related osteonecrosis of the jaws (MRONJ). The case management, lesion progression, sequestration and sequelae are discussed.

*Journal of the Irish Dental Association 2020; 66 (4): 192-194.*

## Introduction

This 68-year-old male developed a lesion of medicine-related osteonecrosis of the jaws (MRONJ) on the lingual surface of the right posterior mandible. The patient had renal cancer five years prior to the appearance of the MRONJ lesion. Following removal of the right kidney, a scan showed that renal cancer nodules had spread to involve the ribs. This was treated with various forms of chemotherapy and he had been on intravenous zoledronate (Zometa) for approximately two months prior to the appearance of the lesion.

Zoledronate is one of the bisphosphonate group of medicines. Bisphosphonates are used in the treatment of osteoporosis and in the prevention of bone complications from cancers. In this case, the zoledronate was used to lower abnormally high blood calcium levels. Here it has the double benefit of reducing the amount of calcium release from the bones into the bloodstream and helping to reduce cancer spread.

In 2003 Marx reported avascular necrosis of the jaws following treatment with zoledronate.<sup>1</sup> Since then there have been numerous scientific publications on MRONJ. A recent review article by Cooney *et al.* in this journal summarises the aetiology, risk factors, incidence and preventive strategies of MRONJ.<sup>2</sup>

The Cochrane Database of Systematic Reviews examined interventions for managing MRONJ. However, it concluded that at present there is not a sufficient evidence base to support any specific treatment strategy.<sup>3</sup> Pichardo and van Merkesteyn have outlined a surgical approach for treating MRONJ. In their cohort study, they achieved a high success rate with a combined surgical and antimicrobial treatment protocol. After a five-year follow-up of their cases, they concluded that their combined surgical and antibiotic protocol is the treatment of choice at all stages of bisphosphonate-related osteonecrosis of the jaws (BRONJ).<sup>4</sup>

This patient was managed conservatively in a general dental practice setting, with hygiene visits every four to six weeks combined with daily use of chlorhexidine mouthwash.

## Case

This 68-year-old male is a non-smoker. He had renal cancer five years prior to



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this point with surgical removal of his right kidney in 2015. Follow-up scans showed localised spread of the renal cancer nodules to the pleural space and the adjacent ribs.

Initial drug treatment was with Sutent, which is a targeted therapy for renal cancer. This continued for approximately one year. This was followed by another year on nivolumab from August 2016 to July 2017. Nivolumab is an immunotherapy drug, which uses principles of the immune response to fight cancer. The patient was then returned to Sutent treatment for another year. In November 2018 he developed hypercalcaemia. This was treated with monthly intravenous administrations of zoledronate for two months. His current treatment is now cabozantinib 40mg, which is proving very successful in his case management. This is a targeted chemotherapy drug that works by slowing or stopping cancer cells. He also takes 2mg dexamethasone (a corticosteroid) daily. During the course of the examination in December 2018, a small area of what appeared to be exposed bone was noticed on the lingual surface of the right mandible. The lesion was on an edentulous area anterior to the last standing molar (**Figure 1**). The lesion was asymptomatic. A dental panoramic radiograph was taken, which revealed no abnormality, but it did show some areas of increased radiopacity in the edentulous bone superior to the mylohyoid ridge (**Figure 2**).

The patient was made aware that he had a potentially severe adverse drug reaction. Clinical photographs and dental findings were communicated with his oncologist. His medication was not changed by the oncologist, as his current medications were managing his cancer and his quality of life, and there had been some challenges in achieving this. The patient was reluctant to seek the opinion of a specialist oral surgeon and it was agreed that he could be managed conservatively in the general dental practice setting.



**FIGURE 1:** December 21, 2018. Initial appearance of lesion.



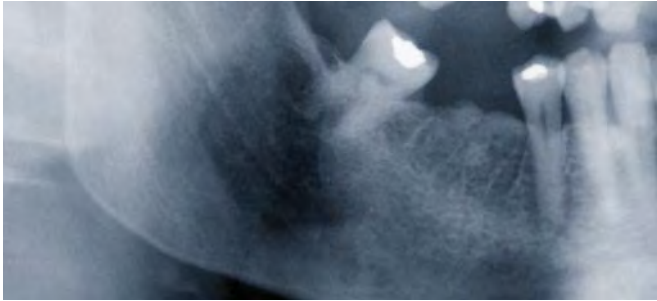


FIGURE 2: Radiographic appearance.



FIGURE 3: March 2019.



FIGURE 4: April 2019.

The treatment plan was for daily chlorhexidine mouthwash and monthly hygiene visits and review. On each subsequent hygiene visit the lesion was monitored and a photograph was given to the patient to aid communication with the oncologist.

By March 2019 the lesion had progressed to give two distinct peaks of exposed, very white bone (Figure 3). The exposed bone did not cause pain but was a minor irritant to the tongue. In April 2019 the peaks of the exposed bone had joined up to display approximately 15mm x 5mm of sequestrum (Figure 4). On the October 2019 visit, it was noted that the protruding bone appeared loose to probing. The bone separated from the mandible and left an erythematous ulcerated area (Figure 5). This procedure was done without local anaesthetic as the sequestrum of bone was ready to come away. The



FIGURE 5: October 2019.

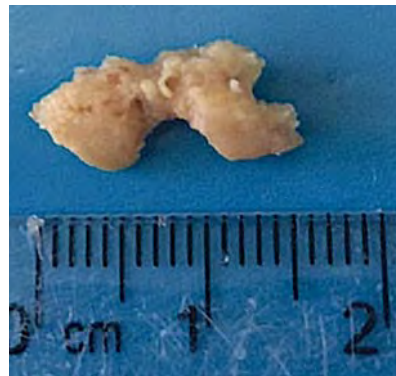


FIGURE 6: Sequestrum.



FIGURE 7: December 2019.

sequestrum measured approximately 15mm by 5mm and was sent for histological analysis (Figure 6). The histology report stated that it was "a fragment of necrotic/non-viable bone showing abundant bacterial overgrowth".

The December 2019 visit showed healing of the bone defect leaving a deep concavity with mucosal coverage. However, a new area of bone sequestrum had appeared mesial to the initial lesion (Figure 7). A further dental panoramic radiograph was taken to check for any further pathology and to check the roots of the molar. Nothing abnormal was noted (Figure 8).

#### Discussion

Initially, it is important for the dentist to rule out that the lesion is a metastatic

spread of the renal cancer or a mouth cancer. Together, the clinical examination, medical history and communication with the oncologist all aid the diagnosis of MRONJ.

MRONJ is more commonly associated with extractions and dental treatment.<sup>5</sup> However, this lesion could be considered to have developed spontaneously following a short period of intravenous zoledronate to treat hypercalcaemia. Cooney *et al.* provided a useful table of risk factors in their recent publication.<sup>2</sup> The medical history suggests that while the MRONJ lesion may have been precipitated by intravenous Zometa, the risk of developing MRONJ is potentiated by concomitant therapy with corticosteroids and the underlying medical condition involving therapy for the malignancy. Khominsky and Lim describe a case report of a similar presentation to this one. In it they query that the lesion should be called spontaneous, as it occurs at the mylohyoid ridge. They consider that an area of underlying protruding bone is a causative factor.<sup>6</sup> In this case, radiographic evidence suggests that the lesion is superior to the mylohyoid ridge.

In the Khominsky and Lim case the patient reported discomfort after four months and a sequestrectomy was performed under local anaesthetic.<sup>6</sup> Luckily in this case the sequestrum came adrift with time.

The Cochrane Review describes the treatment regime used in this case as “standard care”, i.e., regular check-up visits combined with the use of chlorhexidine mouthwash. The review compared standard care to standard care augmented with hyperbaric oxygen treatment. It found that the latter did not significantly improve healing of MRONJ.<sup>3</sup>

The incidence of MRONJ has been quoted as approximately 1% by Cooney *et al.*<sup>2</sup> However, anecdotally the incidence appears to be higher. It is possible that the condition is under-reported as it falls between many stools: dentists, dental specialists, doctors and oncologists.

