IDA
irish dental association

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

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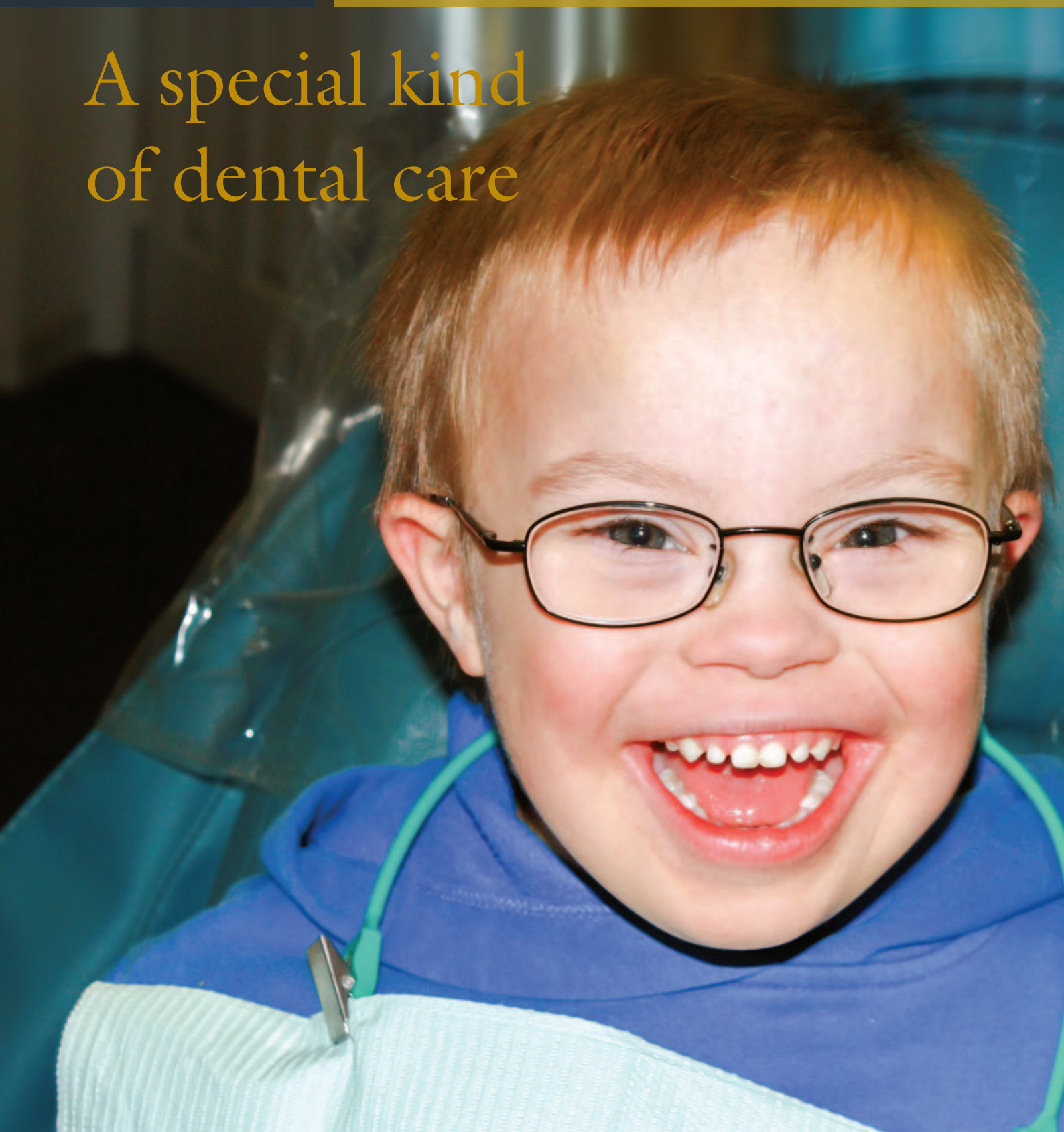
A special kind of dental care



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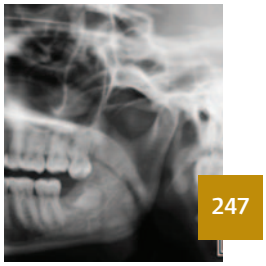

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EDITORIAL

Dr Cristiane da Mata
Honorary Editor

AI in academia: friend or enemy?

Is AI a tool to be embraced, or a threat?

Artificial intelligence (AI) is becoming widely used in multiple fields. In dentistry, AI can be used in multiple dental practice tasks, from booking appointments to treatment planning, even assisting dentists in surgical procedures such as implant placement. In academia, this is no different and AI is rapidly integrating into a variety of administrative and teaching and learning activities. However, with this growing integration, many are left wondering whether AI is a tool to be embraced or a threat to be cautious of. Figures like Elon Musk have cautioned about AI's unchecked potential, with Musk stating that AI could outpace human intelligence to the point where "biological intelligence will be 1%".

Should we rethink our evaluation methods in academia, given the fast development of AI tools?

Assignment

I recently received a phone call from a colleague asking my opinion about a student's assignment. He suspected that the student, who historically produced average work, had used AI to create an outstanding final course project. The text was well written and, differently from cases of plagiarism, where the issue might be more easily detected, trying to find hints of the use of AI was more like a detective's work.

I started by enquiring among colleagues and discovered that although software is available to detect the use of AI in academic work, it is still thought to be unreliable. Basically, it would be hard to prove the student had used AI (if they had) and this made me reflect on two important points: 1) the assessment tools that are still used in undergraduate and postgraduate courses may not be adequate for detecting AI assistance; and, 2) the common perception that AI should be completely avoided in academic settings may be obsolete.

Publishing

The use of AI in publishing and scientific article review has increased, changing the academic and editorial landscape. AI-driven tools can be used to assist in automating manuscript evaluation, including plagiarism detection, grammar checks, and even assessing the relevance of citations. For peer review, AI can rapidly screen submissions for quality and adherence to publication standards, offering preliminary assessments to complement human judgement. This use is expanding rapidly, with AI algorithms being developed to detect flaws in experimental design, statistical analyses, or data integrity, improving the reliability of scientific research. While this increasing use of AI can be very positive, accelerating the review process and ensuring higher accuracy and fairness in assessments, full reliance on AI remains limited. This is where human eyes and experience are needed as AI is still unable to fully comprehend nuanced arguments or novel insights.

Many scientific and academic journals have started to acknowledge the use of AI tools like ChatGPT for tasks such as drafting, editing, or enhancing the readability of manuscripts. However, they often require that authors explicitly disclose AI usage in the submission process, emphasising that AI cannot replace human authorship or accountability. For example, *Nature* and *Science*, among others, have set clear policies: while authors can use AI tools to assist with language and structure, they must ensure the originality of the scientific content, interpretations, and conclusions. They also typically prohibit AI from being listed as a co-author, as it lacks the ability to take responsibility for the work.

Time for a rethink?

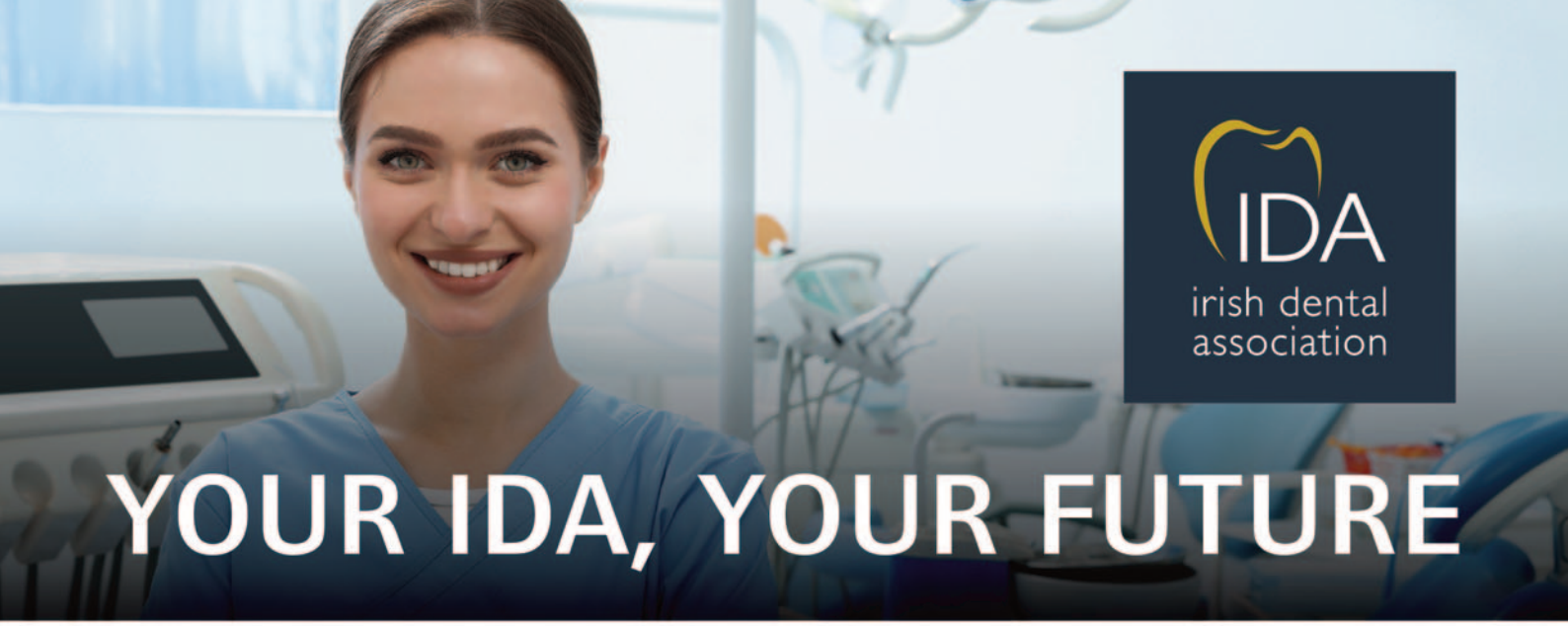
So, going back to the use of AI in academia… The use of AI by students has some negative impacts, such as students becoming overly dependent on AI, potentially stifling their critical thinking, creativity, and problem-solving skills. However, it can also make the learning process more efficient and enhance access to resources and organisation of research material. A publication about the topic called AI in academic writing and research "an essential productivity tool".

My recent interaction with this case of potential use of AI in academic work made me reflect on a few questions:

- should we rethink our evaluation methods in academia, given the fast development of AI tools?;
- should we accept that AI may be used for assignment and dissertation/thesis writing and start training our students to use it properly and responsibly?; and,
- will the potential benefits of AI outweigh its negative impact on students' learning experience?

I am not sure what the answers to these questions are, but I believe we need to confront AI directly and define clear boundaries for its use in academia and scientific publishing, setting guidelines and policies while promoting transparency in its application.

Full disclosure: Since I was writing about the use of AI, I thought it would be fun to use it as a research exercise for this editorial too. Therefore, while the human touch is behind this editorial's wit, I had a little help from my AI co-writer ChatGPT. From polishing ideas to fact-checking at lightning speed, AI was quietly working in the background. But don't worry, all the facts and insights are 100% human.



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Dr Rory Boyd
IDA President

Funding deficits in dental schools must be addressed

Recent media coverage has highlighted the funding deficit in our dental schools, which is contributing to the shortage of dentists in Ireland.

The return of students to college after the summer presented an opportunity for the IDA to raise the issue of underfunding of our dental schools, and of the need for more dental undergraduate places if we are to address the current shortage of dentists. Stories in the media about young people who, despite achieving maximum points in the Leaving Cert, were not offered a place at dental school, only serve to emphasise that something is broken in the way our dental schools are funded. The IDA's story was covered by numerous media outlets, including *Drivetime* on RTÉ Radio One, Newstalk, *Irish Examiner*, *The Irish Times* and *The Journal.ie*, highlighting the fact that this is an important topic for education, and for society as a whole.

Reform of student intake needed

At the moment, both of our dental schools, in Cork and Dublin, are heavily dependent on students from outside the European Economic Area (EEA) to subsidise the schools and mitigate shortfalls in Government funding over decades. These students pay over €45,000 per year to train in Ireland, which is a strong endorsement of the calibre of dental education available here, as well as a vital source of income for the dental schools. However, this has led to a situation where almost half of our dental graduates are from outside the EEA.

Non-EEA graduates tend to return to their home countries to practise, which they are of course entitled to do. Those who wish to remain and work as dentists in Ireland face further hurdles due to the regulations surrounding work permits here. In order to obtain a visa, a dentist must work as an employee for a sponsoring dentist for a period of two years. As the model in Irish dentistry historically is for dentists to work as self-employed associates at the beginning of their careers, positions as employees are very difficult to find.

At the moment, both of our dental schools, in Cork and Dublin, are heavily dependent on students from outside the European Economic Area (EEA) to subsidise the schools and mitigate shortfalls in Government funding over decades.

The IDA has consistently lobbied for increased funding, and for reform of the legislation surrounding work permits, and we will continue to do so, but for now we have a situation whereby too few graduate dentists are available to fill posts here, with IDA surveys showing that 63% of dentists have struggled to recruit associates in recent times.

We have called for a cap on the number of non-EEA students who can study dentistry here of 20% next year, moving to 10% over the next three years, to begin to address this issue, but this alone is not enough – more funding is needed. The Department of Health has acknowledged the need for more undergraduate places, and we certainly welcome the decision to offer an undergraduate course at the RCSI from next year. This does not, however, address the ongoing underfunding of our existing dental schools in Dublin and Cork. In particular, the decision to withdraw funding for a badly needed new dental school in Cork is short-sighted to say the least, and the IDA has strongly argued that this decision must be reversed as a matter of priority.

Smile agus Sláinte

By the time this edition of the *Journal* goes to press, we will know the contents of Budget 2025 for better or worse. We are also awaiting the final draft of the Department's implementation plan for Smile agus Sláinte, the national oral health policy, which has once again been delayed. The IDA was not consulted in the original development of Smile agus Sláinte, and we have raised numerous issues relating to the policy since 2019 when it was first launched by the Department with much fanfare. Five years later, we certainly welcome the impetus from Government at long last for reform of dental services in Ireland, but we are understandably sceptical, given the delays and disappointments of the past.

There are many elements of the policy that we support, such as the legislative change to support the introduction of mandatory CPD for dental professionals. However, there are other elements about which we have serious concerns. Statements about planned (and desperately needed) reform of the medical card scheme are woefully short on detail. The Department has also yet to make clear how the proposed shift of childhood dental screening (and treatment) out of the HSE and into private dental practices is supposed to work.

There are many questions still to be answered, and we hope that the implementation plan will clarify these. In the meantime, the IDA will continue our work of lobbying and advocacy, taking part in consultations where we have the opportunity to do so, and giving the views of dentists so that we can achieve the best reform possible for the profession and for our patients.

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Fintan Hourihan
IDA CEO

Making those vital connections

Networking, or simply making connections, is an essential part of advancing in your career as a dentist. It is also vital for the Association in representing the profession at a time of rapid change.

My experience at FDI, the World Dental Parliament hosted in Istanbul in mid September, showed the importance of connecting at a national and global level. Meanwhile, our highly successful Starting Dentistry event in Dublin in the same week showed how important it is for individual dentists to get away from their chair and make new contacts and acquaintances at dental gatherings.

Global relationships

Perhaps the biggest challenge in recent years has been the Covid experience, and the huge practical difficulties it presented to dentists. We had highly challenging circumstances to deal with in Ireland, reflecting the fact that dentistry is very much outside the mainstream healthcare system, which very much revolves around acute hospitals. There were of course many differing views on science and best practice in terms of managing safety for patients and dental team members, and many challenges in providing appropriate advice for our members.

At that time a network emerged of the Chief Executives of the dental associations in the main English-speaking countries, including the US, Canada, Britain, New Zealand, Australia, and Ireland, where we were very quickly able to swap information, share advice and learn from each other as we struggled and ultimately adapted to representing the interests of our members. That forum has continued to meet online, and has remained an invaluable resource for our Association. This has become even more evident with the publication of the WHO Global Oral Health Strategy, which is essentially a template for worldwide reform in the healthcare system that will see oral health integrated with general health. It is also the theoretical basis for Smile agus Sláinte, our national oral health policy.

It has become increasingly apparent that the impact of the WHO Policy is now being seen at national state level and, in many cases, countries are only waking up to the real impact of its proposed reforms. We are proud to say that the IDA is literally leading the world in our response to its publication. Our policy paper of March this year is being rightly recognised and lauded as a significant and influential response on behalf of practising dentists. Many international colleagues have expressed gratitude for the work done by the IDA in leading the debate, and that was very evident in the multiple bilateral meetings we had during the FDI Istanbul meeting with American, Australian, Belgian, British, Canadian, Dutch, Estonian, French, German, Italian, Norwegian, New Zealand, Polish and Portuguese associations.

