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THE MAGAZINE FOR DENTAL PROFESSIONALS IN IRELAND

JULY 2018

DEFENSIVE ROLE

The case for mouth guards in contact sports
– Pages 9 and 40

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WHOSE GRASS IS GREENER?

Last month I was very pleased to be able to attend the annual LDC Conference which was held in Belfast, only the first time in its long history that it has been held outside England. In another first for the conference, all four UK chief dental officers were either there, or, in the case of Sara Hurley, represented by her deputy Eric Rooney. A highlight for me was seeing the four UK nations together on the stage to discuss and debate the subject "Can devolution improve dental care or are they taking the 'N' out of the NHS?".

What struck me about the debate, and the questions from the floor, was that there seemed to be a big issue with the grass being always greener.

Ask anyone about the system that they work in, and it is unlikely that you will be drowned in praise and joy. Admittedly (as I've already broken my no cliché rule) it can be hard to see the wood for the trees; however, people working outside that system can often see the good things about it much more clearly. Clearly enough to be envious of them, or at least to hope that their system could learn from the bits that others are doing well.

Certainly, in both Northern Ireland and the Republic, there seems to be much frustration with the healthcare systems. In both nations, people talk about a feeling of stagnation and inertia. Of strategies left without review or development, or even publication. Of nothing being done about issues that have been going on for years to the detriment of practitioners and patients.

In Northern Ireland, this situation is no doubt exacerbated by the current political situation, a situation that has been further aggravated by the recent high court ruling around the legal powers, or lack thereof, of senior civil servants. Add to this a profession being buffeted by increasing costs, growing regulatory pressures, and external change in the form of international influences such as GDPR, the phase out of amalgam and the ever-present questions around Brexit – a looming shadow, whether you think it is for good or ill – then it is understandable that those working within the dental profession are growing increasingly frustrated and despairing.

But is it really any different elsewhere, and are the green shoots of recovery (cliché number 3) already beginning to poke through?

I can't claim to have the answers, but our aim for this magazine is at least to ask the questions of those who might. Our ambition is to celebrate the achievements and reflect the concerns of the profession, to ask the difficult questions and demand answers.

Most importantly, we want this to be a magazine that you want to read and that gives you a voice so, please, get in touch. Write, email, tweet! Contact us however you like, but please do contact us.

When I first started working with dental professionals, several years ago, I was struck by how diverse a profession it was. I realised that, as a patient, I had only seen one small corner of the dental world. I was struck by how the profession was so often at the vanguard of developments in treatment and technology, and full of hard-working individuals who were committed to patient-care and who had found their vocation in dentistry, whatever their chosen career path.

As a patient this was reassuring. As a non-dental professional working in the dental world, it was inspiring. And, however bleak things can appear, dentistry remains full of people dedicated to advancing the profession, providing incredible patient care and finding ways to triumph over adversity. Even if, sometimes, you find yourself looking over the fence, at someone else's lawn.

Sarah Allen is editor of *Ireland's Dental* magazine. To contact Sarah, email **sarah@connectcommunications.co.uk**

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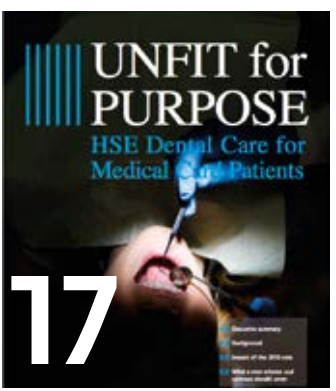

Cover image of Alex Evans (left) and Ben Keane from Loughrea Gaelic Football Club0 courtesy of Dr David Evans

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*Federal Health Bulletin – Health Research Health Protection | 2004, S. 62

TIDES OF CHANGE ARE SHAPING OUR FUTURE

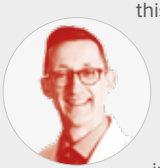
Time is both free and priceless. You can spend it, lose it, buy it, waste it – it's hard to make it, you can never keep it – and it usually flies.

This last year certainly flew, as I found myself making my way to the Annual Scientific Meeting of the IDA in Galway last month. It's always a treat, and this year was no different. Like all good meetings, some of the most enlightening conversations happen at the fringes and coffee breaks. In chatting with colleagues, we all agreed that dentistry in Ireland is currently undergoing many sweeping changes, after a number of years of stagnation.

Importantly, we are all beginning to see many "long-lost" patients finding their way back to the surgery. With this opportunity to finally start reversing the damage inflicted by the harsh cuts comes responsibility and a host of new challenges.