An enquiry to the Health Products Regulatory Authority (HPRA) revealed that the authority had listed six suspected adverse reactions of MRONJ for the period January 1, 2014 to October 31, 2019. The use of HPRA listings comes with their caveat that “the information comes from a variety of sources; an inclusion of an event does not necessarily mean that it has been caused by the medicine in question and that the information does not represent the opinion of the HPRA”.

Dentists who come across MRONJ should report the adverse reaction to the HPRA. In this regard it is also advisable to open a channel of communication with the patient’s oncologist or care team.

MRONJ has been divided into four stages. Stage 0 is an unexposed variant. Stage 1 displays bone exposure. Stage 2 has bone exposure with infection present and a pathological fracture or fistula. Stage 3 has evidence of osteolysis extending to the inferior border of the mandible or the sinus floor.<sup>3</sup>

This case was monitored closely and was managed in general practice. Any progression would warrant a referral to specialist services.

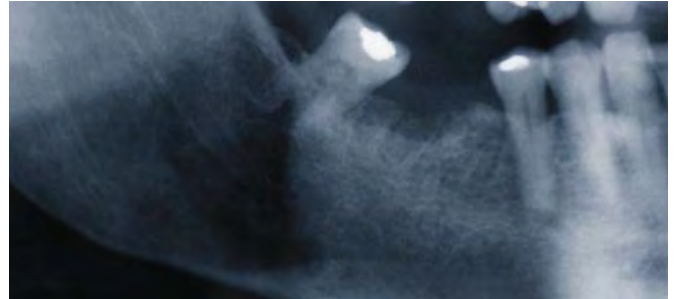


FIGURE 8: Sectional panoramic, December 2019.

### Conclusion

This case of a spontaneous occurrence of MRONJ was managed conservatively in general practice. Care was comprised of monthly hygiene visits combined with daily chlorhexidine mouthwash. The patient was at high risk of developing MRONJ – he had had intravenous treatment with zoledronate, a bisphosphonate, to control hypercalcaemia, along with concurrent use of corticosteroids and previous use of immunotherapy.

There may be an under-reporting of MRONJ as an adverse reaction to bisphosphonates and anti-cancer drugs. Dentists who encounter this type of event are encouraged to open a channel of communication with the patient’s care team. The occurrence should also be reported to the HPRA.

### Acknowledgements

I would like to acknowledge the contribution of the HPRA in providing the listing of suspected MRONJ.

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## CPD questions



To claim CPD points, go to the MEMBERS’ SECTION of [www.dentist.ie](http://www.dentist.ie) and answer the following questions:

CPD

### 1. MRONJ is a lesion that may occur following:

- A: treatment with specific drugs  
 B: radiation therapy

### 2. Standard care in a case of MRONJ includes which mouthwash:

- A: Warm salt water  
 B: Chlorhexidine  
 C: Hydrogen peroxide

### 3. An adverse drug reaction should be reported to which body?

- A: Irish Dental Association  
 B: Dental Council of Ireland  
 C: Health Products Regulatory Authority



# Periodontal disease as a manifestation of cyclic neutropenia: case report with a 34-year follow-up

## Précis

Case report: oral manifestations of cyclic neutropenia.

## Abstract

**Introduction:** Cyclic neutropenia is an autosomal-dominant haematological disorder. It is characterised by a periodic depression of peripheral blood neutrophils at 21-day intervals. Patients have a decreased ability to fight infection and commonly experience fever, ulceration, skin infections and lymphadenopathy.

**Case report:** A 17-year-old patient was referred by her consultant haematologist for periodontal assessment due to painful oral tissues and loose teeth. Clinical and radiographic examination revealed advanced periodontal destruction. A course of cause-related, non-surgical periodontal treatment, followed by an orthodontic and reconstructive phase, was carried out to arrest disease progression and stabilise her dentition. This case was followed up intermittently for over 34 years.

**Discussion:** The oral manifestations of cyclic neutropenia include oral ulcerations, angular cheilitis, periodontal destruction and early tooth loss. Early identification and regular follow-up should be employed for this patient cohort. Restorative procedures should be meticulously planned and executed to facilitate plaque control.

**Conclusion:** This case report illustrates the challenges of long-term management of severe periodontitis in a young individual who suffers from cyclic neutropenia. Delivery of dental and periodontal care was complicated by long travel distances, periods of non-attendance and financial issues. Early interventions to improve periodontal health and align the teeth proved successful, and this case report illustrates the benefit of planning periodontal care on a case-by-case basis. Regular supportive oral care is essential.

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FIGURE 1: Pre-treatment photograph (1985).

### Introduction

Severe periodontal disease is rare in young people. The presence of severe attachment loss in children and adolescents usually coincides with the presence of systemic conditions such as Down syndrome,<sup>1,2</sup> Papillon-Lefèvre syndrome,<sup>3,4</sup> hypophosphatasia<sup>5,6</sup> or cyclic neutropenia.<sup>7</sup>

Cyclic neutropenia (also called cyclic haematopoiesis) is a rare autosomal-dominant inherited haematological disorder with an estimated worldwide prevalence of one to two per million inhabitants.<sup>8</sup> The prevalence in the Republic of Ireland is reported to be at 2.6 cases per million inhabitants according to the EU registry.<sup>9</sup>

The disorder is characterised by a periodic depression of peripheral blood neutrophils at approximately 21-day intervals.<sup>7,10</sup> Neutrophils, or polymorphonuclear leukocytes, are part of the body's innate immune response system, accounting for 50-70% of our circulating white blood cells. Normal neutrophil levels range from 1,500-8,000 cells/mm<sup>3</sup> with neutropenia occurring when levels fall below the lower range.<sup>11</sup> They have important roles



FIGURE 2: Pre-treatment orthopantomogram (1985).

**Table 1: Periodontitis as a manifestation of systemic diseases.<sup>22</sup>**

#### A. Associated with haematological disorders:

1. Acquired neutropenia
2. Leukaemias
3. Other

#### B. Associated with genetic disorders:

1. Familial and cyclic neutropenia
2. Down syndrome
3. Leukocyte adhesion deficiency syndromes
4. Papillon-Lefèvre syndrome
5. Chediak-Higashi syndrome
6. Histiocytosis syndromes
7. Glycogen storage disease
8. Infantile genetic agranulocytosis
9. Cohen syndrome
10. Ehlers-Danlos syndrome (Types IV and VIII)
11. Hypophosphatasia
12. Other

#### C. Not otherwise specified (NOS)

in the body's immune defence system, carrying out functions such as phagocytosis and degranulation to fight infection.<sup>12</sup>

The role of the immune system in the pathogenesis of inflammatory periodontal disease was reported by Page and Schroeder in 1976.<sup>13</sup> The neutrophil was placed as the "front line" defence cell against bacterial attack at the dento-gingival junction. However, over the decades our understanding of the complex interactions of the immune system has increased. A recent review highlighted the expanded role of neutrophils, which are traditionally regarded as merely antimicrobial effectors in acute conditions and protagonists of the 'initial' lesion described by Page and Schroeder, but are currently appreciated for their functional versatility and critical roles in chronic inflammation.<sup>14</sup>

Cyclic neutropenia is caused by a mutation in the *ELA-2* gene, which encodes neutrophil elastase. This mutation results in defective early haematopoietic precursor cell development, in turn leading to failure of neutrophil production in the bone marrow.<sup>15,16</sup> Manifestations of the disease vary in severity and can present as early as the first year of life. They include recurrent fevers, oral ulceration, gingivitis, skin infections and lymphadenopathy.<sup>17,18</sup> A diagnosis of cyclic neutropenia is confirmed by obtaining a number of leukocyte counts at least two to three times per week for a minimum of six weeks.<sup>19</sup>

Currently, management includes regular administration of granulocyte colony-stimulating factor (G-CSF), which is given to promote granulopoiesis. The G-CSF binds to specific receptors on the neutrophils' surface, elevating the neutrophil count in the bloodstream.<sup>16,20</sup>

Periodontitis as a manifestation of cyclic neutropenia is mentioned in previous classifications of periodontal disease as a disease that is associated with clinical attachment loss (**Table 1**). The most recent 2017 classification of periodontal disease mentions systemic disease but does not list any specific associated conditions.<sup>21</sup>

Here we describe the case of a young patient affected by cyclic neutropenia presenting with advanced periodontal destruction. We take the opportunity to discuss the importance of early and regular oral assessment of patients who have increased susceptibility to infection, to identify and manage the occurrence of such advanced periodontal breakdown.