I was delighted to be joined in Istanbul by our Past President Dr Kieran O'Connor, who was an outstanding ambassador for Irish dentistry, making countless connections with colleagues working at the sharp end and gathering essential information on reforms happening across the world. Through his connections we can see the impact the WHO Policy is having in many countries, but also the common experience of dentists where we have low prioritisation of oral health, weak co-ordination between government, government agencies and stakeholders, inequality of access to care, and low oral health literacy. As Kieran rightly said, when these factors are combined with financial limitations and human resource shortages in many countries, national oral health plans and other reforms are failing to deliver.

Kieran learned that in Australia a voucher system for children appeared to deliver much but is failing because of the restrictions on the types of treatment being funded. In New Zealand, a scheme that combines capitation and fee per item is struggling. Of particular interest, we learnt about the roll-out of the Dental Care Plan in Canada, where a scheme has been launched to provide care for almost one in four of the population. Again, there are many problems with its roll-out, including the shortage of dental team members as well as the administrative burden being imposed on dental practices. We learned of many other common issues and challenges facing dentists across the world. These connections will help us to lead the profession in Ireland in managing reform.

Connecting closer to home

The recent launch of the Starting Dentistry in Ireland booklet (for which my considerable thanks go to my colleague Roisín Farrelly) at an event in Dublin hosted by the Association, also showed the importance of making connections. In fact, it was quite notable that some of the speakers admitted that the last time such an event took place, in 2019, they were in the audience. They can see a real progression in their careers already, and also see the value of attending dental events where they meet colleagues facing common experiences and where, ultimately, they make connections that serve to ease their path through dentistry.

Of course, we know that major change is coming and we expect the imminent publication of the three-year Smile agus Sláinte Implementation Plan 2024-2027. From our meetings with the Department of Health over the past nine months, we know that there will be significant legislative and policy changes, including the Department's wish to roll out new State schemes replacing the DTSS, introducing a proposed new scheme for dental care for children, and many other significant changes. Many of these will be welcome changes, but equally we see that these herald a significant challenge for the Association and the profession. In those circumstances, it is ever more important that dentists in Ireland connect, join the Association, make their views known, and play an important part in shaping the response of the profession.

New HSE Group President

The AGM of the HSE Dental Surgeons Group took place online on Tuesday, October 1. Dr Maura Cuffe took on the role of President of the Group, taking over from Dr Siobhan Doherty. Living in Tullamore, Maura is a special needs dentist with the HSE, based in the Midlands. We wish you well in your year of Presidency Maura.

The HSE Dental Surgeons Seminar took place at the Radisson Hotel Athlone on October 10 and 11. A report from the Seminar will feature in the next edition of the *JIDA*.

Mouth Cancer Awareness Day 2024

Many thanks for participating in Mouth Cancer Awareness Day 2024 and helping to spread the word on mouth cancer and its effects. Our thanks to the dentists around the country who supported the initiative by speaking to their local radio station or newspaper on the day about the effects of this disease on patients.

With the help and continued support of both Dublin Dental School and Hospital and Cork Dental School and Hospital, we brought to you an agreed referral pathway from general dental practices into specialist care, which is available on www.mouthcancer.ie.

The day also marked the launch of a very interesting episode of our *The Whole Tooth* podcast with Dr Eamon Croke and Mr David Hickey, transplant surgeon, GAA All Star, three-time All Ireland medallist with Dublin, and mouth cancer patient. To listen, scan the QR code. For further information, see www.mouthcancer.ie.

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Scan for clinical studies

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

UK-LI-2200277

Excitement building

Tickets are now on sale for the social event of the year – The Colgate Caring Dentist and Dental Team Awards 2024 – on Saturday, November 23, at the InterContinental Hotel Dublin. Dress code is black tie.

Of course, you can only book to go to the Awards if you have been nominated by a patient. So if you have received a letter from the IDA telling you that you have been nominated, congratulations and be sure to book your tickets quickly.

As the nominations closed on September 30, the entries are now being judged by the panel consisting of Drs Seton Menton, Clodagh McAllister, Siobhan Doherty and Tom Feeney. Expect great excitement as usual when the winners are announced on Saturday, November 23.

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Annual Conference 2025

Annual Conference 2025 will take place from May 15-17 at the Lyrath Estate in Kilkenny.

Pre-conference courses in endodontics, anterior composites, facial aesthetics, and sleep apnoea are all included on the agenda. We look forward to welcoming well-known national and international speakers, as well as having a full trade show in attendance. Full programme will be available soon.

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Congratulations to the class of '74

UCD BDS Class of 1974. Front row (from left): Dr Billy Davis, Wexford and Dublin; Dr Vincent Nolan, Dublin; Dr Brendan Flanagan, Roscommon and Sligo; and Dr Michael Loftus, Mayo. Back row (from left): Dr Martin Flynn, Clare and Kildare; Dr Niall Kilroy, Dublin and Mayo; Dr Reamon (Ray) Ryan, Dublin; and, Dr Ambrose McLoughlin, Galway and Meath.

The members of the UCD BDS class of 1974 recently celebrated their 50th anniversary reunion, where classmates gathered to catch up with old friends, and celebrate their lives and careers. Apologies and best wishes were received from Dr Mary Pigott Coleman of Dublin and Limerick, Dr Joe Glackin of Dublin, Dr Declan Molloy of Dublin, Dr Tom Hehir of Kilkenny, and Dr Donal Fitzgibbon of Longford.

The group sends best wishes to all their classmates and their families. May those colleagues who have passed rest in peace.

Bioclear method – limited places available in Cork

Dr Claire Burgess, in association with 3M and Optident, will bring her one-day Bioclear course to Cork on Friday October 18 and Saturday October 19. Limited places are currently available on both programmes. To book, go to www.dentist.ie and click on 'Book CPD'.

Online survey on dentists' antimicrobial use

An online survey is being conducted by researchers from the School of Pharmacy, the Dental School and Hospital in University College Cork and the HSE, which aims to investigate general dental practitioners' views and experiences of antimicrobial use and resistance.

Practising full-time or part-time dental practitioners are invited to participate in this anonymised online survey, which should take approximately 10 minutes to complete. Participation is voluntary. By clicking the link, or scanning the QR code, you will be able to complete the survey and will also be provided with further information on the research project.

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COLTENE

Henry Schein's Back to School programme

For the 27th consecutive year, Henry Schein provided backpacks full of school and dental supplies to help students worldwide start the academic year off right. The company states that its Back to School programme in Ireland, the US, Canada, and the UK is helping 5,300 students gain confidence and excitement for the school year, with more events planned in Italy and Spain.

According to the company, the Back to School programme reflects Henry Schein's enduring commitment to communities by empowering its staff with volunteer opportunities to support underserved children in partnership with local not-for-profit social service organisations.

Henry Schein Ireland partnered this year with Barnardos Ireland, a children's charity that provides support services to vulnerable children and their families, helping to improve their well-being, education, and overall quality of life. In Northern Ireland, the company brought the Back to School initiative to life by supporting Aspire NI, a charity dedicated to providing young people with an equal chance in education.

Henry Schein Ireland took part in the company's Back to School programme (from left): Adam Ringland, Telesales Henry Schein Dental NI Office; Norman Crowne, Field Sales Consultant, Henry Schein Dental NI Office; Siobhán Cleary, National Sales Manager, Henry Schein Ireland; Caitlin McCrea, Aspire NI; and, David Wilson, Telesales Henry Schein Dental NI Office.

The bright side of dentistry

Everyone should feel confident when they smile, states Coltene, and according to the company, if you want to help patients who are seeking teeth brightening, try its Brilliant Lumina product.

Coltene states that Brilliant Lumina is a comfortable treatment for patients, leaving them satisfied and without any tooth sensitivity. Coltene's unique formula is the first without hydrogen peroxide and carbamide peroxide. Instead, it uses phthalimido peroxy caproic acid (PAP) for a non-erosive effect on tooth structure that still gives a naturally brighter tooth shade.

According to the company, Brilliant Lumina is easy to use, with a simple treatment protocol that can be followed and performed by dental practice staff, under the prescription of a dentist. Adding the activator to the Brilliant Lumina gel, mixing it, and then applying to the teeth is a simple procedure, states Coltene.

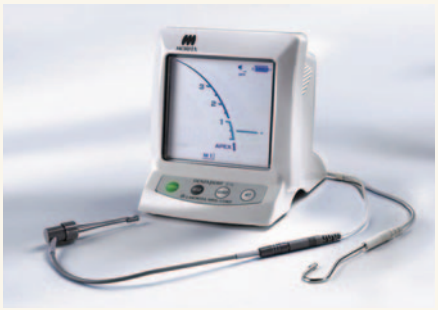
MY FAVOURITE PIECE OF EQUIPMENT

Dr Aisling Donnelly

Dr Aisling Donnelly has a practice limited to endodontics, and works in two practices – the Institute of Specialist and Cosmetic Dentistry in Dublin's IFSC, and Boyne Dental in Maynooth, Co. Kildare. Her favourite piece of equipment is her apex locator, and she uses one manufactured by Morita.

Apex locators measure the length of the root canal system, so for Aisling it's an essential tool for successful root canal treatment: "It's important to be accurate and to carry out the root canal treatment to the correct length. If it's too short, you may leave debris or bacteria in the root canal, which can lead to treatment failure. However, if it's too long, you might compromise the apical anatomy, push out debris, or extrude materials that could irritate the tissues".

Aisling says that it's essential to have a tool that you know you can trust, and the Morita apex locator fulfils that brief for her: "If you can't trust the accuracy of the apex locator, then treatment will be compromised. I've gotten used to interpreting the readings, so it lets me know if I'm at risk of going outside the root canal system. Some dentists rely on radiographs for this information, but I find the apex locator far more accurate".

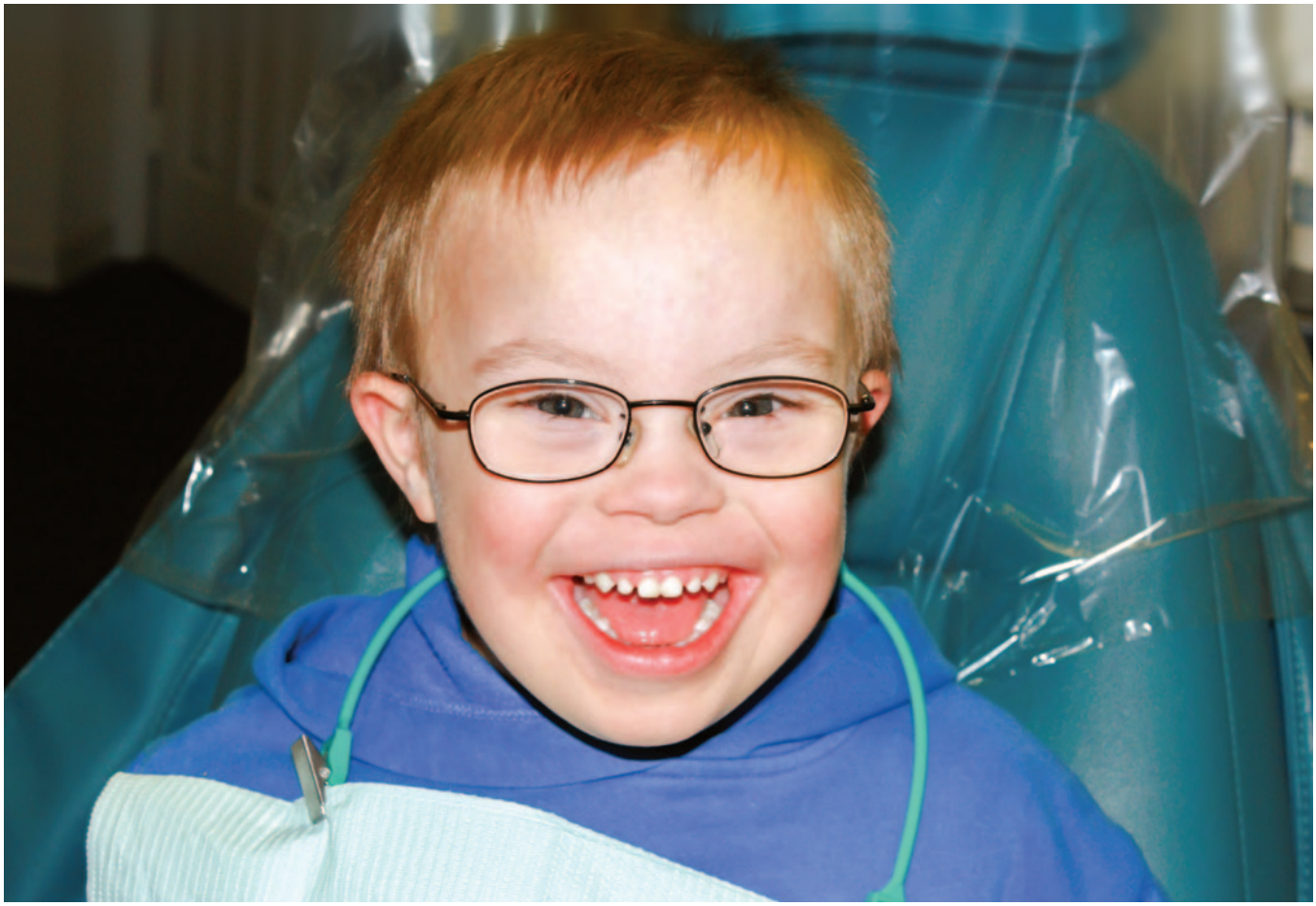


She says patients like it too, although it's important to explain what's happening: "There's a clip that you put on the patient's lip to close the circuit and allow the locator to work, and the machine beeps to let you know how far away or close you are, so you need to let the patient know what's happening".

Once it's explained, however, she finds patients are fascinated by this small gadget: "Patients love to know about the technology you're using, and really appreciate it when you go the extra mile to use the best equipment, and explain it fully to them".

A special kind of dentist

Special care dentistry is essential to our society and provides some of the most vulnerable children and adults with care that makes a massive improvement to their quality of life.



Here we speak to three dentists, two of whom work in children's hospitals in Dublin and one who also works in a hospital setting for the HSE. They talk about the challenges they face but also what they love about working with patients who may not get any oral care otherwise.

Colm Quinn
Senior Journalist,
Think Media Ltd

Dr Kirsten FitzGerald, Consultant in Dentistry, Crumlin Children's Hospital

Kirsten works at Children's Health Ireland at Crumlin, where she treats children with very complex needs. She began working there following postgraduate paediatric training in the US, and became a consultant in 2010: "Our principal work really is with children for whom their medical condition impacts on how dental care is provided and on what is provided".

Kirsten's cohort of patients includes children with the some of the most serious health problems in the country. This includes those who need cardiac surgery, oncology patients, those with hereditary bleeding disorders, complex skin conditions, and others. It's a challenging job but one she enjoys: "Every day is different. No two patients are the same. It's always about problem solving and finding a way around things or working out a solution to a tricky problem. And there's always a new problem. It's never the same one".

There is clinical complexity but also social complexity: "These are families who are carrying a huge burden and dealing with an awful lot, so managing to provide the care for them in a way that causes as little disruption as possible to their life is important".

It's normal to be upset when you see sick children and families that are under so much pressure. Kirsten says you learn to manage that: "What I find is the more difficult part is the fact that there's a moral injury in that I have to decline care to children who I know will benefit from it. Because we just don't have the resources to do it".

Kirsten says this lack of resources is the biggest issue: "We are having to ration care in a way that really doesn't feel right. We are having to say no to even very basic things. Every child with a new diagnosis of cancer should have a dental assessment at the outset, because we need to make sure that their dentition is in good shape so that they don't develop an infection during their treatment that could overwhelm them. We are, at this point, unable to offer that for all children".

Kirsten explains that resources for dental care for children with complex needs are extremely limited. Specialised paediatric health services and clinical programmes are planned at the national level, but the oral health needs of these children are not included in the funding. This further worsens the mismatch between resources and need. New treatment approaches are coming on stream all the time in paediatrics, and life-saving care is advancing rapidly. For example, in paediatric oncology and cardiology, many more children survive into young adulthood and beyond, with quality of life in survivorship being a huge area of focus. Good oral health is crucial to overall health and quality of life for all children, but particularly for these vulnerable patients, yet oral health services are not planned and funded as part of their care programmes. Investment is needed at primary, secondary and tertiary care levels to support the oral health needs of these complex patients.

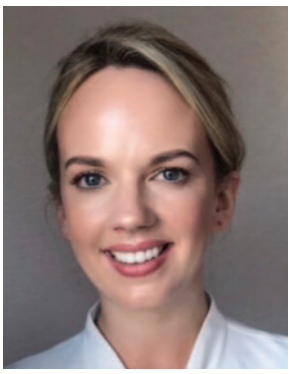
New technology can make a big difference but you need people there to operate it. For instance, Kirsten uses a therapy called photobiomodulation, which treats mucositis – an oral ulceration that you get with some types of chemotherapy. This machine can get children back speaking and eating, and get them out of hospital, but she says: "We've had to limit it to children undergoing stem cell transplant therapy because that's a particularly vulnerable group, and it's a group that we can manage the numbers. But we know there are hundreds of other children who would benefit from this treatment if only we had more people to do it".