First we have GDPR – with which we are by now all familiar. The ever-increasing onus on practitioners to fall in line with evolving data-handling change is burdensome, to say the least. Increased vigilance on data protection is to be welcomed, however we appear now to be data guardians as well as dental guardians. Aside from the downtime to review and train our administrative staff, I am thinking of the time that will inevitably be lost in explaining this issue to patients who are blissfully unaware of it.

Next up we have the ratification of the Minamata Treaty across Ireland from 1 July. The instruction is clear in relation to the placement of amalgam and its avoidance for children under 15, pregnant women, or breast-feeding women. This can leave the general dental practitioner in a quandary – with a multitude of "What ifs?" that come to mind. What if the patient discovers they are pregnant after an amalgam placement? How do we deal with the male relative of a pregnant patient who asks, "Why is it safe for me and not for her?". These are just two queries that will undoubtedly be raised in the months to come. Again I am left wondering about the downtime in explaining this to our patients.



Just as we recover from GDPR and Minamata, we will (I hope) finally get to see the new Oral Health Policy. I am hopeful that this document will prove a worthy roadmap for our profession. As mentioned in these pages previously, we live in an ageing population. The census information, longitudinal studies and common sense suggests that we should be preparing for the ageing cohort and their specific needs for the longer term. I hope that we don't lose sight of our current cohort. It will take time to digest the policy.

Online processing of the Government Dental Treatment Schemes is to be largely welcomed, though there is a note of caution in relation to the next steps as there has been no provision to recompense the inevitable downtime for this essential training. Unlike our colleagues in the UK and elsewhere, such information meetings, teaching and instruction is left to the GDP to source and provide themselves.

The ever-increasing costs associated with indemnity continue to baffle most. I have been with the same provider for almost 20 years. While I have been in the main happy with the service, I am left a little disappointed that the much-touted "listening to our members" has now resulted in a delay in applying this to our premia. I am not alone in this view. At the IDA conference, I spoke with many colleagues who feel that the fee for one year's general practice is inordinately high. I am also left wondering why there is no administrative hub in Ireland – considering that this organisation has an effective monopoly here? I have given feedback directly to the provider on this topic, and regularly.

And final thoughts this year, in speaking with many dentists over the event, I found that there is growing acceptance of the journey man or woman dentist – a phenomenon almost unheard of 20 years ago.

Simply put: many of the class of 2018 will never own a practice, by choice. On graduation, my class and previous generations had the single aim of opening their own surgery and being their own bosses.

However, on review of the above, one wonders if the onuses discussed here (along with continued regulatory changes) have become too costly and prohibitive?

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News, notes and networks

More investment urged for needs of older people

BDA NI staff and representatives met the Commissioner for Older People for Northern Ireland, Eddie Lynch, in early June to highlight the increasing and ever-complex oral health care needs of a growing elderly population.

The Commissioner is an independent champion for older people who safeguards and promotes their interests, helping to advise and influence government.

Tristen Kelso, National Director of BDA NI, said: "The very strong view from our members is that we must do more to address the health care needs of our older people, particularly those within domiciliary care facilities, and beyond.

"Now, more than ever, we have an increasingly dentate elderly population that requires different and additional levels of care, but the resources simply haven't kept pace. It's vital that the oral health care needs of the older population are prioritised, along with all the other aspects of their general health and wellbeing."


Grainne Quinn, Eddie Lynch and Tristen Kelso

Grainne Quinn, Chair of BDA NI Salaried Dentists Committee, added: "Every day, colleagues working in CDS and also within GDS go to great lengths to provide the best oral care for older people. However, dental professionals want to be able to do more to address the growing needs of the older population, but that requires additional investment and a more joined-up approach across a number of key stakeholders.

"We welcome the Commissioner for Older People's shared interest in addressing oral health issues within the older demographic, and in the context of ensuring better health and wellbeing outcomes for older people in general. We look forward to future collaboration with his office in championing older people's oral health in the future."

BDA NI is calling for a new Oral Health Strategy that seeks to address oral health challenges within the older demographic as well as focusing on child oral health and which takes a prevention-based approach.

BDA is calling on the Department of Health to make oral health a key priority, and recognise that oral health is directly linked with wider public health and wellbeing.

Call for compulsory use of mouth guards in contact sports

A specialist in treating sport injuries, Dr Sally McCarthy, has told the Irish Dental Association that the use of mouth guards should be made compulsory for those taking part in contact sports.

It has been calculated that up to 20 per cent of players of contact sports will undergo serious dental trauma during their playing careers.