### Presenting complaint

A 17-year-old female patient was referred to the Periodontology Department of the Dublin Dental University Hospital by her consultant haematologist in 1985. She lived with her family 180km from Dublin. She complained of loose





FIGURE 3: Post periodontal therapy (1985).



FIGURE 4: Post-orthodontic alignment (1986).



FIGURE 5: Periodontal splint (1986).

teeth and recurrent painful ulcers of the oral mucosa, which lasted up to three months at a time. She was especially concerned about the unsightly spaces developing between her front teeth. Her medical history was unremarkable other than her diagnosis of cyclic neutropenia. She was a non-smoker and an irregular dental attender at the time.

#### Examination

Clinical examination revealed poor plaque control and calculus deposits. There was extensive gingival inflammation and widespread periodontal attachment loss, with multiple mobile, drifting and furcation-involved teeth (Figure 1). The patient had a class II division 1 incisor relationship with a complete vertical overlap. Orthopantomogram radiograph displayed moderate-to-severe generalised bone loss (Figure 2).



FIGURE 6: Orthopantomogram in 2007.

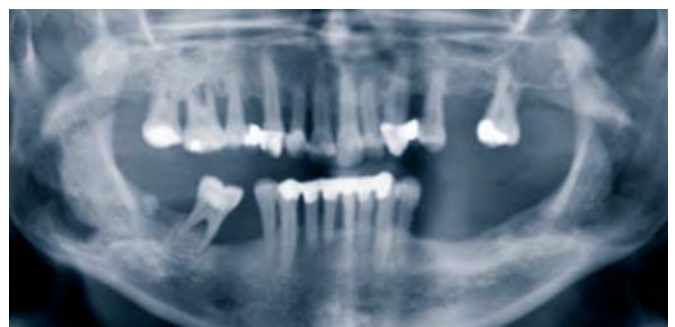


FIGURE 7: Orthopantomogram in 2018.

#### Treatment

The treatment plan included cause-related therapy, and corrective and reconstructive phases. The cause-related therapy phase included oral hygiene instruction and plaque control measures. Following review of oral hygiene, a corrective phase of full mouth non-surgical periodontal therapy was carried out, and the patient responded well to treatment (Figure 3). Following an improvement in oral hygiene, the patient reported a decrease in the frequency and severity of oral ulceration.

The reconstructive phase consisted of fixed orthodontic treatment to align the teeth and correct the traumatic, increased vertical overlap (Figure 4). This was followed by provision of resin-retained metal splints and bridges for retention and stabilisation of the occlusion. The palatal inflammation seen following placement of the fixed bonded retainer in Figure 5 resolved on reinforcing good oral hygiene. The patient was followed up at regular intervals until 1999. Due to relocation for work, she was lost to review for eight years (1999–2007). She re-attended briefly in 2007 but did not wish to have treatment due to personal circumstances, preferring to attend her local general dentist. Examination at that time revealed that the 1.8 and 4.8 had been extracted. There was also progression of the periodontal attachment loss at sites 3.5 and 3.6 (Figure 6).

The patient returned to the Dublin Dental University Hospital in 2018 for advice regarding stabilisation of her remaining teeth. Her medical history now included a diagnosis of osteoporosis in 2016, for which she was on oral bisphosphonates. She reported frequent chest infections requiring antibiotics and hospitalisation on occasion. She also receives infusions of granulocyte colony-stimulating factor (G-CSF). In the time since her previous review in 2007, she had lost several posterior teeth due to dental abscesses (Figure 7).



FIGURE 8: Maxillary view of dentition (2019).



FIGURE 10: Frontal view of dentition (2019).



FIGURE 9: Mandibular view of dentition (2019).



FIGURE 11: Extension of occlusal table on lower left first premolar to provide an occlusal contact with the upper left second premolar.

Clinical examination revealed generalised progression of periodontal attachment loss in spite of excellent oral hygiene. The remaining teeth, including the 4.6, were surprisingly stable despite the attachment levels (Figures 8, 9 and 10).

The primary focus for ongoing oral and dental care was a preventive plan including oral hygiene instruction, dietary advice including fluoride therapy, and supportive periodontal care to prevent further periodontal loss.

Restorative treatment options to stabilise the remaining teeth and increase occlusal function were discussed with the patient. These included:

- maintaining her current dentition and providing no active restorative treatment;
- provision of a mandibular removable partial denture;
- resin-bonded bridge to replace the mandibular right second premolar; and,
- dental implants.

The patient wished to have the edentulous space 45 restored. Following discussion of the associated risk factors, she was reluctant to consider dental implants as she was taking oral bisphosphonates, as well as the risk of clinical

attachment loss due to the cyclic neutropenia.<sup>23-25</sup>

A conservative fixed prosthodontic approach was planned for the patient along with oral hygiene instruction, dietary advice and periodontal supportive therapy. The occlusal table on the mandibular left first premolar was extended with a direct composite resin restoration to provide an occlusal contact between 3.4 and 2.5 (Figure 11). A resin-bonded fixed-partial denture was provided to restore the edentulous space in the mandibular right premolar area (Figure 12). This improved occlusal function bilaterally. A resin and fibre retainer was placed on the palatal of the maxillary incisors where the original metal retainer had recently failed. The patient was advised to use a high-fluoride toothpaste at bedtime and to apply chlorhexidine using interdental brushes.

### Discussion

Neutropenia increases patient susceptibility to infections, particularly those of a bacterial origin affecting the skin and mucosal surfaces,<sup>26</sup> with the risk of infection increasing when the neutrophil count drops below 1,500 cells/mm<sup>3</sup>.<sup>16</sup> Unlike the persistent nature of symptoms experienced in other neutropenias,



FIGURE 12: Buccal view of fixed partial denture.

such as benign familial neutropenia, those seen in cyclic neutropenia occur in episodes corresponding with the periodic fall in levels of neutrophils.<sup>27</sup> The oral manifestations of neutropenia presented in this case report include:<sup>7,17,28,29</sup>

- mucosal ulceration;
- angular cheilitis;
- increased susceptibility to advanced periodontal destruction; and,
- early tooth loss.

These signs are similar to those of recurrent aphthous stomatitis and aggressive periodontitis, making their clinical differential diagnoses challenging without further haematological investigations.

Painful oral ulceration, which occurs in cyclic neutropenia, can deter patients from carrying out good oral hygiene measures; therefore, they commonly present with poor plaque control and advanced periodontal destruction.<sup>28</sup> Improved oral hygiene may result in the improved healing of the ulcers, as occurred in this case.