A big worry for Kirsten is the transfer of care when patients grow older. She recently transferred a patient to adult care who was 20 years old, when this should be taking place at about 16: "The transition of young people with special health care needs into an adult dental care setting is really overlooked, and their dental needs become more and more complex as time goes by. There hasn't been a joined-up plan to look at the patient cohort".

On a positive note, Kirsten enjoys working with a multidisciplinary team in the hospital. She often engages with the anaesthesia team because she often needs to treat patients under general anaesthetic (GA): "Either their needs are so great and overwhelming that they wouldn't manage it over a large number of visits, or maybe they're just not cooperative at all, or the urgency of treatment is such that we need to get it done ASAP". Kirsten would like other dentists to know that she is there to answer questions: "We might not always be available on the spot, but we are very happy to help dentists to provide care for children as close to home as possible, if that's a good idea. So we're very happy to talk with dentists and to help them plan a case and to give advice and support them in that way. I think that's not something that a lot of dentists might think of".

Don't be afraid to refer either, says Kirsten: "I know our waiting lists are terribly long, but unless patients are referred, they're invisible".

"Every child with a new diagnosis of cancer should have a dental assessment at the outset… We are unable to offer that for all children."



Dr Geraldine McDermott, General Dental Surgeon, Cavan/Monaghan Primary Care Dental Services

Geraldine provides comprehensive dental treatment in Cavan and Monaghan for children in targeted classes, an emergency dental service for children under 16 years of age, and an emergency service for special care children and adults. She operates a paediatric dental extraction GA list at Cavan General Hospital and an occasional emergency special care dental GA service for adults and children. This list covers a wide array of comprehensive dental treatments the special care patient may require: "I completed a postgraduate diploma in conscious sedation in dentistry, so children with dental anxiety can be treated with nitrous oxide sedation in the primary care setting and this can be tapered to their needs, allowing them the opportunity to develop coping skills for dental care".

Working with patients who have special care needs is something Geraldine loves doing: "I love developing relationships with my special care patients, as within the HSE community service we become their dental home. These relationships are prudent in establishing and maintaining oral health and improving the quality of life for special care patients".

The patients Geraldine sees often struggle to access dental care because of their complex and sometimes competing medical needs. They may have physical or intellectual disabilities, sensory issues or severe dental phobias. For sensory issues, patients and their parents/carers may be given a sensory story, which explains what their visit to the dentist will be like and what will happen during it. Another thing she finds helpful is to speak to the parents or carers beforehand: "They are able to inform me of what the patient would be more comfortable with or what causes them anxiety. It's just trying to be as prepared as possible".

Another aspect Geraldine enjoys is the problem solving that is required to treat patients who often have very unique needs: "This involves a large multidisciplinary team, from organising admission with the appropriate hospital ward if treatment under GA is needed, communicating with relevant medical specialists and consultant anaesthetists, to discussing instructions with the patients' families and carers, and managing postoperative care. I have an excellent team of dental nurses as well".

The importance of having special care dentists, says Geraldine, is that these patients

can have very high treatment needs that can be missed: "Special care patients, especially non-verbal patients, suffer in silence. They suffer distress and anxiety due to pain and sadly it takes a while for parents/carers to realise this is due to dental infection".

It's great to be able to provide services to patients locally, says Geraldine: "It is wonderful to provide this service locally instead of patients having to travel to Dublin for their care, and this also strengthens the links between hospital and community clinics. It's a patient-centred experience".

Patients don't have the burden of having to travel to Dublin for treatment, possibly while in pain, and also Geraldine says: "It helps me develop relationships with their carers and the patients so that if they're coming back, they're coming back to us because we're the dental home as such for the special care patient".

One of the biggest challenges is the lack of resources: "There is an increase in demand for dentistry for special care patients and unfortunately there are not enough special care dentists in posts".

There is only one senior dental surgeon providing care for vulnerable and special care patients in Cavan/Monaghan HSE. The area had received approval for two additional senior dental surgeon posts, but because a HSE hiring embargo was imposed and then a decision was made to suppress any posts that had been vacant since before December 31, 2023, the area lost these positions: "This is having a big impact on our most vulnerable patients and their oral health, and means presently we are really limited to providing an emergency service only".

"There is an increase in demand for dentistry for special care patients and unfortunately there are not enough special care dentists in posts."

Dr Eleanor McGovern, Consultant Paediatric Dental Surgeon, Children's Health Ireland at Temple Street Hospital

Eleanor works as a Consultant Paediatric Dental Surgeon at Children's Health Ireland at Temple Street, providing dental care for children with very complex and integrated care needs: "We primarily provide dental care for children with cleft lip/palate, craniofacial conditions, children born with inherited metabolic disorders, rare bone disorders, children with severe renal disease who are often pre or post renal transplant, and children attending neurology, neurodisability and neurosurgery services. A significant number of the patients attending our service present with life-limiting conditions and many are also under palliative care teams. Dental care for many of these patients can only be carried out in a tertiary hospital setting and with good support from our medical colleagues".

Over the last number of years Eleanor has seen a significant increase in the number of children under neurology, neurodisability and neurosurgery services who are referred for dental care. These referrals are mostly from other paediatricians as well as dental colleagues. Many of these children present with significant behavioural as well as medical and dental challenges. Some children present with severe epilepsy and regular dental injury due to seizures. Others present with dental injury, as well as multiple other injuries, following road traffic accidents.

Although the dental service is generally limited to children with complex medical needs, some of these children also present with highly complex and challenging social needs: "A number of our patients are under the care of the State. There is regular communication with medical social workers as well as with Tusla".

Eleanor also works with many vulnerable children from minority groups such as the Roma community, as well as children who are in Ireland under international protection: "Many of these children present with complex psychosocial, cultural, and language barriers and challenges. Before we can even start to provide dental care, which is usually urgent, we frequently need to liaise with multiple other agencies and teams, and require translation services on a very regular basis".

The team has developed a dentistry with music therapy service for its patients in recent years: "This involves a trained music therapist (MT) meeting the patient in the waiting room prior to the dental appointment and working out a music therapy plan. The MT then accompanies the child/young person and parent/guardian into the dental clinic and works with them throughout the dental appointment. The music therapy works to relax the child as well as providing lots of distraction, particularly for dental procedures that the child might find more difficult. Throughout the session there is lots of singing and strumming of the guitar and use of a variety of drums, bells and percussion instruments. We have provided dental care to multiple children with complex needs who may have otherwise required dental care under general anaesthesia, or who due to their medical condition would never have been suitable for GA and would therefore never have had the dental care that they need. The feedback we have received from families has been overwhelmingly positive, and our team has won a number of awards for this initiative, which has really allowed us to provide patient-centred care". Part of what Eleanor likes about the job is working with her dental colleagues from across the hospital, community and private dental sectors in delivering dental care for each child. She is also very interested in the medical aspect of the job and working with multiple different multidisciplinary teams: "I am really privileged to work alongside so many esteemed colleagues, as well as to be part of such specialised multidisciplinary teams".

The biggest challenge is the waiting list and access to the service: "There's never enough services for everybody, and there are waiting lists. We would like to be able to give everybody their treatment straightaway but there are limitations on the service. This is very frustrating for staff, families and patients".

The other big challenge is the lack of specialist dental services for patients once they reach 16 years of age and are transitioned to adult services. As young people with highly complex medical needs survive longer due to advances in medical care, there needs to be an increase in hospital-based specialist dental services where patients can receive the dental care required with the support of their medical teams as necessary.

Finally, Eleanor says it is a privilege to work with children with complex medical needs and to provide their dental care.

"We are providing dental care for some of the most complex children in the country and are delighted that this article may shine a light on the work we do."

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[1] Gianasmidis A, DZW 2016 (39), p. 18–19, additional data on file.

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Volume 70 Number 5
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MEMBERS' NEWS

Starting dentistry and making it work

At the Hilton Hotel in Dublin 2 on Friday, September 13, dentists at the beginning of their careers, and those with questions around finance and dentistry, met for two IDA events. Starting Dentistry in Ireland looked to answer questions any dentists newly qualified or arrived in Ireland may have, while in a separate room, Personal Finance was focused on the Show Me the Money event.

Dr Stephen Taylor got his first job through the IDA classified adverts, and said figure out what you want and move to a practice where you can achieve it. It's important to get familiar with your practice quickly and know where everything is. He also spoke about financial advice, such as to be sure to get

David McCaffrey of MedAccount.

Dr James Goolnik of Bow Lane Dental Group.

Then there are system factors. George noted the underfunded nature of the NHS in the UK, which applies to the State schemes in Ireland as well. There are factors relating to the dental professional, such as how they're feeling, and their training in handling difficult situations.

George encouraged effective skills and strategies such as empathy, active listening, and asking open questions. When a patient has an issue, he recommended the AID model:

When dealing with patients, he said personal connection is vital. Be honest if there is a problem, and if someone wants their money back, it's often easier to just give it to them and move on.

Getting started

Roisín Farrelly, Director of Communications and Advocacy at the IDA, went through what dentists need to know when they start working in Ireland, from the steps of registering with the Dental Council, to the types of jobs available.

IDA President Dr Rory Boyd.

From left: PJ O'Brien, OBP Consultants; Dr Tom Feeney; Dr Morgan O'Gara; Billy Sweetman, PwC; and, Roisín Farrelly, IDA Director of Communications and Advocacy.

Declan Egan of Omega Financial Management talked to attendees about income protection. This is hugely important for dentists, he said, because of the physical nature of dentistry. If someone in an office job gets injured, there is a good chance they will be able to continue work, even while injured, but this is not the case with dentists. Income protection provides you with an income if you can't work for any medical reason.

agreement in place specifying how long you will stay on, and on what terms, and recommended staying for at least a year.

Managing wealth

John O'Connor of Omega Financial Management discussed protecting and growing your wealth, and also the most tax efficient ways to pass it on.

Dr Karl Cassidy.

discussed the various tax reliefs available on retirement, and strongly advised getting good professional advice to enable you to maximise those reliefs.

John Connellan emphasised the importance of ensuring that all practice documentation is in order prior to a sale. He said that while transactions are definitely taking place, indications are that 2022 was the peak of the market, and transactions are taking longer to complete.

Sourcing finance

PJ O'Brien of OBP Consultants looked at buying a practice and sourcing finance in a difficult landscape. His advice was to seek professional assistance early from someone who can act as an intermediary with banks, ask the right questions, and help you to navigate the process.

He discussed some of the payment options available, using case study examples to talk about deferred payments and fees. He also listed some of the items he requires from a client before approaching a lender, such as a short biography, two years of accounts, bank and mortgage statements, accounts of the practice you want to buy, projections for that business, details of equipment in the practice, and a purchase agreement.

Like other speakers, he said that transactions are extremely slow, with lenders taking a long time to process applications.

Getting your house in order

The final speaker of the seminar was Billy Sweetman of PwC. It is prudent to make a business as good as it can be while you're still there, as this benefits you, your staff, and your patients, but undoubtedly a well-run, well-operated, growth-oriented business will sell for more, he said.

Billy went through a detailed description of the stages of selling a business. He emphasised the importance of having all documentation in order so that due diligence can proceed as smoothly as possible. This may seem like a daunting task, as the range of documents needed is vast, so all the more reason to start getting things in order now. If you do nothing else today, he said, commit to making a plan for your business. Your business will change hands eventually, so it's far better if the change is on your terms.

The personal perspective

At the end of the day, attendees at the two seminars came together for a panel discussion chaired by IDA President Dr Rory Boyd. Several of the speakers joined the discussion, and the panel was also joined by Dr Tom Feeney, retired dentist and former IDA President, and Dr Morgan O'Gara. Morgan purchased Tom's practice in Blackrock, Co. Dublin, and they each spoke candidly about the process.

Tom spoke about his decision to make a planned exit, rather than one forced by ill health or other circumstances, and said he prepared by taking due diligence issues one by one until he had dealt with each element.

Morgan had always wanted to buy his own practice, and had already experienced a sale falling through while working in Australia, so says he came to the process with a very realistic attitude. They both spoke about the benefits and challenges of practice ownership, praising the freedom and sense of achievement that it can bring. Challenges include rising costs and dealing with staff issues, but there were no regrets on either side.

Dysphagia in adults and its relationship with oral health and dental treatment

Learning outcomes

After reading this article, the reader should:

- increase their understanding of dysphagia and its implications for oral care; and,
- be able to manage dental treatment for patients with dysphagia safely.

Introduction

Dysphagia is the medical term for swallowing problems and is defined as "difficulty in swallowing or impairment in the movement of swallowed material from the pharynx to the stomach".[1] Normal swallowing occurs in the following three phases:

1. Oral – the conversion of food into a bolus that is then transported to the back of the oral cavity.
2. Pharyngeal – pharyngeal swallow is rapid and sequential, occurring within seconds, propelling the bolus through the pharynx into the oesophagus. The larynx and trachea are protected from the pharynx during food passage to prevent the food from entering the airway. Breathing stops momentarily to allow the vocal folds to come together.
3. Oesophageal – peristalsis transports the bolus through the oesophagus, and the lower oesophageal sphincter opens as the bolus approaches the stomach.

Dysphagia can be categorised by the location of the swallowing impairment, but for the purpose of this article, we will use the term dysphagia.

Incidence and causes of dysphagia

The prevalence of dysphagia in the general population is estimated at 16-23%, increasing to 27% in those over 76 years of age. It is higher in the presence of neurological diseases, such as dementia, Parkinson's disease or stroke.[2] Estimated incidences of dysphagia are shown in **Table 1**.[3]
Dysphagia typically occurs secondary to primary medical conditions (**Table 2**).

Table 1: Estimated incidence of dysphagia among patient groups.

Nursing home residents	50-75%
Post head and neck cancer treatment	50-60%
Post stroke	40-78%
Multiple sclerosis	33%
Chronic obstructive pulmonary disease	27%
Learning disabilities	5%
Hospital	36%

Table 2: Medical conditions associated with dysphagia.

System	Condition
Nervous system	Stroke, Parkinson's disease, dementia, amyotrophic lateral sclerosis, multiple sclerosis, brain tumours
Respiratory system	Chronic obstructive pulmonary disease, congestive heart failure
Cervical spine	Cervical fracture
Oesophageal and gastrointestinal disorders	Gastrointestinal motility disorders secondary to scleroderma, achalasia, oesophageal spasm, eosinophilic oesophagitis, hiatus hernia, oesophageal stricture
Cancer	Head and neck cancer, lung cancer with metastasis to the lungs, thyroid cancer with compression of the oesophagus, lymphadenopathy
Psychological	Eating disorders (anorexia or bulimia nervosa), post-traumatic stress disorder, functional neurologic symptom disorder (functional dysphagia), dementia
Medication	Anticholinergic medications (e.g., antidepressants, antipsychotics), calcium channel blockers, non-steroidal anti-inflammatory drugs, bisphosphonates, chemotherapeutic agents, muscle relaxants, sedatives

Impact of dysphagia

The consequences of dysphagia will depend on the severity of the condition and include an increased risk of aspiration of oral matter, malnutrition, dehydration, choking, decreased quality of life, and increased frailty.[4]

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Table 3: General and oral signs and symptoms of dysphagia.

General signs and symptoms	Oral signs and symptoms
Food and liquid escaping from the mouth	Difficulty in chewing
Taking a longer time to eat and drink	Dry mouth
Nasal regurgitation	Drooling
Food sticking in the throat	Food being retained in the mouth
Coughing and choking	Difficulty in chewing
Regurgitation	
Wet voice	
Weight loss	
Repeated chest infections	

Dysphagia can be painful, and individuals are often embarrassed about living with dysphagia. There can be a loss of enjoyment of food and increased social isolation.[5] The signs and symptoms of dysphagia are listed in **Table 3**.

A comprehensive medical history and physical examination by the multidisciplinary team will help to determine the aetiology of dysphagia and will often lead to a diagnosis. Speech and language therapists can undertake swallow assessments to assess the swallow with a small amount of liquid. Videofluoroscopy can be undertaken, where a subject swallows food with barium and real-time moving images of swallowing are obtained radiographically. Fibreoptic endoscopic evaluation of swallowing (FEES) is where a flexible nasendoscope (digital or fibreoptic) is inserted transnasally to directly visualise naso-/oro- and laryngopharyngeal structures, secretions, sensory response, and pharyngeal swallow function.

Aspiration pneumonia and dysphagia

Aspiration has been defined as the misdirection of oropharyngeal or gastric contents into the larynx and lower respiratory tract, and is a significant health risk for adults with dysphagia due to the associated risk of aspiration pneumonia.[6,7] Poor oral hygiene leads to the oral cavity becoming colonised by large numbers of potentially pathogenic microorganisms that, if aspirated, can lead to aspiration pneumonia, a condition with high morbidity and mortality rates.[8] Hence, educating patients and their carers about regular, effective oral care and the links to aspiration pneumonia is very important.