"Using a mouth guard can help avoid chipped or broken teeth, nerve damage to a tooth or even tooth loss.

"They also limit the extent of injuries to lips, the tongue and the soft tissues of the mouth," Dr McCarthy told the IDA's annual conference.

She said national sporting bodies needed to recognise their role in protecting their members by making mouth guard use compulsory.

• Mouth guard use among children: Has the GAA policy made a difference? – See Clinical, pages 40-43

Spotlight

Northern Ireland issues to the fore at LDC Conference in Belfast

Question time debate on devolution: from left, Michael Donaldson (Head of Dental Services NI Health and Social Care Board), Eric Rooney (Deputy CDO England), Margie Taylor (CDO Scotland), Joe Hendron (Chair), Simon Reid (CDO Northern Ireland), Colette Bridgman (CDO Wales) and Ben Squires (Head of Primary Care Operations, GMHSCP)

The 2018 LDC Conference was held in Belfast in June, the first time the conference had been held outside England. Forty topics were debated by 240 delegates, with motions submitted by LDCs from Northern Ireland, Wales and England.

Although many of the motions had relevance throughout the UK, two had particular relevance for practitioners in Northern Ireland.

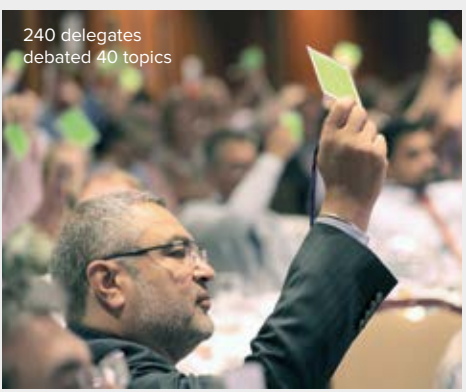
A motion put forward by the Southern LDC asked the conference to agree that the delays in implementation of the pay awards every year, particularly in Northern Ireland, are unacceptable. As with other nations, Northern Ireland continues to have time delays in the application of uplifts. This is usually up to a year from the DDRB publication of its recommendation and is a significant and ongoing issue.

The decision from the DDRB report published in April 2017 was only implemented in April 2017, which meant it had to be backdated for the 12 months it had taken. This followed a zero per cent uplift in the financial year 2015/16 and another 12-month wait in Northern Ireland for the 2014/15 uplift for GDPs, which was implemented in April 2015, again, a full year after the DDRB report was published. For this financial year, the DDRB process was delayed because of the UK elections last year. Evidence was submitted in December 2017, but the DDRB report recommending the GDP pay uplift for 2018/19 is still to be published.

Another motion, again put forward by Southern, asked the conference to endorse the view that it is unnecessary over-regulation to regulate dental practices in Northern Ireland as independent hospitals. James Kelly, Practice Principal and Secretary of the Southern LDC, who spoke to the motion at the conference, explained why his LDC had felt it was so important to raise this issue: "The regulation of dental practices has historically been carried out by dental practitioners appointed by the local health board. This was a local bespoke service, which was used to ensure dental practice met a minimum quality standard. Unfortunately, dental practices were later shoehorned into the independent healthcare regulations 2005(NI). This meant

> "WE WOULD LIKE TO SEE BESPOKE REGULATIONS WHICH WOULD BE RELEVANT AND APPROPRIATE FOR SMALL PRACTICES"

After-dinner speaker Callum Youngson


240 delegates debated 40 topics

Above: Outgoing LDC Chair Joe Hendron, Leah Farrell, Chair Elect for 2020, and Vijay Sudra, 2019 Chair

Right: Henrik Overgaard-Nielsen, Chair, GDPC

that the legislation was extremely onerous, irrelevant and time consuming for practices to meet, as the recommendations generally were only truly relevant to large independent hospitals and nursing homes responsible for complex healthcare needs, not small single or two-handed dental practices."

James is clear that the result of the new system has been detrimental to practices: "We've seen an increase in both practice costs and administration, less clinical time, rising stress on dental profession and increasing costs passed on to patients. We would like to see bespoke dental practice regulations which would be relevant and appropriate for small dental practices. This would take into account the low-risk nature of dentistry as a whole."

Both motions were passed unanimously, and we will be investigating these issues, and any developments around them, in future issues of *Ireland's Dental.*

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September 22
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October 2*
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Professor Tara Renton, Oral Surgery, Kings College London
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October 20
Annual Scientific Meeting 2018: Is It Safe? Understanding & Managing Dental Patients With Medical Problems, RCSI

*Organised by BDA NI. See: https://bda.org/northernireland

In brief

1 New dean and council members at FGDP

The Faculty of General Dental Practitioners has welcomed its new Dean. Ian Mills was inaugurated as Dean of the Faculty of General Dental Practice (UK) in June, and Onkar Dhanoya and Mark Richardson have been elected as the new Vice-Deans.