Given the periodontal complications of systemic diseases such as cyclic neutropenia, restorative procedures should be conducive to periodontal health. The following should be considered when planning for such a patient:

- regular recall and supportive therapy to encourage patient compliance in carrying out oral health measures;
- periodontal splinting, if required, may be used to ensure stabilisation of remaining teeth;
- margins of fixed restorations should be supra-gingival to prevent gingival irritation, and pontics should be hygienic in design and relieved of the alveolar crest as shown; and,
- removable prostheses should be favourably contoured and tooth supported so as not to impinge on soft tissues.<sup>30</sup>

### Conclusion

Predictable, long-term maintenance is challenging in patients who present with advanced periodontal destruction at a young age. Early detection of periodontal problems and intervention are essential and necessitate close co-operation between medical and dental professionals. Excellent oral hygiene is essential in the neutropenic patient to control gingival inflammation and

periodontal destruction. It also results in the reduction of oral microbes, which may promote early healing of recurrent ulceration. The possible need for future bisphosphonate therapy, as in this case, highlights the importance of periodontal maintenance over extraction of teeth, which could lead to the development of medication-related osteonecrosis of the jaw (MRONJ). This patient cohort should be reviewed regularly, with long-term follow-up in general dental practice to control progression of periodontal destruction and to manage acute episodes of infection.

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## CPD questions

To claim CPD points, go to the MEMBERS' SECTION of [www.dentist.ie](http://www.dentist.ie) and answer the following questions:



CPD

1. Oral manifestations of cyclic neutropenia include which two of the following?

- A: Chronic periodontitis
- B: Halitosis
- C: Oral ulceration
- D: Black hairy tongue
- E: Angular cheilitis

2. Neutropenia occurs when neutrophil levels drop below:

- A: 1,500 cells/mm<sup>3</sup>
- B: 800 cells/mm<sup>3</sup>
- C: 1,000 cells/mm<sup>3</sup>
- D: 1,200 cells/mm<sup>3</sup>
- E: 8,000 cells/mm<sup>3</sup>

3. Which of the following has not been associated with periodontal disease?

- A: Down syndrome
- B: Papillon-Lefèvre syndrome
- C: Gardner syndrome
- D: Hypophosphatasia
- E: Cyclic neutropenia



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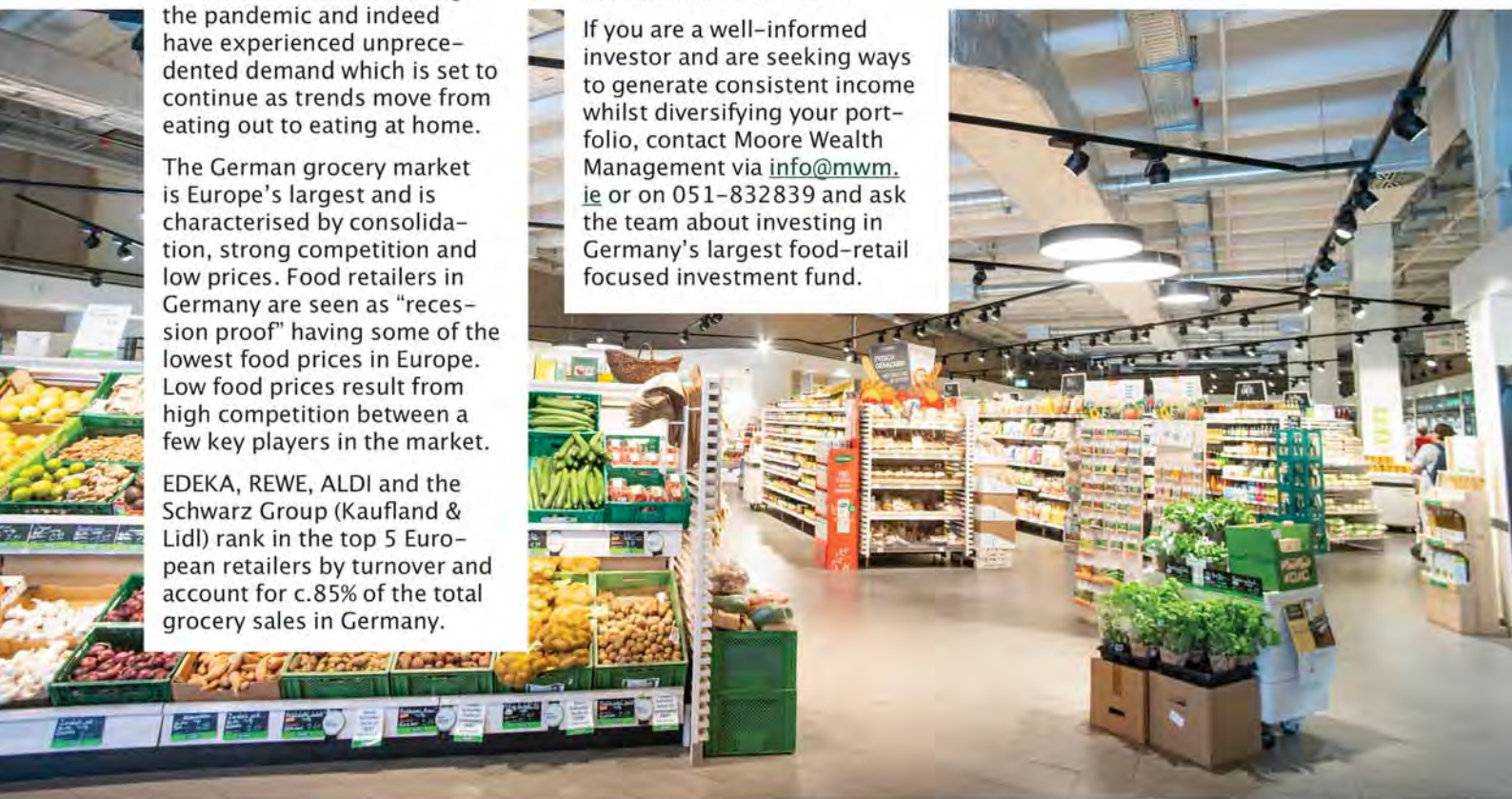
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Potently neutralising and protective human antibodies against SARS-CoV-2

Zost, S.J., Gilchuk, P., Case, J.B., et al.

Abstract

The Covid-19 pandemic is a major threat to global health for which there are limited medical countermeasures. Moreover, we currently lack a thorough understanding of mechanisms of humoral immunity. From a larger panel of human monoclonal antibodies (mAbs) targeting the spike (S) glycoprotein, we identified several that exhibited potent neutralising activity and fully blocked the receptor-binding domain of S (SRBD) from interacting with human ACE2 (hACE2). Competition-binding, structural, and functional studies allowed clustering of the mAbs into classes recognising distinct epitopes on the SRBD as well as distinct conformational states of the S trimer. Potent neutralising mAbs recognising non-overlapping sites, COV2-2196 and COV2-2130, bound simultaneously to S and synergistically neutralised authentic SARS-CoV-2 virus. In two mouse models of SARS-CoV-2 infection, passive transfer of either COV2-2196 or COV2-2130 alone or a combination of both mAbs protected mice from weight loss and reduced viral burden and inflammation in the lung. In addition, passive transfer of each of two of the most potently ACE2-blocking mAbs (COV2-2196 or COV2-2381) as monotherapy protected rhesus macaques from SARS-CoV-2 infection. These results identify protective epitopes on SRBD and provide a structure-based framework for rational vaccine design and the selection of robust immunotherapeutics.

[Published online ahead of print, 2020 Jul 15]. *Nature* 2020. doi:10.1038/s41586-020-2548-6.

A perspective on potential antibody-dependent enhancement of SARS-CoV-2

Arvin, A.M., Fink, K., Schmid, M.A., et al.