Management of dysphagia

The management of dysphagia will depend on the cause and may aim to restore normal swallow function or may include modifications to diet consistency and patient behaviour. Rehabilitative techniques often focus on exercises to achieve lasting change in an individual's swallowing by improving underlying physiological function. Postural techniques aim to redirect the movement of the bolus in the oral cavity and pharynx, and include head rotation after a stroke to redirect food towards the stronger side of the pharynx. The use of capsaicin has been found to have some benefit in longstanding dysphagia.[9]

In patients with severe dysphagia, it may be necessary for enteral feeding via the jejunum with a nasojejunal tube (NJT), or percutaneous endoscopic gastrostomy (PEG) or radiologically inserted gastrostomy (RIG) tube feeding, which are surgically placed in the stomach.

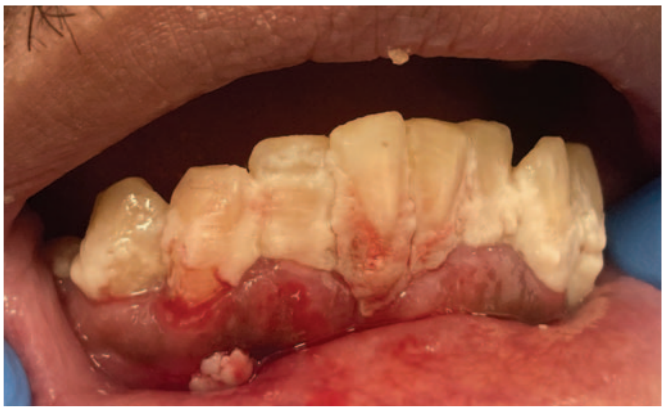

FIGURE 1: Poor oral care post stroke in a patient with dysphagia.

FIGURE 2: Example of a suction toothbrush.

Impact on oral health

There are two main reasons why dental teams must be aware of the importance of dysphagia:

1. Importance of effective daily oral care.
2. Impact on the delivery of dental treatment.

Adults with dysphagia often have increased levels of dental disease as a result of poor oral clearance, resulting in food stagnation in the mouth.[10] Additionally, a dry mouth as a side effect of medication can increase the risk of caries, periodontal disease, and candida infections.[11]

Oral care

The prevalence of caries and periodontal disease is higher in people with dysphagia. Often, patients with dysphagia will need support from a carer, family member, or healthcare professional to maintain a good standard of oral care to prevent dental disease. Furthermore, poor oral hygiene increases the risk of developing aspiration pneumonia. Unfortunately, standards of oral care in care homes and hospitals have been found to be substandard (**Figure 1**), highlighting the need for effective training programmes and accountability for oral care standards.

The dental team's role is to risk assess the patient and advise modifications to their oral care routine to optimise their oral health. This can include:

- an upright or semi-upright posture during oral care can reduce the risk of aspiration;
- people with dysphagia should have mouth care at least three times a day to remove food debris and excess saliva secretions;
- suction toothbrushes that attach to a patient's suction machine or use of oral suction with mouth care (**Figure 2**);

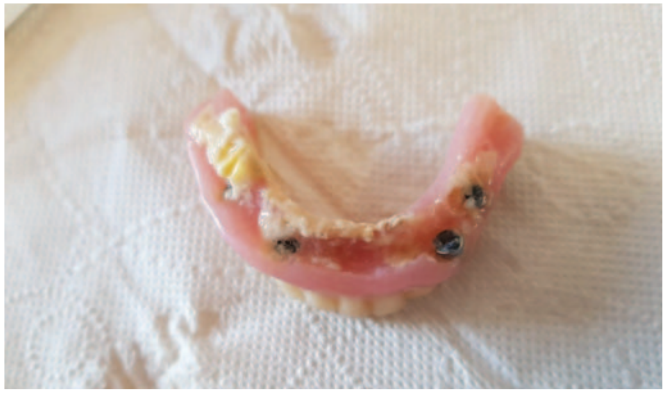

FIGURE 3: Food stagnation on lower implant-retained denture.

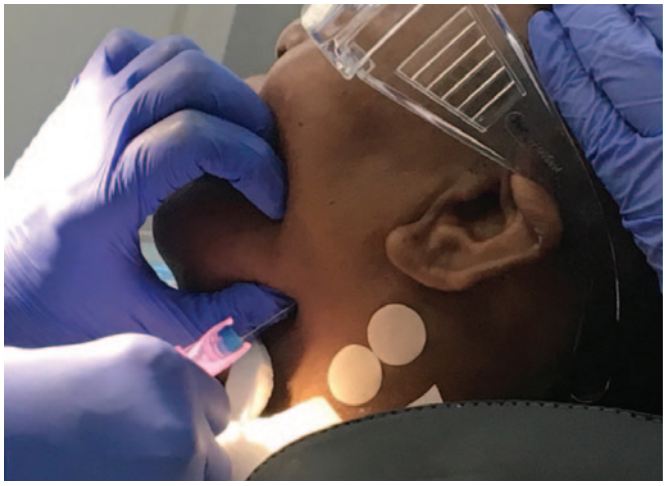

FIGURE 4: Hysocine patches and botulinum toxin injected into salivary gland.

- a pea-sized amount/smear of sodium lauryl sulphate-free toothpaste reduces the foaming action of toothpaste – there are several brands available in most high street shops;
- high-fluoride toothpaste can be prescribed for orally fed patients who have a dry mouth and food stagnation;
- patients may be taking regular nutritional supplements or high-calorie snacks and should be advised, if possible, to brush teeth with a fluoride toothpaste after eating or rinse their mouth out with water to reduce food stagnation;
- caregivers should be advised to remove food residue lodged in the mouth's buccal vestibules, tongue and palate for those who cannot rinse effectively after eating;
- people with dysphagia often have dry mouths, so regular dry mouth care, including sips of water and stimulation of saliva, for example with sugar-free chewing gum or sugar-free sweets, is important for those who can have oral fluids – mouth moisturising products in gel or spray form can be used for non-orally fed patients;
- dentures should be cleaned after mealtimes to prevent intra-oral food stagnation (**Figure 3**). They should be removed at night and safely stored in a named denture container to prevent them from getting lost; and,
- mouth care for non-orally fed patients is very important, and can sometimes be overlooked.

Table 4: Dental considerations and management for people with dysphagia.

Consideration	Management
Treatment positioning	Where possible, do not treat supine – may need to compromise and have patient semi-upright
Airway protection	Rubber dam isolation where appropriate Gauze behind teeth when extracting
Reduce water	Hand scaling over ultrasonic scaling Slow handpiece is preferred where possible Reduce water when using ultrasonic scaler and handpieces High-volume suction with saliva ejector used simultaneously Carboxymethylcellulose pads in the buccal sulcus
Allow frequent rests	Hand sign when they need a rest Countdown from five
Dental care	Aim to make teeth cleansable Use of minimally invasive dentistry over conventional methods Local infiltrations preferred to nerve blocks, which may further reduce swallowing ability Repair rather than replace restorations Consider using fast-setting restorative materials
Prosthodontic considerations	Fast-setting impression material Caution taken when working with small dental components Advise patients with unretentive dentures not to wear them due to the risk of aspiration or accidental swallowing

Management of inadequate saliva control

It is often assumed that drooling results from excessive saliva production (sialorrhoea), but this is not the most common reason. The main cause of drooling is when a person has problems with posture, muscle control, nasal obstruction, or difficulty keeping their lips together. Collaboration with speech and language therapy for techniques to improve motor control is beneficial. The use of anticholinergic medications such as glycopyrronium has proven effective in reducing saliva. Hyoscine patches can be applied topically behind the ears; however, there have been some reports of adverse reactions that might impact their use going forward.[12] Salivary gland injection of botulinum toxin will reduce salivary production in that gland; however, its effects are transient, lasting three to six months (**Figure 4**). Surgery may be considered in cases where alternative therapies have been unsuccessful.

Dental intervention

As people with dysphagia have increased oral health risk factors, regular visits to the dental team are important. Patients with dysphagia may be anxious about choking or the sensation of being unable to swallow during treatment. Dentists/hygienists and therapists should ask specifically about dysphagia if a patient has a history of a condition associated with dysphagia (**Table 2**), and should look for common signs and symptoms (**Table 3**). Modifications to dental interventions can be made to deliver care safely (**Table 4**).

Conclusion

Dental professionals will increasingly care for patients with dysphagia as the population ages with increased medical comorbidities. Dental teams must be

aware of patients who are more at risk of dysphagia, and educate patients and carers about the links between oral health and aspiration pneumonia. Patients with dysphagia may have anxieties about having treatment and modifications to dental treatment can be made to ensure that it is delivered safely.

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Quiz

Submitted by Dr Clair Nolan BDS NUI MSc (Endodontics) ULond

The treatment of deep carious lesions is performed daily in general dental practices. Selective carious tissue removal (one-stage or two-stage stepwise technique) is now recommended in teeth with signs of reversible pulpitis. However, there is a risk of pulp exposure during operative treatment when treating these deep carious lesions, as in the following case, and the correct management of the pulp exposure is essential to maintain the health of the pulp.

A 40-year-old female presents with a sharp pain on eating and drinking, especially cold drinks, which lasts for a few seconds. Her sleep is not disturbed. On clinical examination there were probable caries in the mandibular left second molar tooth, with no tenderness to percussion or palpation. A bitewing radiograph (**Figure 1**) was taken. The soft caries were removed and a carious pulp exposure occurred.

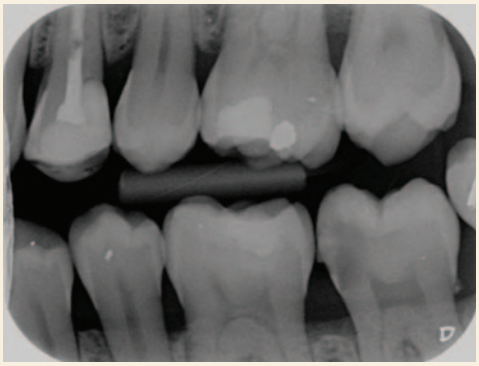

FIGURE 1: Bitewing radiograph.

Questions

1. Based on the classification of caries described by Bjørndal (2018), how would you describe the caries seen in the radiograph?
2. In addition to the clinical examination of the tooth, detailed pain history and radiographs provided in this case, what other special test should be performed prior to treatment to complete the assessment of the carious tooth?
3. What is the current recommended treatment protocol for teeth, similar to this case, presenting with extremely deep caries with carious exposure of the pulp showing signs of reversible pulpitis?
4. Following the vital pulp therapy (VPT) procedure that was performed in this case, how should the tooth be monitored long term?

Answers on page 253

Irrigants in endodontics

Which are the best irrigants in endodontics and how are they used?

Background

In endodontics, the root canal system requires both mechanical and chemical preparation to achieve the goal of resolving or preventing apical periodontitis. Endodontic instrumentation alone may not access all pulp space surfaces and irregularities. Thus, root canal irrigants should possess ideal characteristics, including broad-spectrum antimicrobial properties, pulp tissue dissolution ability, periradicular tissue biocompatibility, lubricating action, chelating action to remove smear layer, and minimal allergic potential.[1] Although no substance yet combines all of these characteristics, clinicians must choose from the current available irrigation methods and materials. This article aims to review the irrigants that are most frequently used in endodontics and provide clinicians with tips on how to use them appropriately.

Sodium hypochlorite

The literature widely supports the use of sodium hypochlorite (NaOCl) solution as a root canal irrigant, as do the European Society of Endodontology and the American Association of Endodontics.

NaOCl is considered the gold standard irrigant mainly due to its antimicrobial and tissue-dissolving actions (**Figure 1**), and it can be found in concentrations of 0.5-6%. The most widely used, for safety reasons, are concentrations ranging from 0.5-2.5%. To maximise the effectiveness of NaOCl irrigation, the solution should be frequently refreshed and kept in motion by agitation or continuous irrigation. The speed of tissue dissolution can be increased with effective agitation and refreshment.[1] **Table 1** summarises the key pros and cons of NaOCl usage.

Complications and accidents

Despite its great advantages, NaOCl can be cytotoxic, and this can be a concern. NaOCl may extrude beyond the apical foramen, causing reactions ranging from mild discomfort to serious tissue damage.

Clinical tip

To help prevent these complications:

- use needles with lateral exit, at a depth short of the patency length of the root canal;
- control the force exerted on the syringe plunger during irrigation;
- do not let the needle stick to the root canal walls; and,
- opt for regular replacement of a weaker NaOCl solution (1-2.5%) with larger volumes, rather than using a higher concentration.

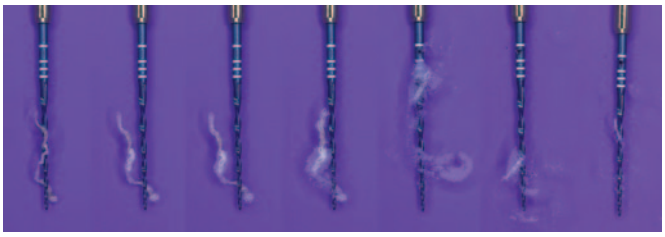

FIGURE 1: Evolution of tissue dissolution observed in pulp after a 40-minute exposure to 2.5% sodium hypochlorite.

Table 1: Main advantages and disadvantages of using NaOCl solution in endodontic treatment.

Advantages	Disadvantages
Antimicrobial activity	Cytotoxicity
Ability to dissolve pulp tissue	Delicate storage
Bleaching action	Strong smell
	Stains clothes

Chlorhexidine

The literature also supports the use of chlorhexidine (CHX), which is available in 2% aqueous solution and gel forms. Some of its desirable properties include antimicrobial activity and substantivity (residual action). However, unlike NaOCl, CHX does not dissolve pulp tissue, and this is one of its main disadvantages. CHX can be used as an alternative to NaOCl, especially in cases of necrotic teeth with an open apex, or when the patient reports an allergy to NaOCl. 2% CHX may also be considered for the final rinse after smear layer removal by ethylenediaminetetraacetic acid (EDTA). Care must also be taken with extrusion accidents, especially when using liquid CHX.[2]

Clinical tip

How to use 2% CHX gel:

- fill the canal with 2% CHX gel;
- start instrumentation;
- flush the canal with inert solution (saline solution or distilled water) to remove 'dirty' CHX gel;
- refill with 'fresh' 2% CHX gel;
- proceed with instrumentation; and,
- repeat until instrumentation is finished.

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Table 2: Main effects of irrigant mixtures and how to prevent by-product formation.

Combination	Reaction product	Clinical effect	How to prevent by-product formation
NaOCl + CHX	Orange-brown precipitate (Figure 2)	Potential discolouration and leaching of unidentified chemicals into the peri-radicular tissues.	Washing the root canal with a 5% sodium thiosulphate solution neutralises NaOCl.
NaOCl + EDTA	Chlorine gas bubbles	Low or null effect on calcium-chelating ability of EDTA.	Intermediate flushes with distilled water.
CHX + EDTA	Milky white precipitate	Unclear	Intermediate flushes with distilled water.

FIGURE 2: Brown precipitate (parachloroaniline) formation when 2% CHX was mixed with 2.5% NaOCl.

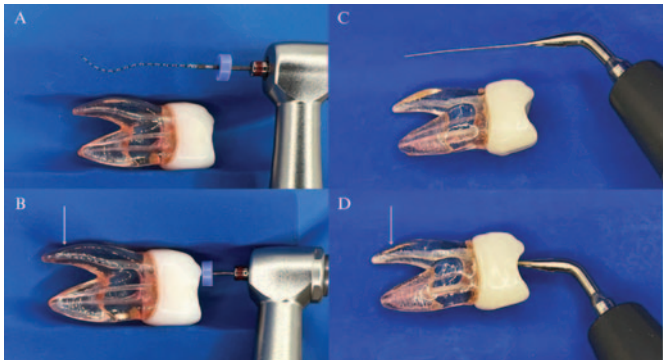

FIGURE 3: A and C: Xp-endo Finisher (FKG), and ultrasonic tip Irrisonic (Helse). B and D: Same instruments inserted into a root canal, 3mm short of canal length (arrows).

Ethylenediaminetetraacetic acid

EDTA (15-17%) is usually used after instrumentation, as a chelating agent to remove the inorganic component of the smear layer produced during root canal instrumentation, followed by an irrigation with NaOCl to remove the smear organic residue.

Effects of combining irrigants

Association of substances may lead to undesirable by-products, forming a chemical layer that can occlude dentinal tubules and interfere with filling.[3] **Table 2** shows the main effects of irrigant associations.