2 SDCEP amalgam implementation guidelines

The Scottish Dental Clinical Effectiveness Programme (SDCEP) has published advice related to the new regulations around the use of dental amalgam, which came in on 1 July. The advice was commissioned by the four UK chief dental officers and it is expected that it will be adopted in all four nations.

3 Tier 2 visa change will not be applied to dentists

The lifting of the cap on tier 2 visas for doctors and nurses was welcomed by healthcare leaders across all specialties. However, it has now been confirmed that the lifting of restrictions will not apply to dentists or DCPs.

4 Funding increase for NHS

It is expected that Northern Ireland will receive a share of the extra £20 billion a year spending promised to the NHS by 2023 by the UK Prime Minister, Teresa May. This could mean an additional £600 million a year in real terms. It is expected that day-to-day spending on the health service in Northern Ireland in £2018/19 will be just over £5.3 billion. However, any government in place in Northern Ireland would not be obliged to spend the money on health.

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[1] Croft L. Int J Periodontics Restorative Dent. 2003. [2] Compared to other Cavitron models.

‘Morale is low. The system is in meltdown’

Dentists voice their deep discontent over the Dental Treatment Services Scheme’s failure to deliver basic oral care to those who need it most

Writer: Maggie Stanfield

Dentists in Ireland are, officially, disillusioned. Many will use stronger words. Nine out of 10 say they can’t provide adequate care under the current medical card scheme. Even more feel the scheme prevents them from doing their job properly.

In a survey by the Irish Dental Association (IDA) and published at the end of May, the entire Dental Treatment Services Scheme (DTSS) was given a decisive thumbs down.

Indeed, one highly experienced dentist, clinical advisor to 14 practices across the country, says: “Honestly, if I saw this scheme in a Third World country, I’d be wringing my hands.

“Morale is low. The system is in meltdown and the losers are on both the professional and the patient side. As is often the case where cutbacks are concerned, it is those patients with the lowest incomes and most complex needs who are suffering most.”

Since 2010, the number of patients eligible for free dental care has risen to 1,340,412, an increase of almost 260,000 or 24 per cent since April 2009, according to the IDA.

Despite that increase, the number of treatments funded by the HSE has fallen by 24 per cent. Since April 2009, surgical extractions have increased by 41 per cent and routine extractions have increased by more than 12 per cent. Fillings, on the other hand, have fallen by 37 per cent as a direct result of the limitation to two per year.

Overall, state support for dental treatment, through PRSI and medical card schemes, has fallen from a high of almost €150 million in 2009 to less than €75 million last year.

On top of this, the crash forced people to reprioritise their spending. According to the Central Statistics Office, average family spend on dental care has fallen from €197 in 2010 to €84.53 in 2015, even though the majority of dentists have held their own fees static.

How did we get here?

Following the economic collapse in 2009, entitlements to treatment, under the PRSI Dental Treatment Benefit Scheme, were cut severely. Employed people had been entitled to a free check-up and cleaning, as well as subsidised gum cleaning, fillings, extractions, root canal treatments, X-rays and denture work. After the 2009 budget, only the free examination was retained and most people were

Decisive thumbs-down for DTSS

[1]Dentists have voiced their deep discontent over DTSS provision:

"I am scaling down the DTSS work I do now and hoping, long-term, to not do it as it causes too much stress."

"Fees do not cover basic overheads."

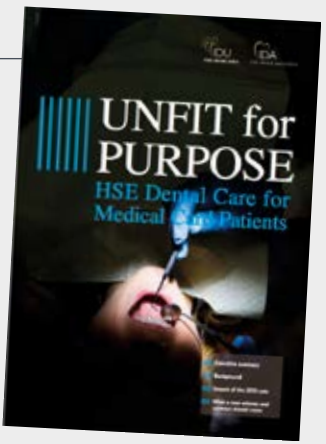
"[There is] an inability to provide the correct treatment."

"Emergency patch-up jobs only for DTSS patients, no comprehensive care; this is very damaging to long-term health."

"[I am] not doing scale and polish in mouths that clearly need it because the patient can't afford it, and only filling the two worst teeth and neglecting others that require treatment because the patient can't pay. [I am] giving prescriptions for pain where a filling would fix the problem but quota has been reached for the year."

"[I am] more or less just doing extractions now."