Abstract

The possibility of antibody-dependent enhancement (ADE) of disease is a general concern for the development of vaccines and antibody therapies because the mechanisms that underlie antibody protection have the theoretical potential to amplify viral infections or trigger immunopathology. Observations relevant to the risks of ADE of disease require careful review at this critical point in the SARS-CoV-2 pandemic. At present, no clinical findings, immunologic assays or biomarkers are known to differentiate any severe viral infection from immune-enhanced disease, whether by antibodies, T cells or intrinsic host responses. *In-vitro* systems and animal models do not predict the risk of ADE of disease, in part because protective and potentially detrimental antibody-mediated mechanisms are the same, and designing animal models depends on understanding how antiviral host responses may become harmful in people. The implications of our lack of knowledge are twofold. First, comprehensive studies are urgently needed to define clinical correlates of protective immunity against SARS-CoV-2. Second, since we cannot predict ADE of disease reliably after either vaccination or treatment with antibodies, regardless of what virus is the causative agent, it will be essential to depend on careful analysis of safety in humans as immune interventions for Covid-19 disease move forward.

[Published online ahead of print, 2020 Jul 13]. *Nature* 2020. doi:10.1038/s41586-020-2538-8.

Quiz answers

Questions on page 165.

1. What type of implant restoration is this?

Screw-retained implant crown.

2. What are the main advantages of this type of implant prosthesis?

- i. Ease of retrievability
- ii. Suitable where limited interocclusal space is present (minimum of 4mm)
- iii. No risk of excess cement at the implant-abutment interface and consequently lower risk of peri-implant mucositis and peri-implantitis
- iv. Fitting of the prosthesis is less technique sensitive

3. What are the main disadvantages of this type of implant prosthesis?

- i. Visible screw access hole, especially where emerging from the facial



aspect in the aesthetic zone

ii. A more rigid connection between prosthesis and implant leading to:

- a. Higher incidence of screw-loosening
- b. Higher incidence of porcelain chipping.

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## SARS-CoV-2-specific T cell immunity in cases of Covid-19 and SARS, and uninfected controls

Le Bert, N., Tan, A.T., Kunasegaran, K., et al.

### Abstract

Memory T cells induced by previous pathogens can shape the susceptibility to, and clinical severity of, subsequent infections. Little is known about the presence of pre-existing memory T cells in humans with the potential to recognise SARS-CoV-2. Here, we first studied T cell responses to structural (nucleocapsid protein, NP) and non-structural (NSP-7 and NSP13 of ORF1) regions of SARS-CoV-2 in Covid-19 convalescents (n=36). In all of them we demonstrated the presence of CD4 and CD8 T cells recognising multiple regions of the NP protein. We then showed that SARS-recovered patients (n=23) still possess long-lasting memory T cells reactive to SARS-NP 17 years after the 2003 outbreak, which displayed robust cross-reactivity to SARS-CoV-2 NP. Surprisingly, we also frequently detected SARS-CoV-2-specific T cells in individuals with no history of SARS, Covid-19 or contact with SARS/Covid-19 patients (n=37). SARS-CoV-2 T cells in uninfected donors exhibited a different pattern of immunodominance, frequently targeting the ORF-1-coded proteins NSP7 and 13 as well as the NP structural protein. Epitope characterisation of NSP7-specific T cells showed recognition of protein fragments with low homology to “common cold” human coronaviruses but conserved among animal betacoronaviruses. Thus, infection with betacoronaviruses induces multi-specific and long-lasting T cell immunity to the structural protein NP. Understanding how pre-existing NP- and ORF-1-specific T cells present in the general population impact susceptibility and pathogenesis of SARS-CoV-2 infection is of paramount importance for the management of the current Covid-19 pandemic.

[Published online ahead of print, 2020 Jul 15]. *Nature* 2020. doi: 10.1038/s41586-020-2550-z.

## An mRNA vaccine against SARS-CoV-2 – preliminary report

Jackson, L.A., Anderson, E.J., Roupheal, N.G., et al.

### Abstract

**Background:** The severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) emerged in late 2019 and spread globally, prompting an international effort to accelerate development of a vaccine. The candidate vaccine mRNA-1273 encodes the stabilised prefusion SARS-CoV-2 spike protein.

**Methods:** We conducted a phase 1, dose-escalation, open-label trial including 45 healthy adults, 18 to 55 years of age, who received two vaccinations, 28 days apart, with mRNA-1273 in a dose of 25µg, 100µg, or 250µg. There were 15 participants in each dose group.

**Results:** After the first vaccination, antibody responses were higher with higher dose (day 29 enzyme-linked immunosorbent assay anti-S-2P antibody geometric mean titre [GMT], 40,227 in the 25µg group, 109,209 in the 100µg group, and 213,526 in the 250µg group). After the

second vaccination, the titres increased (day 57 GMT: 299,751, 782,719, and 1,192,154, respectively). After the second vaccination, serum-neutralising activity was detected by two methods in all participants evaluated, with values generally similar to those in the upper half of the distribution of a panel of control convalescent serum specimens. Solicited adverse events that occurred in more than half the participants included fatigue, chills, headache, myalgia, and pain at the injection site. Systemic adverse events were more common after the second vaccination, particularly with the highest dose, and three participants (21%) in the 250µg dose group reported one or more severe adverse events.

**Conclusions:** The mRNA-1273 vaccine induced anti-SARS-CoV-2 immune responses in all participants, and no trial-limiting safety concerns were identified. These findings support further development of this vaccine. (Funded by the National Institute of Allergy and Infectious Diseases and others; mRNA-1273 ClinicalTrials.gov number, NCT04283461.)

[Published online ahead of print, 2020 Jul 14]. *New England Journal of Medicine* 2020. doi: 10.1056/NEJMoa2022483.

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Experienced associate wanted for modern dental practice in south Dublin. Full-time or flexible days available. Fully digitalised, OPG, CBCT, multidisciplinary. Implant experience an advantage. Predominantly private patient list. Great opportunity to join a progressive practice. Contact [info@killineydental.com](mailto:info@killineydental.com).

Galway City. Ambitious associate required to join modern practice – large portion of implant and cosmetic dentistry. CBCT, Omnicam, microscope. Hygiene, nursing, front desk team supporting with four-handed dentistry, financial/treatment co-ordination. Email [associategalway2020@gmail.com](mailto:associategalway2020@gmail.com).

Experienced associate dentist required for our fabulous Donaghmede practice. Fantastic opportunity, with fantastic earning potential, and full patient list available! GMS experience preferred. Contact [recruitment@smartdentalcare.co.uk](mailto:recruitment@smartdentalcare.co.uk).

Advertisements will only be accepted in writing via fax (01-295 0092), letter or email ([liz@irishdentalassoc.ie](mailto:liz@irishdentalassoc.ie)). Non-members must pre-pay for advertisements, which must arrive no later than **Friday, September 18, 2020**. Classified ads placed in the *Journal* are also published on our website [www.dentist.ie](http://www.dentist.ie) for 12 weeks. **Please note that all adverts are subject to VAT at appropriate rate.**

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

The maximum number of words for classified ads is 40. If the advert exceeds 40 words, then please contact: Think Media, The Malthouse, 537 North Circular Road, Dublin 1. Tel: 01-856 1166 Fax: 01-856 1169 Email: [paul@thinkmedia.ie](mailto:paul@thinkmedia.ie)

Please note that all classified adverts MUST come under one of the following headings:

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

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

Associate required for busy and modern south Dublin practice. Full/part-time. General and cosmetic experience preferred. Contact drerikawhitesmile@gmail.com.

Dublin City. Experienced associate, good competency in oral surgery and endo a must. Full-time in high-profile, very busy practice. Excellent location. Supportive, progressive, contemporary environment, equipment, staff. Good long-term prospects for suitable ambitious, empathetic candidate. Contact niall@innovatedental.com.

Experienced associate required for a busy practice in Meath. Full-time/part-time options considered. Modern, computerised practice with excellent support staff. Strong book with a mix of private, PRSI and public patients. Contact: careers@dentalcareireland.ie.

Part-time associate required for busy and modern dental practice in Longford. Flexible working hours. Please email your CV to annedental@hotmail.co.uk.