How to irrigate the root canals

Irrigants are typically delivered into the root canal using a disposable syringe and a fine needle (27-30 gauges) capable of reaching 2-3mm short of the canal length. Gentle pressure with a flow rate of around 4mL/min ensures effective and safe irrigation.[4]

Clinical tip
Activation

Traditional needle and syringe irrigation may fail to reach the full canal length. Enhance irrigant action with an agitation method, especially as a final step. This is known as dynamic/active irrigation.

Manual dynamic activation

- Flood the root canals with irrigant and place a well-fitting gutta percha cone 2-3mm short of the canal length; and,
- perform a repeated 'in and out' movement at a rate of around 100 strokes per minute, for one minute.[5]

Sonic irrigation

- Operate a sonic system such as EndoActivator System (Dentsply Sirona, USA), positioned 2-3mm within the root canal, at 10,000 cycles per minute for one minute.[5]

Passive ultrasonic irrigation (Figure 3)

- Set the ultrasonic device to 10% power;
- position a thin insert, like Irrisonic E1 (Helse Technology, Brazil), 2-3mm short of the canal length or until the curvature;
- activate for three 20-second cycles; and,
- refresh irrigating solution at the start of each cycle.

XP-endo finisher (FKG, Switzerland) (Figure 3)

- Calibrate the instrument to a position 2-3mm short of the canal length;
- cool the file with a coolant spray just before inserting it into the canal to maintain the straight shape; and,
- activate it with a rotary motion at 800-1,000rpm and 1N·cm of torque, for one minute.

Conclusion

Irrigation is an important step in endodontic treatment and must not be neglected. Appropriate chemicals and agitation optimise the effects of the irrigant, enabling more predictable patient care outcomes to be achieved.

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Coronectomy? A case report following coronectomy of a 'high-risk' mandibular third molar

Précis: Coronectomy presents as a viable alternative surgical option for the removal of mandibular third molars that are at high risk of inferior alveolar nerve damage.

Abstract

Background: The surgical removal of a mandibular third molar (M3M) is a common procedure performed by oral and maxillofacial surgeons, oral surgeons and general dental practitioners. Apart from risks such as pain, swelling, bruising, bleeding, trismus, alveolar osteitis, postoperative infection and damage to adjacent structures, which are common to all surgical extractions, M3M removal includes the risk of permanent or temporary damage to the inferior alveolar nerve (IAN) or the lingual nerve. IAN damage can significantly impact on quality of life (QoL) due to an altered sensation of the lip and chin area. As such, the alternative surgical option of coronectomy, which is the sectioning of the crown from the tooth and deliberate retention of the roots, can be offered to high-risk cases to avoid IAN damage.

Case presentation: A 36-year-old female patient was diagnosed with recurrent pericoronitis of her left M3M. Her left M3M was partially erupted and horizontally impacted, with bulbous roots that were in close proximity to the IAN. Due to a higher risk of IAN damage, she underwent a coronectomy procedure of her left M3M instead of a complete removal. She experienced typical postoperative pain and swelling, but no other complications such as altered nerve sensation were reported. The surgical site was healed with full mucosal coverage after 12 weeks.

Conclusion: Coronectomy provides a viable alternative surgical option for removal of M3Ms that are at high risk of IAN damage. This is due to the significant reduction of risk of IAN damage and low incidence of failure.

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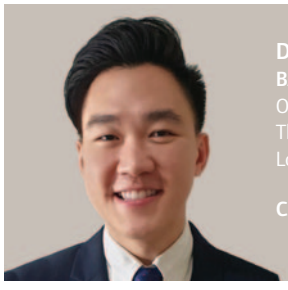
Introduction

The surgical removal of the mandibular third molar (M3M) is a common procedure performed by oral and maxillofacial surgeons, oral surgeons, and general dental practitioners. In England, it has been estimated that more than 150,000 patients have third molar surgery each year.[1] Most M3Ms that require surgical removal are usually impacted due to failure of eruption into occlusion beyond their chronological age of eruption.[2] The impaction of third molars, especially in the mandible, is reported to occur in 58% of individuals, and can cause a myriad of clinical issues such as pain, swelling and infections.[3] The benefits of M3M removal may include rendering the area free of symptoms or disease. However, apart from risks such as pain, swelling, bruising, bleeding, trismus, alveolar osteitis, postoperative infection, and damage to adjacent structures, which are common to all surgical extractions, M3M removal includes the risk of permanent or temporary damage to the inferior alveolar nerve (IAN) or the lingual nerve.[4] IAN damage can significantly impact on quality of life (QoL) due to an altered sensation of the lip and chin area. Factors such as horizontal impactions, close radiographic proximity to the inferior alveolar canal, or patients over the age of 24 years, are associated with significantly higher risk of IAN damage.[5] As such, the alternative surgical



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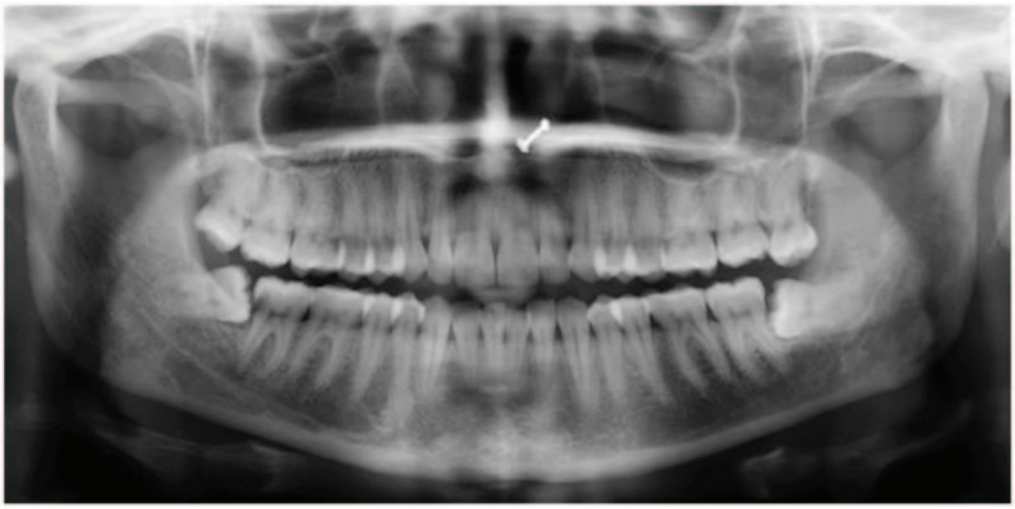

FIGURE 1: Full orthopantomogram of acceptable quality.

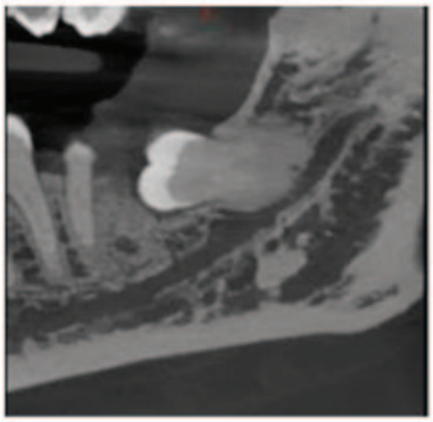

FIGURE 2: CBCT LL8 sagittal view.

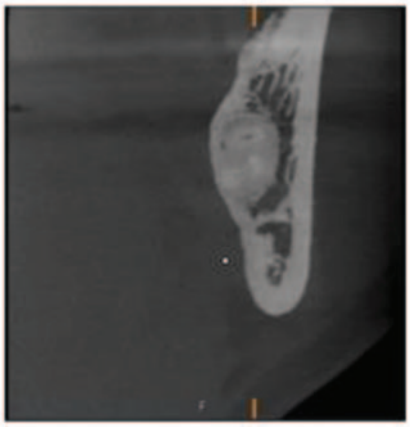

FIGURE 3: CBCT LL8 coronal view.

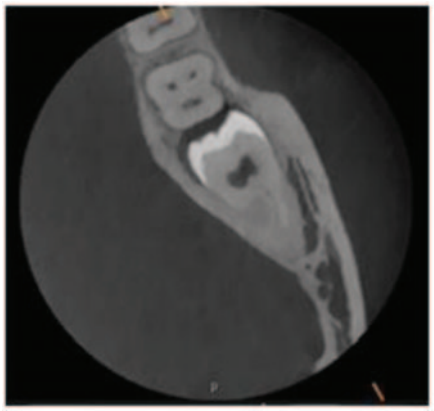

FIGURE 4: CBCT LL8 axial view.

option of coronectomy, which is the sectioning of the crown from the tooth and deliberate retention of the roots, can be offered to high-risk cases to avoid IAN damage.[6] This case report discusses a patient who underwent the alternative surgical option of coronectomy for her left M3M – which had a high risk of IAN damage – instead of a surgical removal.

Case presentation

A 36-year-old female was referred by her general dental practitioner to the oral surgery department at the Royal London Dental Hospital regarding her left M3M. The patient complained of recurrent throbbing and aching localised pain from the left M3M, which had occurred for over six months. The pain usually lasted for a week and had accompanying symptoms such as swelling and trismus. She managed her symptoms pharmacologically with over-the-counter analgesics (paracetamol and ibuprofen). In addition, she had been prescribed a course of antibiotics (amoxicillin, 500mg three times daily for five days) by her general dental practitioner, which helped to ease her symptoms. The patient was fit and well with no relevant medical history. She was not taking any prescribed medications and had no known drug allergies. She was a non-smoker and only consumed alcohol on rare occasions. The patient had had a mesially impacted right M3M surgically removed under local anaesthetic about six months previously, with no complications reported, and subsequently had a restoration on the lower right second molar.

Examination and investigations

On examination, there was no palpable lymphadenopathy, facial asymmetry or swelling. The patient's temporomandibular joints and muscles of mastication had no abnormality detected and were functioning within normal values. There was no abnormality detected in her soft tissues (palate, tongue, floor of mouth, buccal mucosa). Her left M3M was partially erupted and horizontally impacted against the left mandibular second molar, and while the surrounding operculum appeared inflamed, there was no sign of swelling or pus exudation. However, the operculum posed as a food trap, making it difficult for the patient to clean. The left maxillary third molar was over-erupted and appeared to be traumatising onto the opposing third molar's operculum. The right M3M extraction site had healed well with mucosal coverage. An orthopantomogram (OPG) (**Figure 1**) that had been taken on a previous occasion displayed a horizontally impacted left M3M. It had no associated apical pathology and appeared caries free. Its roots appeared bulbous and there was slight darkening of the mesial root. The OPG also displayed bifurcation of the IAN, which was present on bilateral sides of the mandible. A cone beam computer tomography (CBCT) scan (**Figures 2-4**) was taken to further investigate its relationship. It displayed three fully formed roots on the left M3M: a fused mesiobuccal and mesiolingual root, and a distal root. The roots had a degree of hypercementosis that contributed to the bulbosity. The canal appeared inferior to the mesial root in its mid-third, then passed along the buccal aspect of its apex and buccal to the distal apex. Furthermore, there was a loss of cortical

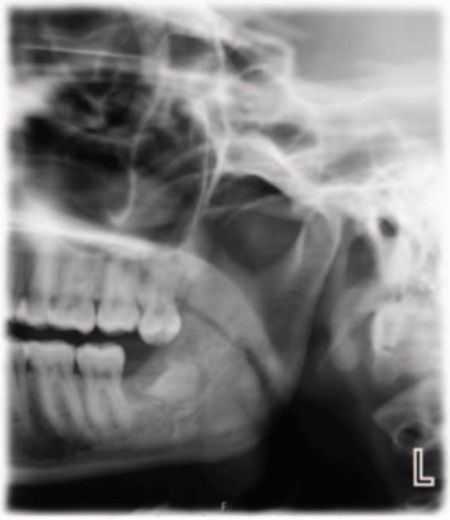

FIGURE 5: Half OPG LL8 at 10 weeks post op.

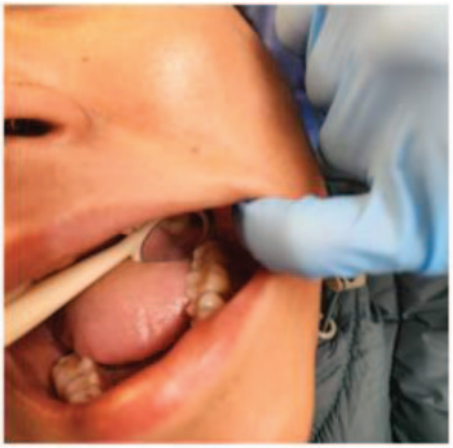

FIGURE 6: Clinical photograph at 10 weeks post op.

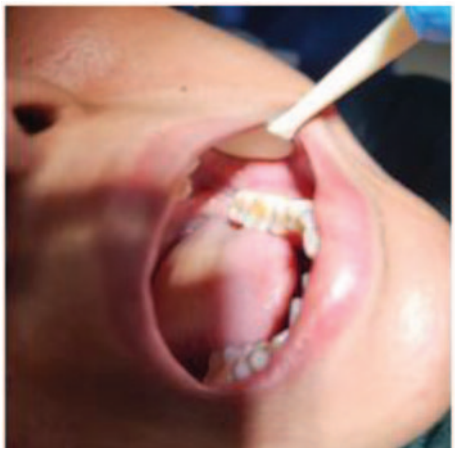

FIGURE 7: Clinical photograph at 12 weeks post op.

outline and a slight narrowing of the canal associated with the mesial root and distal apex. There was a prominent branch off the canal, which was buccal to the coronal third of the roots and exited the mandible approximately distobuccal to the crown.

Diagnosis and treatment

The diagnosis of recurrent pericoronitis was based on the history, and clinical and radiographic findings. The treatment options included no treatment, removal of the left maxillary third molar, or the removal or coronectomy of the left M3M with or without the removal of the left maxillary third molar. With information on the treatment options, along with the accompanying risks and benefits, the patient decided on the option of coronectomy of her left M3M. The patient was offered the choice of having the procedure carried out under local anaesthetic or with intravenous sedation. Once informed consent was obtained, the procedure was carried out under local anaesthetic.

Standard preparation and draping were carried out. Local anaesthetic solution (2.2ml 2% lidocaine with 1:80,000 adrenaline for IAN block and 2.2ml 4% articaine with 1:100,000 adrenaline for local infiltration) was administered. A full mucoperiosteal flap was raised with mesial and distal relieving incisions, and a conservative buccal trough was drilled using a straight surgical handpiece and fissure bur. Once the crown was sectioned and removed, the remaining enamel was removed and the roots were reduced to a height 3mm below crestal bone level. Copious amounts of saline irrigation were used, and before primary closure of the wound using 4-0 vicryl rapide suture, the roots were checked for mobility. Haemostasis was achieved and the patient was given written and verbal postoperative instructions before discharge. The procedure was carried out without any complications, and no postoperative antibiotics were prescribed.

Outcome and follow-up

The patient was clinically reviewed at 10 and 12 weeks after the surgery at her request. She reported postoperative pain, swelling and facial asymmetry from the left mandible that lasted for two weeks. There was no report of fever, trismus, or pus exudation. The symptoms eventually subsided and she was asymptomatic at presentation. The surgical site appeared to be healing well with mucosal coverage and no signs of infection. A half OPG was taken to assess for any pathology (**Figure 5**). It displayed left M3M roots in situ with no evidence of enamel remaining. There was a slight radiolucency at the apices of the roots, which may be evidence of root migration from the IAN. However, the remaining root structure still appeared to be around 3mm below crestal bone level and there was no sign of pathology noted. The symptoms of pain and swelling experienced by the patient were deemed to be a typical presentation of postoperative pain and swelling instead of an infection. The patient was reviewed once more at 12 weeks, at which time she remained asymptomatic, and the surgical site was completely healed with full mucosal coverage (**Figures 6** and **7**). There was no report of altered sensation of the lip, chin and tongue areas.

Discussion

Indications for surgical intervention

National Institute for Health and Care Excellence (NICE) guidelines have outlined indications for the removal of third molars, which include untreatable tooth decay, abscesses, cysts or tumours, disease of the tissues around the tooth, or if the tooth impedes other surgery.[7] Diseases of the tissues around the tooth include recurrent episodes of pericoronitis, which is the swelling and infection of the gingival cuff around a partially erupted tooth. Thus, based on the diagnosis of recurrent pericoronitis of the left M3M, the patient met the criteria for surgical intervention. Furthermore, the horizontal impaction of the left M3M significantly increased the risk of distal caries developing in the adjacent mandibular second molar, which was evident on the contralateral side. This is supported by recent parameters of care by the Faculty of Dental Surgery (FDS) of the Royal College of Surgeons of England (RCSE).[8]

Radiographic investigations

A dental OPG is well recognised as a standard imaging tool to identify specific radiographic features in relation to risk of nerve injury.[9] Although there are seven main radiographic signs associated with IAN damage (darkening of root, defected roots, narrowing of roots, bifid root, interruption of the cortical outline of the canal, diversion of the canal, and narrowing of the canal), the most significant features that indicate a close proximity to the IAN include darkening of the root, diversion of the canal, and interruption of the white cortical outline of the canal.[8] The patient's OPG displayed a slight darkening of the mesial root apex, which may indicate a close proximity to the IAN. Due to the complex root morphology and the bifurcation of the IAN, the clinical decision to take a CBCT scan in addition to the OPG was agreed on to further investigate the relationship between the roots and the IAN. Despite increasing support for the use of pre-operative CBCT when indications of close proximity to the IAN are observed,[10,11] there remains a lack of evidence to show a reduction of risk of IAN damage.[12-15] In addition, there is an increased exposure of four to 42 times the radiation of a dental OPG and an accompanying increased risk of stochastic effects.[16,17] However, CBCT was indicated and justified in this case as it might alter the course of treatment. In addition, as the roots might be mobilised during a coronectomy procedure, it may be beneficial to be fully aware of the relationship between the roots and IAN to minimise risk of damage if it requires removal.