"It is horrendously stressful trying to explain to patients, routinely, that you cannot provide the basic care that they require."



[1]From the IDA Unfit for Purpose report, 2016 https://www.dentist.ie/_fileupload/AGM%202016/UnfitForPurpose_web.pdf
*Anopa et al 2015

required to pay for the cost of all other treatments.

In 2010, the medical card Dental Treatment Services Scheme was also cut back. Entitlements to cleaning, gum cleaning and X-rays were suspended, root canal treatment could only be performed on an emergency basis and only on front teeth, denture work was only allowed on an emergency basis and people could only have two fillings per year. But extractions, the cheapest of dental pain remedies, could still be performed on an unlimited basis.

The fallout from the financial crash has left an ever-growing number of people, across all age bands, with untreated problems. IDA Chief Executive Fintan Hourihan was quoted as saying: "[The DTSS] is a disgrace for patients and dentists, it's broken and underfunded...[Dentists] are tired of battling with the HSE and having to explain to disappointed patients why they cannot provide them with basic dental care."

And, he added, it's the medical card patients who tend to have poorer oral hygiene and more complex treatment needs as a result.

"How has the HSE addressed their needs? They have quite simply removed preventive and restorative treatments from the very people with the greatest need. Research shows that there was a 38 per cent increase in the number of patients admitted to hospital with severe infections in 2011 and 2012 following the introduction of those cuts," Mr Hourihan said.

> **"[THE DTSS] IS A DISGRACE FOR PATIENTS AND DENTISTS, IT'S BROKEN AND UNDERFUNDED"**

Lack of investment in preventive strategy is a constant complaint from dentists across the country. The publication of the promised new national oral health policy seems to be constantly put off. Chief Dental Officer Dr Dympna Kavanagh has said that she hopes to complete by the end of the year but offers no guarantees.

Meantime, there is little recourse for those in pain and little incentive for regular attendance and review. But it is estimated that one euro spent on prevention avoids three euros in later treatment.

The IDA is calling on the Minister for Health, Simon Harris, to resume contract talks urgently and to commit funding to a new scheme in the next budget.

"Until that is in place, the costs of poor dental health will continue to be borne by the most disadvantaged in society," Mr Hourihan added.

All expectations great and small

Beginning life as a newly qualified dentist brings its own hopes, fears, expectation and excitement. In the first of a two-part series, Keith Moloney from the class of 2018 at University College Cork explains why he chose the profession

Writer: Stewart McRobert

Dentistry was a second thought for 24-year-old Keith Moloney. But don't get the impression he's not fully committed to the profession. It's simply that on leaving school he'd initially taken up veterinary studies at University College Dublin.

However, after a year there he found the course wasn't for him. Ultimately, it seems he prefers working with people rather than animals.

"I always had a huge interest in the health sciences in school and it was actually the clinical aspect of veterinary that led me to believe that dentistry might be the option for me. Also, I was quite good with my hands when growing up, which I thought might provide an advantage when it comes to the intricate work involved in dentistry."

After opting to switch, the decision to choose Cork was determined by geography, family history and reputation. Keith grew up in Limerick, so Cork was always just over an hour away. His father had previously graduated from UCC and on carrying out his own research Keith found that the college is very highly regarded.

Right choice

His own experience over the past five years has confirmed his initial thoughts. "I enjoyed being at UCC; it's a great place to go to college. It is a comparatively small college community, so it was easy to get to know people. The first two years of dentistry provided a typical student experience – a mix of lectures and exams, making friends and going out.

"In third year there was a much greater focus on clinical work. This turned out to be my favourite part of the course, and it confirmed I'd made the right choice. I can say that having experienced clinical work over the past three years I think I will enjoy my career as a dentist."

Keith specifically valued the experience of building a rapport with patients. "It helps boost your own confidence and you learn how to deal with all sorts of different people. As time went on it felt less like college and more like a job."

He has very few, if any, negative comments on the course or college. "I have to say they ease you into

Keith Moloney
Picture by Keith Wiseman

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things at the start and the learning is taken at a very comfortable pace. The staff really do look after you if you ever have any problems. The support they provide is very important in a course like this, which can be quite stressful (reflecting what life is like in the dental sector). Overall, I think we got everything we needed."

The student/staff ratio certainly helped in terms of allowing that support. In Keith's class there were approximately 35 students (although in subsequent years the total has crept up to nearer 50).

Despite their relatively small number, many of Keith's peers were international students. Looking to the future, he believes the global connections he has made could prove useful.