Excellent opportunity for a talented associate to join Eyre Square Dental. Minimum two years' experience. A great opportunity for mentorship in advanced implant and cosmetic dentistry. Great facilities, Omnicam, CBCT. Supportive team. Apply by email to paula@eyresquaredental.ie.

Experienced associate required for an extremely busy, recently renovated, established multi-surgery practice, high remuneration. Part-time may be considered. Commutable from Dublin or Galway. Fantastic opportunity. CVs to bddentalassociate@gmail.com.

Dental associate with minimum two years' experience for three-surgery, modern, busy, holistic dental practice in Bray with view to partnership. Dental and facial aesthetics and IDC reg. desirable. CV to drjohnmurphy@gmail.com.

Associate dentist required part/full-time, to work in established country practice in Ballyjamesduff, Co. Cavan. Hygienist, denture technician, EXACT computer software. One hour from Dublin. Contact info@ballyjamesduffdentalsurgery.com.

Experienced, ambitious and enthusiastic associate dentist required for busy practice in Mayo. Part-time/full-time options considered. Modern, computerised practice with excellent support staff. Strong mature appointment book, full support with PPE. Contact info@tobindental.com.

Part-time enthusiastic, motivated, friendly, associate required for busy three-surgery practice six miles from Galway City. Excellent support staff, OPG. Immediate start available. Please email CV to info@orantowndental.ie.

Busy private practice seeking conscientious associate two days/week initially. Navan, Meath, excellent support staff, facilities and remuneration. Applications to deirdreodwyer4@me.com.

Conscientious, ambitious associate required two to four days in established high-profile practice in Meath. One hour from Dublin, 80 minutes from Belfast, 45 minutes from Newry/Cavan/Drogheda. Full clinical freedom, 95% private, established list. Contact scotty6@gmail.com.

Associate required in private only practice in Carlow/Kilkenny. Be part of a skilled multidisciplinary team with many visiting specialists. Established book. Excellent facilities and backroom support. CEREC, digital scanner, in-house laboratory, CBCT. Suit experienced colleague. Please send CV to bpm.gmedical@gmail.com.

## Dentists

Shields Dental Group is recruiting an experienced general dentist to join our team. We are a well-established, expanding practice. Contact jobs@shieldsdentalclinic.ie.

Want to work with the best patients? Looking to carry out more cosmetic

treatments on people who expect the best results? Full digital practice – CT, 3shape scanner, CEREC, lab on site, photo suite. Email: ed@seapointclinic.ie.

Ambitious dentist required, immediate start, for expanding, modern Dublin 7 practice. We're looking for a great personality with strong consultative selling skills. Contact hello@plazahealth.ie.

Donegal Town dental practice with special interest in orthodontics and implants, seeks enthusiastic dentist. Practice established 2010. Excellent reputation. CBCT, OPG and Ceph. Sister practice in Letterkenny. Practice situated in town centre. Close to beaches, mountains and golf courses. Contact: siomurr@hotmail.com.

Ambitious dentist required for immediate start, full time, for a very busy clinic in Fermoy, Co. Offaly. Full support with PPE and safe working practices. Excellent equipment, including CEREC, and experienced dental colleagues. Apply with CV to deirdre@thejamesclinic.com.

Exciting opportunities for self-motivated and experienced dentists in D8. Email diamonds-mile-jobs@gmail.com.

Experienced cosmetic dentists required in a modern, busy, south Dublin practice. CT, Primescan scanner, CEREC, fully manned lab on site, photo suite, treatment co-ordinators and a strong support team to assist. Experience in composite bonding, crowns and veneers essential. Contact shauna@3dental.ie.

Enniscorthy – Smiles Dental is looking for a passionate dentist to join our well-established, state-of-the-art practice in Enniscorthy, Co. Wexford, to initially cover maternity leave. Four to five days per week, established list, great earning potential. Contact joanne.bonfield@smiles.co.uk.

Athlone – Smiles Dental is looking for a passionate dentist to join our well-established, state-of-the-art practice in Athlone, Co. Westmeath to initially cover maternity leave. Four days per week, established list, great earning potential. Contact joanne.bonfield@smiles.co.uk.

Full-time dentist required for modern, computerised, friendly and expanding practice. Guaranteed minimum €100k salary with higher earning potential. Own nurse, surgery and any equipment required will be supplied. Please email your CV to northdublindentalclinic@gmail.com.

We are delighted to offer a part-time opportunity for an experienced and committed dentist to join our team in Drogheda. If like us you are dedicated to providing a high standard of dental care, please forward CV for consideration to angelam Kearney@gmail.com.

Cork City centre – dentist required part-time, Tuesday/Wednesday with alternating Saturday morning. Enthusiastic, hardworking with long-term view. Private/PRSI/GMS experience essential. Contact corkassociate2020@gmail.com.

Experienced dentist required for a busy practice in Carlow. Ideally full-time but part-time options considered. Refurbished, computerised practice with excellent support staff and visiting specialists. Very strong mature book to be taken over. Contact careers@dentalcareireland.ie.

Looking for an experienced dentist for well-established, busy, two-surgery modern practice in Dublin. Must be IDC registered and ready to start. Contact northdublinclinic1@gmail.com.

Therapie Clinic is recruiting qualified dentists with Botox and filler experience. We have positions nationwide with flexible hours and great remuneration. Get in touch for more information. Contact ciarani@therapieclinic.com.

Experienced, confident dentist required to join the Dental Options team in our busy fully private clinic. Invisalign training provided. Excellent support staff. Contact louise@clearbraces.ie.



**Specialist/limited practice**

Shields Dental Limerick requires an experienced endodontist to join our well-established, growing private practice. Great earning potential. CVs to jobs@shieldsdentalclinic.ie.

Endodontist and prosthodontist required for modern specialist practice in Killarney. MSc or equivalent. Onsite CBCT, sedation, microscope. Excellent income. Email tomas.allen@kingdomclinic.ie.

Swords Dental requires an oral surgeon and a facial aesthetics practitioner for a session each at our modern, busy practice. Implant and oral surgery book in place. CVs to colinpatricklynam@hotmail.com, or see www.swords-dental.ie.

Oral surgeon – Smiles Dental is looking for a specialist oral surgeon to join our well-established, state-of-the-art practice in Wexford. Practice offers full support team and great referral base. Must be on Specialist Register. Email Joanne.bonfield@bupadentalcare.co.uk.

Implant surgeon – Smiles Dental is looking for an implant surgeon to join our well-established practice in Wexford. Practice offers full support team and great referral base. Must be able to provide an implant portfolio. Contact Joanne.bonfield@smiles.co.uk.

Part-time specialist oral surgeon required at established, computerised practice 30 minutes from the M50. Excellent support team and great referral base. Days and times negotiable. Must be on Specialist Register. Send motivation letter and CV to info@kinnegaddental.ie.

Paediatric dentist wanted for very busy multidisciplinary practice in Dublin 6. We currently have an extensive paediatric list to care for. Ortho, endo, implant, general practice, CT. Contact alex@beechwooddental.ie.

Cork City multi-surgery practice requires orthodontist. Terms negotiable including partnership. Contact corkcityassociate@gmail.com.

Specialist registered orthodontist required to work in multiple locations in Dublin metropolitan area. Remuneration is experience dependent. CVs to elaine.hand@dublinorthodontics.ie.

Registered orthodontist required to work flexible days with immediate start. Contact dunboyneorthodontics@gmail.com.

Experienced endodontist required for leading specialist practice in Dublin 4. Part-time role with potential for other Leinster locations. Good referral base, strong earning potential with excellent support team. Contact careers@dentalcareireland.ie.

Orthodontist – Ortho Dundalk (Smiles Dental) is looking for a specialist orthodontist to join our specialist practice in Dundalk. Position offers state-of-the-art working environment, full support team, four to five days per week and established referral base. Contact Joanne.bonfield@smiles.co.uk.