Treatment options

The average risk of IAN damage during M3M removal is reported to range from 0.35% to 8.4%.[5] The surgical removal of this patient's left M3M had an increased risk (up to 20%) of IAN damage due to its close proximity to the nerve.[18] This was discussed with the patient, along with alternative treatment options such as no surgical intervention (which might run the risk of recurrence of symptoms, progression of disease or development of pathology to the adjacent second molar), the removal of the left maxillary third molar (which could remove the source of mechanical insult and reduce symptoms or pericoronitis), or coronectomy of the left M3M.[8] The patient was a suitable candidate for a coronectomy procedure as the left M3M was caries free, vital with non-inflamed pulp, and she was not medically compromised. In addition, the position of the IAN did not impede the area where the crown would be sectioned. Despite the risk common to surgical extractions, coronectomy has been reported to reduce the risk of IAN damage by 84%.[6] However, the procedure itself runs the risk of IAN damage, with an incidence of 1.3%. Furthermore, the risk of failure of the coronectomy procedure has been reported to be around 7%, which is due to mobility of the roots or root migration.[19] There is still a debate in the literature regarding the long-term fate of the retained root due to the need for second-stage surgery for its removal along with its complications.[20,21] It has been reported that up to 91% of roots migrate within six months, and the incidence of second-stage surgery was 2.2%.[6,22] Thus, with the risks and benefits of the different options discussed, the patient was provided with sufficient information to make an informed decision.

Coronectomy

Coronectomy is an alternative surgical procedure to complete removal when the wisdom tooth is considered at high risk of IAN damage. It reduces the risk of IAN damage by ensuring retention of the vital roots that are in close proximity to the canal, thus avoiding direct or indirect damage to the IAN. The coronectomy technique used on the patient was adapted from the technique as described by Frafjord and Renton.[23] This involved using the buccal approach and removal of buccal bone using a fissure bur down to the cemento-enamel junction, partial sectioning of the crown from the root using a fissure bur and elevated from the buccal approach, removal of all remaining enamel using a rose head bur, and closure of buccal flap over the roots with sutures. As no lingual retraction was used for this case, a small amount of tooth structure was left intact lingually to prevent iatrogenic damage to the lingual nerve from the bur during horizontal sectioning. The crown was then separated from the roots using a Coupland's elevator.[24-26] This technique may risk mobilising the roots, especially if the roots are conical, or if the patient is young and female.[18] However, this patient's roots' had a degree of hypercementosis, which contributed to its bulbosity and reduced the chances of mobilisation. The removal of all remaining enamel is essential due to its inert dental structure of ectodermic origin, which prevents the attachment of gingival connective tissue to its surface, preventing complete mucosal coverage and facilitating alveolar osteitis and infection.[27] Furthermore, the roots must be reduced to 3mm below crestal bone level to allow osseous formation over the roots and the preservation of its vitality.[19,27]

Complications

The patient experienced postoperative pain and swelling for two weeks, which was managed with over-the-counter analgesics. As there were no signs of infection such as trismus, purulent drainage, or fever, it was presumed that the patient did not experience a postoperative infection. Despite the concern of an increased risk of postoperative infection due to the deliberate retention of roots, it has been reported that there is no difference as compared to surgical removal.[6] While the half OPG taken at 10 weeks post operatively displayed no pathology, radiolucency at the root apices may indicate a slight degree of migration. The reported incidence of root migration varies from 13% to 85% of cases, of which roots tend to migrate from 0 to 6mm within 24 months.[6,22] However, migration of roots should not necessarily be considered a risk as migration away from the IAN can be beneficial if second-stage surgery was required. One limitation of this case includes the short-term follow-up period of three months, after which the patient may present with further complications such as root migration, eruption, or infection.

Conclusion

Coronectomy presents as a viable alternative surgical option for the removal of M3Ms that are at a high risk of IAN damage. This is due to the significant reduction of risk of IAN damage and low incidence of failure. Although definitive conclusions cannot be made about the long-term fate of the retained roots due to the lack of high-quality, long-term studies, patients may view the risk of a second surgery to be less than the high risk of IAN damage from the surgical removal.[6] As such, the risks and benefits of the different treatment options should be clearly explained to patients for them to make an informed decision.

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CPD questions

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

IDA irish dental association
CPD

1. Which mandibular third molar would be suitable for a coronectomy procedure?

- ○ A. Vital pulp with caries
- ○ B. Irreversible pulpitis with no apical pathology
- ○ C. Caries-free, vital and non-inflamed pulp
- ○ D. All of the above

2. Why is the removal of all remaining enamel during coronectomy essential?

- ○ A. For aesthetic purposes
- ○ B. Enamel is inert, which prevents attachment of gingival connective tissue
- ○ C. Enamel is a source of infection
- ○ D. Its removal is not essential

3. What are the significant features on an OPG that indicate a close proximity of the roots to the IAN?

- ○ A. Darkening of the root
- ○ B. Diversion of the canal
- ○ C. Interruption of white cortical outline
- ○ D. All of the above

Sleep quality and comfort reported by sleep bruxism individuals wearing the occlusal splint and mandibular advancement splint: revisiting two crossover studies

Abe S, Huynh NT, Rompрß PH, et al.

Purpose: To assess: (1) whether an occlusal splint (OS) or mandibular advancement splint (MAS) allowed better sleep quality and was more comfortable in individuals with sleep bruxism (SB); and, (2) the relationship between sleep quality, comfort, and reduction in rhythmic masticatory muscle activity (RMMA) related to SB.
Materials and methods: Polysomnographic data from 21 SB subjects (mean ± SD age 25.6 ± 4.5 years) collected in two previous studies were compared. Morning self-reports on sleep quality and comfort of the oral device, polysomnographic data, and RMMA index data from no-device nights were compared to nights using an OS or MAS. The reduction ratio of the RMMA index was calculated for both devices. A responder to the oral device was identified when the RMMA index was less than 2 and when it showed a reduction of at least 50% from the no-device control night.
Results: Self-reports for sleep quality and comfort of the oral device showed a mild advantage of the OS when compared to the MAS ($r^2 = 0.47$, $r^2 = 0.32$; $P \leq 0.01$). In responders, the MAS induced a greater reduction in the RMMA index ($P = 0.03$) than the OS.
Conclusions: In the short term, the comfort of the oral device seemed to influence sleep quality in SB individuals. However, despite the slightly higher degree of comfort offered by the OS, the MAS induced a greater effect on the RMMA index.

Int J Prosthodont. 2023;36(2):138-147

Self-reported allergy to penicillin and clindamycin administration may be risk factors for dental implant failure: a systematic review, meta-analysis and delabelling protocol

Edibam NR, Lorenzo-Pouso AI, Caponio VCA.

Objective: Growing evidence is highlighting the inefficacy of clindamycin as an effective substitute to amoxicillin in patients self-reporting a penicillin allergy. The hypothesis is that implant failure is higher in these patients, when compared to patients receiving penicillin. To test this hypothesis, a systematic review and meta-analysis was undertaken and a protocol for delabelling penicillin-allergic patients was presented.
Materials and methods: A systematic review was undertaken by searching across three different databases, namely PubMed, Scopus and Web of Science.
Results: Out of 572 results, four studies were eligible to be included. Fixed-effects meta-analysis showed a higher number of failed implants in patients who were administered clindamycin because of a self-reported allergy to penicillin. Results showed that these patients are over three times more likely (OR = 3.30, 95% CI 2.58-4.22, $p < 0.00001$) to undergo implant failure, with an average cumulative proportion of 11.0% (95% CI 3.5-22.0%) versus 3.8% (95% CI 1.2-7.7%) of patients not requiring clindamycin and administered amoxicillin. A protocol for penicillin allergy delabelling is proposed.
Conclusions: Current evidence is still limited and based on retrospective observational studies. It is difficult to state if penicillin allergy, clindamycin administration or a combination of both is responsible for the current trends and reported findings.

Clin Oral Implants Res. 2023;34(7):651-661

Association between subclinical atherosclerosis and oral inflammation: a cross-sectional study

Papi P, Pranno N, Di Murro B, et al.

Background: The aim of this cross-sectional study was to investigate the association between carotid intima-media thickness (c-IMT) values and periodontal and peri-implant diseases in a sample of patients with hypertension.
Methods: A total of 151 participants with presence of at least one dental implant in function for greater than five years were recruited. Anthropometric measurements, 24-hour ambulatory blood pressure monitoring, ultrasound assessment of carotid arteries (c-IMT and presence of plaque) were recorded, and venous blood samples obtained. An oral examination was performed by calibrated examiners to ascertain the prevalence and severity of periodontal and peri-implant diseases. Binomial logistic regression was performed to investigate the potential association between various measures of exposure of dental diseases and predictors of cardiovascular risk (c-IMT > 0.9mm and presence of plaque or their combination).
Results: Diagnosis of periodontitis (OR 6.71, 95% CI: 2.68-16.76, $P < 0.001$), cumulative mucosal/gingival inflammation (Periodontal Screening and Recording score) (OR 1.25, 95% CI: 1.12-1.41, $P < 0.001$), and mucositis (OR 3.34, 95% CI:1.13-9.85, $P < 0.05$) were associated with c-IMT > 0.9mm and/or plaque presence independent of age, sex, smoking, 24-hour systolic blood pressure and body mass index differences. No statistically significant results were noted for peri-implantitis. Linear regression models confirmed a positive association of cumulative mucosal/gingival inflammation ($\beta = 0.011$, SE 0.002, $P < 0.001$), diagnosis of periodontitis ($\beta = 0.114$, SE 0.020, $P < 0.001$), and peri-implant diseases ($\beta = 0.011$, SE 0.002, $P < 0.001$) with increased c-IMT values.
Conclusions: This study confirms a positive association between mucosal/gingival inflammation and subclinical atherosclerosis assessed by c-IMT values and the presence of carotid plaque in patients with hypertension, independent of traditional cardiovascular risk factors. Future studies are needed to further characterise this relationship.

J Periodontol. 2023;94(4):477-486.

Relationship between laryngopharyngeal reflux and obstructive sleep apnoea in adult males

Liu L, Wang X, Zhang J, et al.

Objective: To investigate the relationship between laryngopharyngeal reflux (LPR) and obstructive sleep apnoea (OSA).
Methods: Patients diagnosed with OSA who were hospitalised in the Department of Otolaryngology-Head and Neck Surgery from November 2021 to April 2022 were selected, and male patients with non-OSA during the same period were selected as the control group. Patients who participated in the study completed the Reflux Symptom Index (RSI), the Reflux Finding Sign (RFS), and 24-hour multichannel intraluminal impedance-pH (MII-pH) monitoring. RSI, RFS, and outcomes of 24-hour MII-pH monitoring were compared between the OSA group and the control group.
Results: A total of 86 patients were enrolled, of whom 49 were OSA patients and 37 were non-OSA patients. The positive rate of LPR (97.96% vs 75.68%) and the median number of LPR episodes (nine vs five) were significantly higher in OSA patients than in non-OSA patients ($P < 0.01$, $P < 0.05$, respectively). A logistic regression model including body mass index, alcohol consumption, and the presence of OSA showed that having OSA was a risk factor for the occurrence of LPR ($P < 0.05$, OR [odds ratio] = 9.995, 95% CI [confidence interval] 1.084-92.181). There were correlations between Apnoea-Hypopnea Index and the number of non-acid LPR episodes and the number of alkaline LPR episodes ($r = 0.243$, $P < 0.05$, $r = 0.274$, $P < 0.05$, respectively).
Conclusions: Having OSA is a risk factor for LPR, and LPR episodes occur more frequently in patients with OSA compared to those without OSA. When OSA is comorbid with LPR, the occurrence of alkaline LPR, such as bile reflux, should be a concurrent concern.

J Voice. Published online October 12, 2023.

Quiz answers

Questions on page 244.

1. Extremely deep carious lesion. The caries penetrates the entire thickness of the dentine clinically and radiographically.

2. Pulp sensibility testing using low temperature cold testing in combination with electric pulp testing (EPT) is necessary to assess the status of the pulp.

3. As a carious pulp exposure occurred in this case of extremely deep caries in a tooth with reversible pulpitis, the following protocol has been recommended. Complete removal of soft and firm carious dentine from the cavity is recommended. The pulp exposure should stop bleeding and appear healthy within five minutes of the exposure and only then can damaged and exposed pulp tissue be treated with the direct application of a capping material. The use of magnification to assess the caries removal and appearance of the pulp has been shown to improve outcomes, and the use of sodium hypochlorite to disinfect the cavity should be achieved using cotton pellets soaked ideally with sodium hypochlorite (0.5-5%) or chlorhexidine (0.2-2%). A hydraulic calcium silicate material should be placed directly on to the exposed pulp prior to definitive restoration.

4. After VPT, teeth should be carefully monitored by history and clinical examination at six months, and then via a periapical radiograph at one year. Cold and electric pulp sensibility testing should be carried out to monitor pulpal response. In this case, the tooth has remained symptom free 18 months postoperatively. A periapical radiograph was taken at 12 months (**Figure 2**) and the tooth continues to give positive cold testing and electric pulp testing responses.

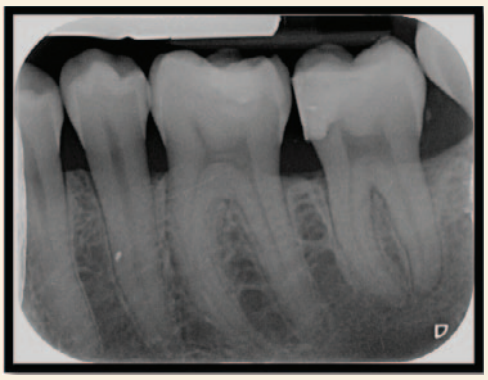

FIGURE 2: Review periapical radiograph 12 months post op.

First principles in confidentiality

The expectation of confidentiality is central to a patient's trust in not only their dental team, but the profession as a whole.

Patients must be able to trust that dental professionals will keep their information confidential. If patients have any doubt about this, they may conceal certain information, which they feel might embarrass them if revealed to others. Alternatively, they may tell us nothing at all. It is no wonder, then, that the profession has taken steps to codify a set of rules and guidance dedicated to confidentiality.

Law

Privacy laws such as the Data Protection Act 2018 and the GDPR have not changed the principles of confidentiality that the profession has recognised and sought to protect. These laws simply codify, supplement and reinforce those principles. The important point is that patient information is sacrosanct in ethics and in law, and patient confidentiality is protected by both lawmakers and the healthcare professions.

Dr Yash Naidoo
Dentolegal Consultant,
Dental Protection

Practical considerations

With countless articles, bulletins, blogs and the like regarding confidentiality, it is perhaps understandable that practitioners bombarded with such information may find it difficult to see the wood from the trees when faced with real-life situations in practice where confidentiality comes into play. Let us explore some examples. It all starts in the waiting room. There may be several patients sitting quietly, staring at their mobile devices while they wait their turn. Because they're all there for the same general purpose (i.e., dental care), that does not mean that their expectation of privacy disappears and does not need to be protected. A receptionist or clinician can still breach a patient's privacy even in this setting, for example by asking a patient, in front of other people, if they are here for the large abscess drainage. Apart from potentially embarrassing the patient, this clearly breaches their right to confidentiality and privacy. It may seem like an innocent and harmless question to a patient who is obviously there for dental work, but it is much more than that to the individual who wants to keep their health information private. It need not be an abscess or something with more obvious potential to embarrass – any treatment or clinical condition ought to be kept confidential between the patient and the practice.

Grey areas

As clinicians (and practice staff), we are told many things by our patients. Some information is clearly confidential – the contents of a medical history for example. However, a lot of other information may not be quite so easy to categorise. Is a

patient's address confidential? Should the time that a patient attends your surgery be confidential? Is it reasonable to tell a wife, who calls to ask if her husband is having dental treatment at your surgery, that yes, he is there, or should you say that the information is confidential? The information may seem innocuous but the reasons why it is being requested may not be.

Other situations are more complicated still. Should you give information to a schoolteacher (or so they say) who phones up to check on the whereabouts of a pupil on a particular day? There could be concerns for that pupil's safety. Should you give information to the Gardaí when they enquire whether a person they suspect of a crime was having treatment on a particular date at your surgery or not? This may be considered to be in the public interest.