"As far as the quality of teaching is concerned, everyone I came across was extremely skilful, friendly and good at dealing with students. I found staff were very approachable and always happy to help."

Ireland first

Before the summer's graduation ceremony, Keith followed the example of many a student before him by taking three weeks off to relax after an intensive five-year course.

His aim is to get a job in general practice in Ireland soon. It has always been his intention to stay in his home country and disregard, for the foreseeable future at least, the attractions of working abroad.

"In the past a lot of people have headed off to the UK, and back then it was a very easy option to take. However, times have changed and there seem to be jobs available in Ireland for young graduates. I have

University College Cork

Cork Dental School at UCC

The Cork Dental School & Hospital is located in a 90-chair facility on the campus of Cork University Hospital, the main hospital in the south of Ireland. Along with facilities on the nearby University College Cork (UCC) campus, the Dental School is equipped to deliver each stage of the dental curriculum as well as specialised patient treatment. UCC has a complement of more than 17,000 students.

friends in years above me who have stayed and really enjoyed life here so I'm very happy to follow their lead."

Keith has no preferences for any specific part of the country. Most important as far as he is concerned is a practice that gives him support and helps him to learn and grow.

"I plan to develop my skills working alongside a supportive team. Looking long term, I do intend to continue my education, but I still don't know in what direction. I hope my experience in general practice will help guide me.

> **"I PLAN TO DEVELOP MY SKILLS WORKING ALONGSIDE A SUPPORTIVE TEAM"**

"Often you hear people say that the things you love in college you hate in practice and the things you hated in college you love in practice. That's the reason I'm waiting to see how things work out. At college I loved restorative dentistry and oral surgery."

One thing's for sure, even if he ultimately commits to general practice, Keith will undertake further training in areas such as implants. "That's one area that's going to become a necessity for a general dentist.

"I fully realise that there's still an awful lot to learn. Nevertheless, I'm delighted I made the switch from veterinary. So far, things couldn't have worked out any better."

The second part of this series, focusing on a newly qualfiied dentist from Northern Ireland will feature in the September edition of *Ireland's Dental*.

Dental hub marks another enhancement in the student experience

A new 'dental hub' at University College Cork (UCC) was officially opened in April 2018 by Prof Patrick O'Shea, President of UCC, and Dr Christine McCreary, Dean of the Dental School and Hospital.

The hub is said to mark another improvement in the student experience at UCC. It will provide a space for approximately 250 undergraduate dentistry students studying dental hygiene, dental nursing and dental surgery.

In the reconfigured space, students can learn through peer interaction, IT and participation in seminars and lectures.

Notably, the new space provides a quiet and reflective area for students, as well as being a place where they can meet and relax with their peers.

The school ran a competition for a logo for the dental hub and BDS IV student Sinéad McKenna produced the winning design, which is displayed on plaques entering the new space.

Dr Christine McCreary, Dean of the Dental School and Hospital, and Prof Patrick O'Shea, President of UCC

The overall project was supported by funding from the UCC Students Union & Teaching and Learning Spaces initiative of the Vice-President for Teaching and Learning and Cork University Dental School and Hospital.

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Practice market better, but not perfect

The market in dental practices in Ireland is on the up, according to one of the sector's key players. However, uncertainties loom and a return to pre-economic crisis levels of activity are not guaranteed

Writer: Stewart McRobert

If you'd like a barometer of dental practice sales, check out the feelgood factor among Ireland's middle class. That's the view of Dr Niall Jennings, the country's only independent dental broker.

As a dentist, Dr Jennings has been involved with the profession for 45 years, and he believes the fallout from 2008's economic crash crushed middle-class Ireland, which in turn led to practice numbers reducing by around 40-50 per cent.

"In Ireland patients have always been used to spending money on their teeth, and parents too, particularly orthodontics for their children. The crisis saw dental business as a whole shrink markedly," he said.

"Until two years ago credit was extraordinarily difficult to get for dental practitioners. Banks were wary of lending for property, never mind the goodwill of a dental practice, which in many cases is unsecured lending.

"The restrictions they imposed meant if you wanted to buy a €300,000 practice you'd have to find €100,000 of that yourself, and very few people have that kind of money rattling around in their back pocket.

"However, in the last two years, and more especially in the last year, things have relaxed somewhat. The banks are ready to look at the market again."

Valuations

The downturn had an equally negative impact on valuations. Dr Jennings noted that three or four years ago a valuation would be approximately 50 per cent of gross earnings. Now, it's more likely to be 60 per cent, taking into consideration EBITDAR (earnings before interest, taxes, depreciation, amortisation and rent/rates). "It can go higher if certain conditions exist," he added. "For example, if the practice is fully equipped with the latest digital technology, whether there's room to expand, a positive ratio of private/medical card patients, and/or the opportunity to expand services within the practice, and so on."