Registered specialist orthodontist required for long-established Limerick City centre specialist orthodontic practice. Contact sarahc06@live.ie.

Orthodontist required to join our orthodontic team in Dental Options. Busy, fully private clinic treating with both Invisalign and fixed braces. Full Invisalign training provided if necessary. Excellent support staff. Salary dependent on experience. Contact louise@clearbraces.ie.

Exciting opportunities for experienced orthodontist in D8. Email diamondsmljobs@gmail.com.

**Orthodontic therapists**

Orthodontic therapist required to replace departing colleague in Athlone. four days per week. Please call for further information or email CV to info@shannonsmiles.ie.

Orthodontic therapist required for a busy, state-of-the-art clinic in south Dublin. Large friendly team, great working environment, fully digital practice with an iTero scanner. On-site ortho technician. Salary €45,000- €60,000 depending on experience. Contact shauna@3dental.ie.

Registered orthodontic therapist required four days per week at Dublin Orthodontics. To work in multiple locations in Dublin metropolitan area. CVs to elaine.hand@dublinorthodontics.ie.

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

**Dental nurses/managers/receptionists**

Dental nurse required four days a week for modern, private, airy, proactive dental clinic in Dublin 2. Experience with EXACT would be useful. The ideal candidate would be enthusiastic, conscientious and friendly. Please email us at dentalclinic210@gmail.com.

Swords Dental requires part/full-time nurse with experience and computer skills for our busy, modern practice. Hours to include a Saturday morning. Email CVs to colinpatricklynam@hotmail.com.

Full-time position available for a qualified dental nurse at our modern and busy Limerick City practice. Please send CVs to bowedentalclinicjobs@gmail.com.

Full-time senior dental nurse required for busy, modern, private practice in Dublin 4. Experience with CEREC, cosmetic dentistry and orthodontics preferable. To work with principal dentist and periodontist. Email CV to d4dentalclinic@gmail.com.

Full-time dental nurse required, 40 hours per week, long-term position. Modern, Friendly, 90% private general practice in Celbridge Primary Care Centre. Start ASAP. Further details available from <https://1drv.ms/p/s!Au2G9pTl1owEqgEp5HCw1CjYAaCe?e=SFDmra> or email poboyleriverside@hotmail.com.

Part-time dental nurse required two to three days per week (to include Saturdays) for a busy north Balbriggan private practice. Candidate should be enthusiastic and motivated to join a highly skilled team in an expanding practice. Contact brianjpagni@gmail.com.

Full-time dental nurse required for a dental clinic located in south Co. Dublin. Experience would be ideal but not essential. Candidates should possess excellent organisational and communication skills, with a friendly and positive attitude. Email CV to dentalnursecareer@gmail.com.

Nurse required for Saturdays only in Dunboyne with the view of further days. Experience essential. Please email CV to dublinmeath@gmail.com.

Due to expansion we are looking to recruit a dental nurse to our growing Co. Monaghan practice. Candidate should be friendly and enthusiastic. Please email CV to chris@qtdentalcare.com.

Beaumont Dental seeks an enthusiastic professional dental assistant with excellent reception skills for maternity cover, 39-hour week – initially one-year fixed-term contract. Experience helpful but a positive attitude and strong work ethic our vital priorities. Contact reception@beaumontdental.ie.

Nurse/nurse trainee required full-time for both chairside and reception desk duties in an expanding dental practice in Kilkenny City. Contact brianjpagni@gmail.com.

Experienced dental surgery assistant required for position in Ennis. Contact hickeyaudrey@hotmail.com.

Trainee dental nurse/dental nurse required to work part-time. Contact [dunboyneorthodontics@gmail.com](mailto:dunboyneorthodontics@gmail.com).

Full-time dental nurse required for busy general practice in Scariff, Co. Clare, from September. Experience preferred but not essential. Please email CV to [judyomearadental@gmail.com](mailto:judyomearadental@gmail.com).

A state-of-the-art, modern specialist practice is looking for a full-time dental nurse to work in the clinical and administrative sides of the practice. A positive attitude, great communication skills and excellent teamwork are required. Contact [jobs@ncdental.ie](mailto:jobs@ncdental.ie).

### Hygienists

Dental hygienist required for friendly staff, busy, computerised general dental practice in Sandyford. Position will include some evenings. Please send CV to [blackglendental@gmail.com](mailto:blackglendental@gmail.com).

Northern Cross Dental is a busy specialist practice that requires a dental hygienist to join our team on a fixed-term contract for up to one year, which may be extended. Please send CV to [jobs@ncdental.ie](mailto:jobs@ncdental.ie).

Dental hygienist required to cover maternity leave in Kildare. Immediate start. Two days (semi-flexible on days), seeing patients for regular periodontal maintenance and initial therapy. All modern equipment and full PPE provided. Contact [akildaredentist@gmail.com](mailto:akildaredentist@gmail.com).

Part-time hygienist required. Busy, modern, primary care centre in Celbridge. Four sessions to start. July 2020. Computerised, air-conditioned, purpose-built. Friendly, helpful team. Further details available from <https://1drv.ms/p/s!Au2G9pT11owEkzIEHXifcviDfTSX?e=d0jeyk> or email [poboylerriverside@hotmail.com](mailto:poboylerriverside@hotmail.com).

Hygienist required for busy practice. Established patient list. Three to five days available. Please send CV to [reception@molloydental.ie](mailto:reception@molloydental.ie).

Dental hygienist required two days per week in Meath. Full book with a mixture of periodontal, orthodontics and PRSI. Friendly, supportive team, full PPE provided. Contact [dentalpracticemeath@gmail.com](mailto:dentalpracticemeath@gmail.com).

Part-time hygienist required. Busy, modern clinic in south Dublin. Computerised, air-conditioned, Cavitron. Friendly, helpful team. Contact [shauna@3dental.ie](mailto:shauna@3dental.ie).

Hygienist needed two days per week, immediate start, to replace colleague in modern Drogheda practice. Details available on request. Contact [info@wq dental.com](mailto:info@wq dental.com).

Blessington, Co. Wicklow – part-time hygienist, Tuesday, Thursday and Friday. General practice. Taking over list. Computerised, U/S, immediate start. Email [niall@blessingtodental.ie](mailto:niall@blessingtodental.ie).

Letterkenny, Co. Donegal. Modern, progressive, busy practice seeks hygienist. Practice has special interests in implants and orthodontics. CBCT scanner. Great staff and lovely patients. Contact [siomurr@hotmail.com](mailto:siomurr@hotmail.com).

Experienced, flexible and enthusiastic dental hygienist required for part-time position. Great patients and excellent support staff in a modern, computerised practice in Westmeath. Send motivation letter and CV to [info@kinnegaddental.ie](mailto:info@kinnegaddental.ie).

Kilkenny – hygienist required for a busy family dental practice. Days and hours flexible. Contact [ayrfielddentalpractice@gmail.com](mailto:ayrfielddentalpractice@gmail.com).

Hygienist required for a maternity cover starting December 2020 in a modern practice in Nenagh, Co. Tipperary. Days and hours flexible. Contact [rczemko@gmail.com](mailto:rczemko@gmail.com).

Experienced, flexible dental hygienist required for part-time position. Great patients and excellent support staff in a modern, computerised practice in south Dublin. Email [siobhan.kbmdental@gmail.com](mailto:siobhan.kbmdental@gmail.com).

Dental hygienist required for one day a week for a busy practice in Dunboyne, Co. Meath. Please email CV to [dublinmeath@gmail.com](mailto:dublinmeath@gmail.com).

### PRACTICES FOR SALE/TO LET

South Tipperary practice for sale. Freehold/leasehold. Three surgeries, great location with parking. Fully computerised. Experienced, loyal, qualified staff. Excellent opportunity. Flexible lead-in arrangements negotiable, including associate arrangement with a future purchasing agreement. Email [seiredent@gmail.com](mailto:seiredent@gmail.com).