It is these types of situations in which confidentiality ought always to be a default consideration before acting. Not all situations will have clear-cut answers, but when in doubt, consult the regulator's guidance booklets, a senior colleague, or ask Dental Protection for advice.

Many patients will research a clinician or practice online before visiting, and it would be useful if the photos they come across online have captions assuring the public that the photos were taken and posted with the patient's written consent.

Social media

In modern times and with the rise of social media influencers, it may seem as if patients want the opposite of privacy when it comes to their dental work – particularly cosmetic treatments. No doubt many of you will have experienced a patient asking if they can record or take photos of their clinical journey to post on their vlog, website or social media profile. This does not mean that all patients want their information or photos to be posted online.

The Dental Council reiterates this in the Code of Practice relating to Professional Behaviour and Ethical Conduct 2022.[1] Section 15.4 states: "Your personal and professional use of social media and other digital platforms should be appropriate, responsible and discreet, and should not bring your own reputation or the reputation of the profession into disrepute. As a dentist, when posting on social media, you should be aware that any information shared may become public and you should: act professionally at all times; respect different and alternative views; only share information you know or believe to be true; and, ensure patient confidentiality is respected".

This again takes us back to the fundamental issue of trust. Patients need to trust that if they attend our practices, we will not post photos of them (whether anonymised or otherwise) without their written permission. Many patients will research a clinician or practice online before visiting, and it would be useful if the photos they come across online have captions assuring the public that the photos were taken and posted with the patient's written consent.

A one-way street

It is worth mentioning the following because from time to time we are asked about it at Dental Protection. The confidentiality is the patient's, not the clinician's. When patients consult with us, it is their clinical/personal information that they disclose to us, which is deemed by the regulator and lawmakers as worthy of protection. As the professional in the relationship, we have the obligation to keep the patient's disclosures confidential – the patient has no such reciprocal obligation.

This query comes up often in the context of audio recordings of consultations. The safest attitude for a clinician to adopt is to assume that all patients are recording everything that happens during the confines of a consultation room or on the chair. It is their confidential information being recorded, and it is likely that they can do with that as they please.

This point also has a bearing on our clinical notes. Always remember that the information contained in the patient's records is their information and they are entitled to access that information on request. So, when making notes, it is useful to always bear in mind that the notes are not only for your records but may some day be seen by the patient and anyone they choose to disclose them to, such as a colleague for a second opinion, a lawyer investigating a potential claim, or a judge in court if the claim ever materialises. The importance of keeping factual, dispassionate notes, which are relevant to the patient's clinical care, cannot be overemphasised.

Conclusion

Being a healthcare professional gives us many privileges. Perhaps the most important is the right to ask our patients questions of a confidential nature, and to expect truthful answers. However, this privilege also imposes upon us an ethical (and legal) obligation to treat any information obtained as completely confidential. Confidentiality is central to the relationship of trust between you and your patient. In general, it is a straightforward concept, but there are situations that may require guidance from the regulator and, as always, if you are in doubt, you can always ask Dental Protection for advice.

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SITUATIONS VACANT

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Associate required to join our team at Peter Doyle's Dental practice Sligo/Leitrim. A busy and well-established private book. High earning opportunity. Excellent, friendly support staff and facilities, ideal for a new graduate. Email summerhilldental@gmail.com.

Part-time associate position in Newbridge, Co. Kildare, to replace a departing colleague. Very busy clinic, nice patients and staff. CBCT, scanner available. Great earning potential. Contact shackletonclinic@gmail.com.

Carton Dental Maynooth seeks associate. Scanner, microscope, Aquacare, RA, best materials, SOE Exact, excellent support staff. Loupes essential. No medical card. Fees to increase. Contact cartondentalclinic@gmail.com.

Dental associate required to join our long-established and newly refurbished dental practice in Charleville, Co. Cork. Full book and fair remuneration. Excellent, experienced support team and friendly patients. CV please to eamonnnoonan@hotmail.com.

Associate wanted to join our modern, private surgery with full book. Excellent support staff. High earning potential. Implants, endo, facial aesthetics all well established. Contact Claire.osullivan91@gmail.com.

Associate required in modern three-chair practice in Youghal. Computerised, digital X-ray, scanner. Full-time hygienist. Excellent support staff. Experienced dentists and new graduates welcome. Enquiries to youghaldentist@gmail.com.

Associate wanted part time (Tuesday and Friday ideally). Rare opportunity to join excellent multidisciplinary practice. Highly equipped, superb team. Very busy. Dublin City 20km. Experience preferred. Start September. CV and references please. Contact Conor.irwin@ratoathdental.ie.

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

Dental associate required in Blackrock, Dublin, to join our modern, newly refurbished and expanding practice. Ideally 2+ years' experience. Friendly environment and full support staff. Contact flanners@tcd.ie.

Associate position available in busy Mallow dental surgery. Full/part-time. Modern, friendly practice with great support staff. Contact mallowdentist@gmail.com.

Associate position, Monasterevin, Co. Kildare. Part-time. Option for longer hours. General practice, computerised, digital X-rays. Experience preferable. Email CV to drniallcollins@gmail.com.

Dental associate position, Rathdrum, Co. Wicklow. Part time. Option for longer hours. General practice, computerised, digital X-rays. Experience preferable. Email CV to info@dentalsuite.ie.

Associate wanted to join our busy, modern practice in the heart of Malahide village. We aim to provide high-quality general dental care at a relaxed pace. Fully digital, CEREC Primescan, TRIOS scanner, sedation, Invisalign, hygienists. Private, some PRSI. Contact eamonnugent@ivorydental.ie.

Part-time dental associate required for busy, modern Dublin 3 practice. Excellent, friendly support staff with immediate start. Contact dublin3associate@gmail.com.

Associate dentist required for busy, friendly, well-established family practice in Portmarnock, Co. Dublin. Fully computerised with digital X-ray. Part-time position with the opportunity to expand to full-time. Please contact info@blessingdental.com or call 01-8169474.

Associate dentist required to fill position in busy, friendly, newly renovated, modern practice in Galway. Private/PRSI only. Please send CV to office@renmoredental.ie.

Maternity cover required for associate three days/week, in modern surgery in Cork suburb. October start, full support. CV to customer@smilesandmore.ie.

Associate required for three days/week. Long-established, busy northside practice. Very well remunerated, modern and computerised. Well supported by several colleagues, oral surgeon, hygienists. Contact archiefinn07@gmail.com.

Associate required for family dental practice in Limerick, replacing retired partner. Three days a week with opportunity to build more. Hygienist on staff. Fully digital practice. One of Limerick's longest-established practices with friendly staff. Email associatedentistrequired@gmail.com.

Associate required for long-established private practice one hour south of Dublin. Award-winning principal dentist. Areas of special interest: prosthodontics, sedation, oral surgery, implants. Excellent clinical support. CBCT, iTero, fully digital. Complete clinical freedom. Fantastic earning potential. Contact info@gracefielddental.ie.

Classified advertisements are accepted via the IDA website – www.dentist.ie – only, and must be pre-paid. The deadline for receipt of advertisements for inclusion in the next edition is **Friday, November 15, 2024**. Classified ads placed in the *Journal* are also published on www.dentist.ie for 12 weeks.

Please note that all prices are inclusive of VAT.

Advert size	Members	Non-members
up to 25 words	€135.30	€270.60
26 to 40 words	€161.70	€330.65

The maximum number of words for classified ads is 40.

If the advert exceeds 40 words, then please contact:

Think Media, The Malthouse, 537 North Circular Road, Dublin 1.

Tel: 01-856 1166 Fax: 01-856 1169 Email: paul@thinkmedia.ie

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

- Situations wanted
- Situations vacant
- Practices for sale/to let
- Practices wanted
- Equipment for sale/to let

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

Smiles Dental Wexford/Enniscorthy is seeking an associate dentist to join our well-established practice. We can offer an established diary of patients, supportive and welcoming teams and great earning potential. Open to discussing location, days and hours. Contact leah.hall@bupadentalcare.co.uk.

Associate dentist to join our well-established busy dental practice. Full/part-time, private GMS, PRSI. CV required. Experience essential. With immediate start. Contact info@ndentalclinic.com.

Dentists

Opportunity for ambitious dentist with an interest in orthodontics. In-clinic training/mentorship provided along with funding for academic advancement (master's). Would suit candidate with some orthodontic experience. Galway/Limerick. Strong remuneration potential. Experienced support team. Contact shauna@3dental.ie.

Dental Care Ireland Limerick/Ennis – great opportunity to join our established, modern practice. Strong earnings with full patient book on offer. Private and PRSI only, flexible days/hours. Experienced, friendly support team in place. IDC essential. Contact careers@dentalcareireland.ie.

We are seeking applications from community dentists based in Northland New Zealand. There are both full- and part-time roles available. Contact jobs@northlanddhb.org.nz.

Dental Care Ireland Meath – flexible full/part-time hours, high earnings available within our established practice. Strong patient books and our experienced clinical support team in place. IDC essential and experience. Contact careers@dentalcareireland.ie.

Enthusiastic dentist required for part-time work in busy north Dublin patience. I/O scanner, Sprintray 3D printing set-up, friendly staff and relaxed atmosphere. Contact reception@castlemilldental.ie.

Waterford: Experienced dentist required. Full-time. Private practice, fully digital, full book, excellent support and excellent package including educational support. IDC registration essential. Contact jobs@dentaltech.ie.

Eden Medical seeks a passionate dentist for facial aesthetic medicine. Part-time role available in Dublin. Join our team to blend dental expertise with cutting-edge cosmetic treatments. Enhance smiles and confidence in patient-focused environment. Contact careers@eden-medical.ie.

Experienced dentist or new graduate required for busy general family practice in Celbridge, Co. Kildare. Full- or part-time position. Remuneration negotiable. Full support and mentorship available. Replies with CV to brian.corcoran26@gmail.com.

Colm Smith Dental and Specialist Centre Monaghan. General dentist required to join our team of orthodontists, oral surgeons, endodontists and general dentists. Excellent nursing and support staff. Must be IDC registered. Email drcolmsmith@gmail.com.

Dentist required for busy general practice in Athlone. Great support staff, and interest in endo and implant restoration helpful. Happy to support recent graduate. Contact campbelldentald@yahoo.ie.

Join our dynamic team of three other dentists on either a full- or part-time basis. Very good working conditions and terms, in a modern, fully digitalised practice. Ethical dental care where staff enjoy a positive atmosphere, great camaraderie. Contact Sarahrymer@expressionsclinic.com.

Dental Care Ireland Ballincollig/Douglas Cork – flexible days available in both locations, strong patient books with competitive hourly rates within our established modern practices. Join our experienced and friendly clinical teams. IDC registration is essential. Maternity leave cover. Contact careers@dentalcareireland.ie.

Dental Care Ireland Kilkenny – Wednesday and Thursday available, strong patient book on offer within our established modern practice. Great Place to Work 2024 recently awarded. Competitive hourly rate, working alongside our experienced and friendly clinical team. IDC registration essential. Contact careers@dentalcareireland.ie.

Dental Care Ireland Dundrum – three Fridays per month, strong patient book with competitive hourly rate on offer within our established, modern practice. Join our experienced and friendly clinical team. IDC registration is essential. Permanent or locum hours. Contact careers@dentalcareireland.ie.

Looking for a new team member to work in central Switzerland on the lake of Luzern. German speaking but this is not required. Great team! Great experience! Flexible hours. Email info@pro-smile-dental.ag.

WoodQuay Dental Galway is seeking a dentist and a hygienist to join our well-established practice. We can offer an established diary of patients, supportive and welcoming teams, and great earning potential. Open to discussing location, days and hours. Contact leah.hall@bupadentalcare.co.uk.

We are recruiting for full-time general dentists in the Dublin, midlands and west coast regions. We can assist with employment permits and relocating from overseas. All applicants must be IDC registered, or EEU graduated. Please email in confidence. Contact dr.odonovan@cubedental.ie.

Locums

Gate Dental Ireland seeks a specialist orthodontist for our established Galway practice on a locum basis. Enjoy a full patient diary, supportive team, and excellent earning potential. Flexible days and hours. Apply at leah.hall@bupadentalcare.co.uk.

Specialist/limited practice

Orthodontist required to join modern, digitalised, fully private Galway City practice. Potential to work in multiple chair set-up supported by multiple assistants/co-ordinators. Excellent remuneration potential. Contact shauna@3dental.ie.

Prosthodontist required for well-established implant team at state-of-the-art specialist practice in Dublin. Part-time position, potential for growth. On-site digital laboratory, fully digital workflow, CBCT, Intra-oral scanner, 3D printer, milling machine. Contact hrmanager@ncdental.ie.

Orthodontist required in digitalised multidisciplinary practice in Newbridge. Full/part-time. Multiple chairs available with experienced back-up team. Please apply in confidence to bbarrett@pembrokedental.ie.

Urgently wanted periodontist and prosthodontist. Long treatment waiting lists. All modern facilities. Fantastic earning potential. Contact tomas.allen@kingdomclinic.ie.

Oral surgeons, orthodontists and facial aesthetics specialists required for a very busy private general dental practice in Ballinteer, Dublin. Available to rent on a daily basis. All sedation and surgery equipment newly bought. Contact tfbc16@gmail.com.

Gate Dental Galway is seeking a specialist orthodontist to join our well-established clinic. We can offer a diary of patients, supportive and welcoming teams, and great earning potential. Open to discussing location, days and hours. Contact leah.hall@bupadentalcare.co.uk.

Smiles Dental Ireland is seeking paediatric dentists to join our well-established practices in Dublin and Cork. We can offer an established diary of patients, supportive and welcoming teams and great earning potential. Open to discussing location, days and hours. Contact leah.hall@bupadentalcare.co.uk.

Orthodontist required for busy specialist practice in Rathfarnham, south Dublin. Favourable remuneration, excellent support and modern practice. Please contact Isy.keyes@gmail.com.

Orthodontic therapists

Position for an orthodontic therapist available in our Tralee practice. Apply today to become a valued member of our fun, energetic and friendly team. Contact colettecostello@dancounihanortho.com.

Orthodontic therapist required to join our fun and friendly team. Busy orthodontic practice in Waterford City. Full- or part-time hours available. Salary dependent on experience and bonuses available. Contact maryeokeeffe@hotmail.com.

Hygienists

Part-time hygienist to replace relocating colleague. Two days per week, new graduates welcome, excellent remuneration. Busy private practice with full book. Cavitron and Woodpecker. Flexible hours and days. Great team. Contact info@rogersdental.ie.

State-of-the-art specialist dental practice seeks experienced dental hygienist to join the team, initially one day a week, working closely with in-house periodontist and dental specialist team. Must be IDC registered. Opportunity for enthusiastic hygienist. Contact hrmanager@ncdental.ie.

Opportunity for two days in busy practice in Waterford for hygienist on a Monday and Friday from October. Hygiene room will be fully refurbished for start date, including new chair, Cavitron, instruments. New graduates welcome. Busy, supportive practice. Contact deisedentist@gmail.com.

Colm Smith Dental and Specialist Centre Monaghan. Dental hygienist required to join our team of orthodontists, oral surgeons, endodontists and general dentists. Excellent support staff. Must be IDC registered. Email drcolmsmith@gmail.com.

Full-time hygienist required for a busy, friendly and modern practice in north Co. Dublin. New graduates welcome. Excellent support staff. Flexible working hours. High earning potential. Great location for public transport. Email your CV to northdublindentalclinic@gmail.com.

Part-time dental hygienist required for busy, modern Dublin 3 practice. Excellent support staff and generous terms. Contact dublin3associate@gmail.com.

Hygienist position available Co. Wexford. Three days a week. Established book of patients. Full support staff. Newly refurbished surgery. Days and hours negotiable. Minimum starting salary €45 p/hr gross. Travel allowance available. Contact jonnyk289@gmail.com.

Full-time dental hygienist positions available to join our existing experienced team. Busy private practice, newly renovated, computerised and Cavitron. Excellent and friendly staff. Contact office@renmoredental.ie.

Unique opportunity for dental hygienist to relocate to Maine, USA. Visa and housing provided. Base pay $50 per hour. Cohesive and supportive practice environment. Contact mreznikdmd@gmail.com.

Part-time dental hygienist required in Cork. Initially for maternity cover 1.5-2 days a week with possible option of longer-term role. November start. Contact dremills@airportdentalcork.com.

WoodQuay Dental Galway is seeking a dentist and a hygienist to join our well-established practice. We can offer an established diary of patients, supportive and welcoming teams, and great earning potential. Open to discussing location, days and hours. Contact leah.hall@bupadentalcare.co.uk.

Full-time position at Elmwood Dental, Douglas, Cork. No evenings/weekends. Respectful, supportive and friendly environment. €40-42 per hour. Contact info@elmwooddental.ie.