One factor helping to increase the turnover of practices is Ireland's tax system. Retirement relief allows a practitioner to sell his/her business and assets

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and avoid capital gains tax on revenue gained up to €750,000, under certain criteria.

"You don't even have to retire to take advantage of the relief," said Dr Jennings. "You can offload your practice and continue to work through a transition phase that might last one, two or three years."

That transition is a vital period for the new owner. According to Dr Jennings, Irish dentistry is based hugely on personality and relationships. Few principals sell a practice on a Friday and are gone by the following Monday. Patients are wary of change and often there will be a period of adjustment before a new practice owner is accepted.

"That puts huge pressure on those taking over practices to get the right fit, taking into account staff, the dentists themselves and, especially, patients."

Brexit and beyond

The ongoing saga of Brexit casts its uncertain shadow over a great deal of Irish commerce, and dentistry is not immune. Following the vote in 2016, a good number of Irish dentists decided to return home from the UK, but, Dr Jennings said, that flow has now abated somewhat. "What I'm finding is a big increase in colleagues coming in from Romania and the Baltic states. They are avoiding the UK, but keen to go to an English-speaking country that is relatively stable, open and welcoming."

These newcomers are boosting an existing central and east European presence with a significant number of Polish and Hungarian dentists already established in the country. The changes taking place are adding to the state of flux that Niall believes is currently affecting the profession.

On the positive side, he highlighted the successful response to recession and growing economic strength. "That's brought middle-class Ireland back to a reasonably good level. Dentistry has benefited from that."

On the negative side is the issue of dental associates, in most cases now being regarded as employees by the Revenue. Or rather, Dr Jennings said, it's the consternation caused by the lack of clear guidelines from the Revenue.

> **"DENTISTS WHO FIT IN WITH THEIR PATIENT BASE, ARE SKILLED AND ARE PREPARED TO GIVE A COMMITMENT TO A COMMUNITY WILL PROSPER"**

Dental practices are being approached on a case-by-case basis, which has led to a certain amount of uncertainty within the profession.

"Five years after the ruling, the confusion remains. Recently, Revenue have brought up the concept of VAT being applicable on associates' fees in certain cases."

The lack of clarity can make it difficult for an associate to plan their move to take over a practice. This usually involves building up a war chest beforehand. However, that could be difficult if you are being taxed as an employee, rather than a self-employed individual.

Property rental costs have escalated in recent times, often increasing by up to 50-80 per cent. Meanwhile, planning permission is complicated for anyone who wants to build or develop a practice, and patient fees have become more competitive. "Journeying to Northern Ireland is not quite as attractive for patients as it was 10 years ago when fees there were a fair bit lower than the south. These days, people have to work out if it's worth travelling back and forth to the north for treatment."

There is a persistent belief the country is failing to produce dentists in sufficient number, while EU regulations mean it is difficult to plug any gaps by recruiting non-EU dentists.

Despite the challenges, Dr Jennings believes Ireland remains a great place to work and the marketplace in practices will continue to rise. "Dentists who fit in with their patient base, are skilled and are prepared to give a commitment to a community will prosper and enjoy being part of a fruitful profession."

Chief Executive Colm Davitt says DCI will continue to be an active purchaser in the Irish marketplace for the foreseeable future

‘There are now more career options open to young dentists’

One of the most active players in the current market is Dental Care Ireland. Established in March 2015, the group has embarked on a rapid programme of acquisition. Its most recent addition in Claregaway, Co Galway brings the total number of practices in the network to 13. It is on track to reach a target of 15 by early 2019.

Colm Davitt, founder and chief executive, sees no reason to let up on the company’s ambitions. “It is our vision to have a national network of established, high-quality practices right across the country, so we are open to considering all locations if the opportunity is right.

“All of our practices have a long-standing reputation and loyal patient base in their local area. We look for dentists who are committed to remaining with the practice for at least the medium term and generally our practices have a minimum of three chairs.

“We work closely with the incumbent dentists to build on the individual traditions of the practice, so a positive fit is key. We see potential in places that may not have the time to market themselves, for example, and where we can introduce a specialist. Our aim is to free dentists from administrative burden, allowing them to focus on clinical dentistry.

“We will certainly continue to be an active purchaser in the Irish marketplace for the foreseeable future.”