Co. Mayo – two-surgery, long-established, active practice with ample room to expand. Low overheads. Leasehold/freehold options. Excellent new patient numbers. Strong hygienist service. Very good profits. Dentist retiring. Priced post Covid. Contact [niall@innovativedental.com](mailto:niall@innovativedental.com).

Co. Tipperary – two-dentist established and profitable dental practice for sale. Good patient mix. Hygienist two days per week. Excellent opportunity in superb location with free patient parking. Owners retiring. Email [steven@medaccount.ie](mailto:steven@medaccount.ie) or call 086-068 1242.

Dublin north. Two-surgery, well-established private practice with potential to expand. Full hygiene book, exceptional turnover. Apply in confidence to [steven@medaccount.ie](mailto:steven@medaccount.ie) or call 086-068 1242.

Mid-west practice for sale. Multi-surgery, long-established practice in a large catchment area. Low overheads, high turnover and profits, full books. Great potential for growth. Principal retiring. Ideal for ambitious dentist or couple. Email: [midwestdentalpracticeforsale@gmail.com](mailto:midwestdentalpracticeforsale@gmail.com).

### EQUIPMENT FOR SALE

Dublin. Dentist retiring. Equipment, two full surgeries, extensive hand instruments. Photos available. Full job lot €2,500 or nearest offer as surgery areas need clearing. First come, first served. Contact: [niall@innovativedental.com](mailto:niall@innovativedental.com).



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## Lifelong member

Dr JANE RENEHAN joined the IDA early in her career in pursuit of education, and over the years became involved in the provision of that education, as well as finding collegiality and friendships.

### What led you to first get involved in the IDA?

I joined the IDA a few years into my career and I recognised that I needed to get continual professional development. I was working in the public sector and I didn't want to deskill, so the IDA was providing education on general practice and specialist topics. Very quickly, I saw that the IDA gave me something else. It gave me networking and the opportunity to meet a lot of colleagues. I started very young in my career with the IDA and I've never looked back.

### What form did that involvement take and what is it now?

I very quickly got involved in the political side of the IDA. I went onto the committee for the HSE, and from there I went onto the executive, that today would be called the board, and I represented the HSE on that. I was very influenced by some of the senior members of the IDA and the commitment that they had. I've been on various committees and I was president of the HSE group. Now I'm on three committees, the Quality and Patient Safety Committee, the CPD Committee and the International Affairs Committee, and I'm enjoying my role in all of those.

### What has your involvement in the IDA meant to you?

It has allowed me to enjoy my profession more. It has provided me with education. It has provided me with lifelong friendships. It has given me a healthy respect for the fact that there are so many people committed to looking after their patients, committed to being excellent

practitioners, whether in the public, private, specialist or hospital sectors. It has really enriched my professional career. It's been of great value to me personally.

### What has been the single biggest benefit of IDA membership for you?

I think the collegiality of the profession. Wherever dentists are in their career, the Association brings people together. The commitment of people together within the IDA has always been for the good of the patients, the good of the population, and the good of the profession.

When I was in the public sector, I was very interested in management and I spent 20 years as a Principal Dental Surgeon. And as manager of a very large service of salaried and contracted people, I had to be committed to regulation and to processes and standards. In the IDA other people had a commitment to those things as well and coming together in the Quality and Patient Safety Committee allowed me to bring skills I had learned in my employment. That Committee has produced so much guidance to the profession and I'm very proud of my input into the development of that guidance. I think the IDA is giving all the time to the members but it's very important the members give back. I've always been committed to giving back because you get so much out of that.

### How would you like to see the Association progress into the future?

My interest is regulation. When I finished working with the health service I set up my company Dental Compliance Ltd. Part of that is helping the profession to make regulation, guidance and governance simpler to implement. That is not something I am doing on my own; the IDA is also doing that through so many strands of its structures and processes. I'd like to see the IDA continue supporting members, make the regulation simple and continue to provide education. I've been very fortunate that the IDA gave me that. I like to be part of providing education to the members. That has changed in recent times through webinars, through online guidance, and the *Journal* has improved so much. The IDA is constantly giving back and we need our members to keep engaging with us. I would like to see more young members coming through.

### How has Covid-19 affected the work you do in infection prevention and control, the advice you give dentists, and IDA CPD?

I would usually visit dental practices and then provide a written report for the practice owner, giving them guidance and a road map as to how they would navigate themselves through the regulation in a simple manner, making it simple and specific for them. Because of Covid, visiting the practices was not an option, so I moved my business online. And I now do Zoom calls with my clients. That's working really well. The video calls are so much better than being on a telephone call.

The training I do with the IDA has gone online as well. I've done a few webinars. The IDA has moved its own meetings online and that's so much more efficient as well, and has made it easier to have meetings and have more involvement.

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Jane lives with her husband, Derek Brauders, in Co. Wexford, and is a keen gardener.





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**CAR LOAN**

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4.97%  
(5.08% APR\*)



**HOME  
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5.97%  
(6.14% APR\*)

**7 year term**  
6.47%  
(6.67% APR\*)

**10 year term**  
6.97%  
(7.20% APR\*)



**EDUCATION LOAN**

4.97%  
(5.08% APR\*)



**COVERED LOAN**  
(SAVINGS HIGHER THAN LOAN)

4.97%  
(5.08% APR\*)



**HOME LOAN**

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\*The APR (Annual Percentage Rate) included is an example only; all APR examples are based on a €10,000 loan over a period of 60 monthly repayments.

\*\*The APRC (Annual Percentage Rate of Charge) included is an example only; all APRC examples are based on €200,000 over a period of 300 months.  
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## DENTAL ADVISORY BOARD

## VACANCY

We are seeking an Irish-based dentist to join our Dental Advisory Board to provide support to the Dental Protection team, ensuring that it continues to provide the expert advice and support that our members trust and value.



As a Dental Board member you are the voice of our members and are integral to our success; helping to deliver our purpose and vision.

You will understand the complexities of working in the dental profession and bring your specific expertise to the Board to ensure that the present and future dento-legal and regulatory challenges, which could affect the whole profession, are considered fully.

You will be required to demonstrate high levels of integrity and to be a role model for outstanding standards of quality, probity and engagement with the profession. With the ability to listen and constructively challenge in a board environment, your commitment and engagement with your fellow members and our executive team will be critical to ensure delivery of high quality and dental-specific advice to the Medical Protection Society (MPS).

MPS is committed to creating a Board that reflects the diversity of the members we serve. We welcome applications from dentists who are members of Dental Protection and can articulate the views of our practicing dentists, so that they can inform the future strategy of the dental business.

Approximate annual commitment will be around four days a year for Dental Board meetings. Time will also be required to prepare for meetings and attend any professional development. Meetings are mainly held in central London and on occasion in our Leeds and Edinburgh offices. There is potential to attend some of these meetings virtually and where travel is required, full expenses will be provided.

MPS is the world's leading member-owned, not-for-profit protection organisation for doctors, dentists and healthcare professionals. Founded in 1892, we exist to protect and support the professional interests of more than 300,000 members around the world, helping them to understand and navigate the ongoing challenges of modern practice. Today we proudly support members in the United Kingdom, Ireland, South Africa, New Zealand, Australia, Hong Kong, Singapore, Malaysia, the Caribbean and Bermuda.

Our philosophy is to support safe practice in medicine and dentistry by helping to avert problems in the first place. We do this by promoting risk management through our workshops, e-learning, clinical risk assessments, publications, conferences, lectures and presentations. We also actively campaign for regulatory and legal reforms that benefit members and the wider healthcare professions.

**For more information please visit**  
<https://www.dentalprotection.org/uk>

**Apply here:** <https://careers.medicalprotection.org/jobs/job/Dental-Advisory-Board-Member/649>