Vacancy in three-surgery clinic due to departing colleague returning to own country. Implants, ortho, routine dentistry. Good X-ray facilities including I cept, OPG, and cone beam. Good list of patients and support staff. Contact hygieneplacement@gmail.com.

Part-time hygienist required for a busy, friendly and modern practice in Athlone. New graduates are welcome with hygiene mentor available. Great support staff. Contact athlonedental@gmail.com.

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Part-time hygienist required to replace departing colleague, only 30mins south of Dublin. Flexible days and hours with highly competitive fixed hourly rate. Contact wicklowdentist@hotmail.com.

Dental nurses/receptionists/managers

Experienced full-time practice manager required in private Limerick City practice. Private and PRSI only. €18-25/hour dependent on experience and history. Performance-related bonuses. Salary is dependent on experience and a proven ability for successful practice management. Contact hr@murphydentalcare.ie.

Specialist endodontic practice in Galway requires a qualified dental nurse on a full-time or part-time basis for our friendly practice. Contact eoinomorain@gmail.com.

Nurse required for full-time work in Kerry. Nice working environment in a modern surgery. Pay above going rate for experienced candidate. Contact Info@castleislanddental.ie.

Dental nurse\receptionist required for four days per week in busy Newbridge practice. Experience preferred but not essential. Free parking. Contact boguedental@gmail.com.

Exciting part-time opportunity for an orthodontic nurse to join a supportive practice in south Dublin. Orthodontic experience ideal but not essential. Essential skills include caring approach, organised, excellent communication. Please reply to orthos090@gmail.com.

Dental Care Ireland practice manager – exciting company growth Sligo, Killarney, Kells and Ashbourne. Elevate your clinical career, do you have people management and dental experience? Then this role is for you. Working FOUR flexible days with competitive salary. Contact careers@dentalcareireland.ie.

Experienced receptionist with good IT skills required to join our friendly team at Swords Dental on a full-time or part-time basis. Nursing experience a benefit but not essential. CVs to colinpatricklynam@hotmail.com.

PRACTICES FOR SALE/TO LET

Modern, single-handed, established dental practice for sale Cork. Room to expand. Principal retiring. Contact margaret1mrng@gmail.com.

South Dublin. Long-established two-surgery, fully private/PRSI practice. Excellent location with room to expand. Low overheads. Plentiful free parking close by. Very strong new patient numbers. Computerised/digitalised. Strong potential for growth. Principal available for transition. Contact niall@innovativedental.com.

Co Westmeath. Very busy, active two-surgery practice. Prime location. Ample parking close by. Very low overheads, rent, etc. Computerised, digitalised, hygienist. Strong new patient numbers. Dentist retiring, competitively priced for speedy sale. Contact niall@innovativedental.com.

South east. Thriving private/PRSI practice, long established, strong figures, substantial profits. Two newly equipped surgeries. Loyal patient base, high new patient numbers. Leasehold – low rent and overheads. Excellent location, high traffic area, strong footfall Significant growth potential. Contact niall@innovativedental.com.

Consultation room to let in Ballinteer, Dublin 16. Suitable for facial aesthetics, dermatologist, orthodontics, counselling, reflexology or chiropodist. Recently refurbished practice with surgery four upstairs to let, rental on daily basis. POA. Contact tfbc16@gmail.com.

Mullingar town centre – purpose-built dental centre for sale. Four clinical rooms with two waiting rooms. In excellent condition throughout. Contact Alan Bracken on 087-925 7346.

IYKYK … Midlands: Two-surgery dental practice recently vacated due to dentist relocating. Mass of longstanding patients without local dentist. Ground floor building, cabinets, plumbed, no dental equipment. Recent renovation, OPG room, parking. Building available to rent or buy competitively. Contact dentalopp2024@gmail.com.

EQUIPMENT FOR SALE/WANTED

Dentsply Sirona CEREC Primescan milling machine for sale. Excellent condition, like new. Full service back-up included. Please phone 086-881 5105 or email kilrossclinicbishopstown@gmail.com for more information.

Temporary surgery set-up. All equipment needed within the next two months. Please respond with photos. Will arrange removal and collection. Contact ciaramagner@thenationalimplantcentre.ie.

W&H Implantmed SI-923/SI-915 machine for sale including one surgical handpiece bought in 2018. Please email me for more information. Contact maca.petrickova@gmail.com.

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Final edit

The Editorial Board of the *Journal of the Irish Dental Association* ensures that the *Journal* meets the highest editorial standards, and features relevant content for Irish dentists.

The *Journal of the Irish Dental Association* (*JIDA*) is the IDA's flagship publication, published six times a year and circulated to all dentists on the island of Ireland. The *JIDA*'s content is overseen by an Editorial Board comprised of dentists from a range of specialties, supported by members of the IDA's Executive staff and representatives from the publishers, Think Media, and chaired by Honorary Editor Dr Cristiane da Mata.

Cristiane is a lecturer in restorative dentistry at Cork University Dental School and Hospital. She took over the role of Honorary Editor in January 2022, and has just been re-appointed for a second three-year term. She explains how the Board does its work: "We meet three times a year, and at each meeting we plan two editions of the *Journal*. That involves deciding on the content for each edition, based on the topics we think readers will be interested in".

The *Journal* has a strong educational remit, and the Board works to ensure that clinical content meets the highest standards, and can offer both an informative read, and practical tips and guidance for dentists.

Cristiane says the role of the Editorial Board is also to plan for the future of the *Journal*: "We are always trying to make the *JIDA* better, and use resources such as our readership survey to find out what readers are happy with, and what they are not. We also keep an eye on what other dental journals are doing, collaborating with other journal colleagues, and taking an outward-looking approach to development".

Some of the more recent developments include the new clinical tips section, and the decision to upload scientific articles to Scholastica, which means that accepted articles are published promptly online, and are citable. Cristiane oversees the submission and review of articles (also via Scholastica), ably assisted by Journal Co-ordinator Liz Dodd of the IDA staff.

New members welcome

The Board is always seeking new members in an effort to remain diverse, and reflect views and expertise across the profession: "We aim to have a balance of gender, age, specialty, level of experience, and geographic location. It's so important to have a broad range of experience and perspectives from across the profession, including our dental hygiene and dental nursing colleagues, as the Board's role is to bring the views and opinions of the profession to the *Journal*".

Cristiane points out that even if members don't wish to join the Editorial Board, their views and suggestions are very welcome: "When you're not part of a group, you might think that it's hard to approach us with ideas, but I would love readers to feel that they can contact me or the other Board members, and bring their voices to the table. We are a small group trying to represent the views of the wider profession. People can contribute in many ways, by writing or reviewing an article, or offering their opinion, so I would encourage people to email me with topics they might like us to cover, or just to offer their view on how we are doing".

Cristiane can be contacted at journaleditor@irishdentalassoc.ie.

Meet the members

Dr Patrick Quinn

Patrick works as a Principal Dental Surgeon with HSE South-West and is also a Senior Lecturer in Law, Ethics and Professionalism at Cork University Dental School and Hospital. He is currently undertaking a doctorate with specialist training in dental public health at Trinity College Dublin: "I joined the Board of the *JIDA* as I have a keen interest in research and education, being from a dental public health background. For me, the *JIDA* is one of the things that binds the dental profession together in Ireland, and it is therefore important that we strive to make it the very best publication that it can be".

Dr David McReynolds

David is Deputy Editor of the *JIDA*. He is a part-time PhD student at Dublin Dental University Hospital, and also works as a consultant-trained prosthodontist at a number of practices in Dublin.

"I joined the Editorial Board in 2016 to represent the views of postgraduate dentists in training. Over the years I have sought to support the development of the scientific integrity of the *Journal*, and support the Honorary Editor. The *Journal* is the only vehicle where we can disseminate home-grown dental scientific content. The wonderful value of the *JIDA* is that thousands of dentists in Ireland and beyond read our content."

Members of the *JIDA* Editorial Board

Dr Cristiane da Mata (Hon. Editor)
Dr David McReynolds (Deputy Editor)
Dr Meriem Abbas
Dr Geraldine McDermott
Dr Clair Nolan
Dr Adedeji Daniel Obikoya
Dr Judith Phelan
Dr Patrick Quinn
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References: 1. Daniels et al, Maxigesic® 325 Acute Dental Pain Study. *compared with the same daily dose of standard paracetamol alone. †Faster onset of action than standard ibuprofen alone. **Easolief DUO 500 mg/150 mg film-coated tablets** Each tablet contains paracetamol 500 mg and ibuprofen 150 mg. **Presentation**: White, capsule shaped tablet with breakline on one side and plain on the other side. **Indications**: Short-term symptomatic treatment of mild to moderate pain. **Dosage**: **Adults/elderly**: The usual dosage is one to two tablets taken every six hours up to a maximum of six tablets in 24 hours. **Children**: Easolief DUO is contraindicated in children under 18 years. **Contraindications**: Severe heart failure, known hypersensitivity to paracetamol, ibuprofen, other NSAIDs or to any of the excipients, active alcoholism, asthma, urticaria, or allergic-type reactions after taking acetylsalicylic acid or other NSAIDs, history of gastrointestinal bleeding or perforation related to previous NSAID therapy, active or history of recurrent peptic ulceration/haemorrhage, severe hepatic failure or severe renal failure, cerebrovascular or other active bleeding, blood-formation disturbances, during the third trimester of pregnancy. **Warnings and precautions**: This medicine is for short term use and is not recommended for use beyond 3 days. Clinical studies suggest that use of ibuprofen, particularly at a high dose may be associated with a small increased risk of arterial thrombotic events. Patients with uncontrolled hypertension, congestive heart failure, established ischaemic heart disease, peripheral arterial disease and/or cerebrovascular disease should only be treated with ibuprofen after careful consideration and high doses should be avoided. Careful consideration should be exercised before initiating long-term treatment of patients with risk factors for cardiovascular events. The use of paracetamol at higher than recommended doses can lead to hepatotoxicity, hepatic failure and death. Patients with impaired liver function or a history of liver disease or who are on long term ibuprofen or paracetamol therapy should have hepatic function monitored at regular intervals. Severe hepatic reactions, including jaundice and cases of fatal hepatitis, though rare, have been reported with ibuprofen. Paracetamol can be used in patients with chronic renal disease without dosage adjustment. There is minimal risk of paracetamol toxicity in patients with moderate to severe renal failure. Caution should be used when initiating treatment with ibuprofen in patients with dehydration. The use of an ACE inhibiting drug, an anti-inflammatory drug and thiazide diuretic at the same time increases the risk of renal impairment. Blood dyscrasias have been rarely reported. Patients on long-term therapy with ibuprofen should have regular haematological monitoring. Like other NSAIDs, ibuprofen can inhibit platelet aggregation. GI bleeding, ulceration or perforation, which can be fatal, has been reported with all NSAIDs at anytime during treatment. Combination therapy with protective agents (e.g. misoprostol or proton pump inhibitors) should be considered. Use with concomitant NSAIDs including cyclooxygenase-2 selective inhibitors should be avoided. NSAIDs may lead to onset of new hypertension or worsening of pre-existing hypertension and patients taking antihypertensive medicines with NSAIDs may have an impaired anti-hypertensive response. Fluid retention and oedema have been observed in some patients taking NSAIDs. NSAIDs may very rarely cause serious cutaneous adverse events such as exfoliative dermatitis, toxic epidermal necrolysis and Stevens-Johnson syndrome. Acute generalised exanthematous pustulosis (AGEP) has been reported in relation to ibuprofen-containing products. Products containing ibuprofen should not be administered to patients with acetylsalicylic acid sensitive asthma and should be used with caution in patients with pre-existing asthma. Adverse ophthalmological effects have been observed with NSAIDs. For products containing ibuprofen aseptic meningitis has been reported only rarely. NSAIDs may mask symptoms of infection and fever. In order to avoid exacerbation of disease or adrenal insufficiency, patients who have been on prolonged corticosteroid therapy should have their therapy tapered slowly rather than discontinued abruptly when products containing ibuprofen are added to the treatment program. Caution is advised if paracetamol is administered concomitantly with flucloxacillin due to increased risk of high anion gap metabolic acidosis (HAGMA). **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, flucloxacillin. **Fertility, pregnancy and lactation**: Easolief DUO is contraindicated during the third trimester of pregnancy. **Driving and operation of machinery**: Dizziness, drowsiness, fatigue and visual disturbances are possible after taking NSAIDs. If affected patients should not drive or operate machinery. **Undesirable effects**: Dizziness, headache, nervousness, tinnitus, oedema, fluid retention, abdominal pain, diarrhoea, dyspepsia, nausea, stomach discomfort, vomiting, flatulence, constipation, slight gastrointestinal blood loss, rash, pruritus, alanine aminotransferase increased, gamma-glutamyltransferase increased, abnormal liver function tests, blood creatinine increased and blood urea increased. Refer to Summary of Product Characteristics for other adverse effects. Adverse reactions should be reported via HPRA Pharmacovigilance, website: www.hpra.ie. **Pack size**: 24 tablets. **Marketing authorisation holder**: Clonmel Healthcare Ltd. Waterford Road, Clonmel, Co.Tipperary. Marketing authorisation number: PA0126/294/1. Supply through pharmacies only. **Date last revised**: October 2023. **Date prepared**: January 2024. 2024/ADV/EAS/004H

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1. Data at Align Technology, as of September 30, 2021

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Tristen Kelso
Director, BDA Northern Ireland

Seeking full back pay

We are pressing the Department of Health (DoH) to provide assurance to practitioners that the full 6.47% back pay for 2023-24 has now been paid correctly.

The full 6.47% (non-recurrent) uplift for 2023-24 should now have been applied to all 2023-24 claims while only 4.92% is to be applied recurrently. On August 12, the Department's Head of Dental and Ophthalmic Policy, Michael O'Neill, wrote to all GDS practitioners to outline how both the uplift and Scale Additions errors would be corrected.

The correspondence included a worked example, which only included the 4.92% aspect of the uplift. Some practitioners, in particular orthodontists with a large proportion of claims straddling payment years, remain unsure that they have received the full back pay owed.

Asking for assurances from the Department, Northern Ireland Dental Practice Committee Chair Dr Ciara Gallagher referred to the impact on practitioners of the considerable delays in uplift payments firstly being approved, and then issued.

Indeed, it is deeply regrettable that almost a year and a half after this uplift applies, some practitioners continue to have doubts about whether they have correctly received the full amounts of back pay owed to them, even after 'corrections' have been applied. Fundamentally, we are asking the Department to assure practitioners that the full 6.47% pay award that was approved by the Minister has now been paid in its entirety.

The letter adds: "At a time when Health Service dentistry is under such financial pressure, and faith in the system at an all-time low, the experience this year, beset with delay, error and confusion, has been deeply unhelpful. Once again, Northern Ireland is lagging behind the other UK nations when it comes to application of the Review Body on Doctors' and Dentists' Remuneration (DDRB) recommended uplifts".

"We want to see more clarity, including making payment reconciliation easier, and better communications at the outset around the timetable for payments."

Department pressed on 2024-25 DDRB recommendations

The letter also seeks an early response from the Department to this year's DDRB recommendation: "While we continue to work through payment issues relating to 2023-24, colleagues in other jurisdictions have received clarity on the pay uplift which will be applied for the 2024-25 year. Our practitioners deserve no less, and as such we have also requested an update from the DoH on its response to the DDRB recommendations for 2024-25.

There is an urgent need for greater clarity, accuracy and timeliness around the pay uplift process. At the very least, practitioners should have a clear understanding of which components of backpay will be received, and when. This is vital in being able to reconcile back pay; also, that pay awards are approved by the Department in a much more timely manner".

Discussions are underway with the Business Services Organisation around how the payment process can work better for practitioners. We want to see more clarity, including making payment reconciliation easier, and better communications at the outset around the timetable for payments. These issues will be raised at our forthcoming non-contract meeting.

We will keep you updated on developments.

Suicide postvention resource

A comprehensive guide aimed at supporting organisations has been launched, providing evidence-based strategies and recommendations.

The 'Suicide postvention in the workplace guide: supporting organisations and employees' offers key insights into managing and responding to suicide within the workplace. Developed through extensive consultation in a working group with experts across various fields, the guide addresses the complexities and sensitivities involved in responding to the death by suicide of a colleague, or an unexpected death from other causes.

Written by Professors Gail Kinman and Neil Greenberg, the guide emphasises the importance of promoting recovery, and preventing further adverse outcomes, ensuring that workplaces remain healthy and compassionate environments. The guide is tailored to meet the needs of occupational health practitioners, well-being leads, HR professionals, managers, and policymakers. It offers key insights into critical areas such as immediate response approaches, communication protocols, support mechanisms for affected individuals, and long-term strategies for fostering a supportive workplace culture.

Roz McMullan, Chair of the Northern Ireland Council, formed part of the guide's working group. All BDA members have access to Health Assured to help deal with personal and professional problems that impact well-being. The Health Assured helpline is available 24/7, 365 days a year.