He has noted a trend towards larger practices that focus on a particular niche, such as cosmetic treatments. “The sector is still in recovery following a long period of stagnation from the recession, but the outlook is generally positive. The reinstatement of some PRSI benefits is a good indicator, and I’m happy to say Dental Care Ireland is going from strength to strength.

“There are now more career options open to younger dentists, and I hope they will continue to be supported to pursue their ambitions. I also hope we will see continued restoration of publicly funded dental benefits, with a view to improving access for patients to quality dental services.”

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Dental implants in the aesthetic zone

An increasingly popular treatment is not without its risks. Full understanding of the process and potential complications will lead to a satisfied patient

Dr Michael Koukoulis

Dental implants are, with little doubt, the preferred choice for replacing missing or failing teeth. They are becoming increasingly popular, more widely available and more affordable as a treatment option.

It is therefore essential that the general dental practitioner has the necessary knowledge and tools to be able to assess and discuss in relative detail the option of dental implants with their patients, regardless of whether they are surgically placing them or restoring them.

The purpose of this article is to provide a quick overview of the specific challenges when considering dental implants in the aesthetic zone and the different approaches to meet these.

The Swiss Society of Oral Implantology developed the SAC classification system (Simple – Advanced – Complex) as a way to broadly categorise the difficulty of dental implant treatment. By that system, "a single tooth gap in the anterior maxilla without a bone defect present" is automatically classified as an Advanced case as it involves an area of high aesthetic demand combined with difficult pre-existing anatomy that presents both surgical and prosthetic challenges.

Clinical conditions that present with tissue deficiencies can be divided into two categories[1].

1. **Anatomic**, which exist naturally, such as a narrow alveolar crest or the facial undercut of the alveolar process.
2. **Pathologic**, which includes dental trauma, acute or chronic infections (periodontal, periapical, endo-perio lesions) and bone atrophy due to long-term tooth loss. (Figures 1a, 1b, 2)

Faced with the above, the treating dentist/surgeon has to keep in mind the following surgical aspects for maximising the aesthetic outcome[2].

1. Pre-surgical planning
2. Implant positioning
3. "Aesthetic" bone grafting
4. Soft tissue management.

1. Pre-surgical planning

Anatomic site analysis – This is arguably the most important decision-making step as it will determine the overall approach to the treatment. The general practitioner, even if not directly involved with implants, needs to be able to provide an initial assessment and have the confidence to discuss available options with the patient before proceeding with treatment or referring as required.

The alveolar crest needs to be evaluated intra-orally and radiographically. Is there a horizontal or vertical bone deficiency? Will a bone augmentation procedure be necessary for *functional* (i.e to maintain primary stability and long-term integration of the fixture) or aesthetic reasons (see below). To quote a colleague of mine, when assessing the aesthetic outcome of an implant, *"soft tissue is the issue but bone sets the tone"*. Hence there are two critical bone structures under consideration:

- **The height and thickness of the facial/buccal bone wall** Several studies have shown that the concept of biologic width can be applied to osseointegrated implants[3-5], in a similar manner that exists

around natural teeth. This translates to a relatively constant thickness of peri-implant soft tissues of approximately 3mm. Therefore, when a facial bone defect is present and in the absence of a bone augmentation procedure, one can expect soft tissue recession and an apically positioned gingival margin resulting in either exposure of the implant collar or an elongated crown with poor aesthetic outcome (Fig 3).

- **The height of the alveolar crest in interproximal areas** This effectively determines the presence or absence of peri-implant papillae ("black triangle disease"). It has been described as highly predictable in **single-tooth** gaps as it is dependent on the proximal bone level of the adjacent teeth and not the implant itself [6,7]. A distance of ≤6mm from the height of the crest to the contact point of the restoration will result in an increased chance of intact papillae filling in the interproximal spaces (Figs 4a, 4b). Inter-implant papillae in edentulous spaces of two or more missing teeth are not predictable, so it is important to discuss the aesthetic limitations prior to therapy to avoid unrealistic expectations. In these cases of multiple missing teeth, the use of implant supported bridges with ovate pontics to create pseudopapillae or the use of pink porcelain may be indicated.

In addition to the above, CBCT scans offer invaluable information with relation to the three-dimensional proximity of anatomical structures in the area such as the nasal floor and the nasopalatine canal, the position and axis of adjacent roots and any "foreign" bodies such as root filling materials, root fragments, unerupted teeth etc.

> "WHEN ASSESSING THE IMPLANT SITE IT IS IMPORTANT TO AVOID 'TUNNEL VISION' IN CONCENTRATING ON JUST THE MISSING OR FAILING TOOTH"

When assessing the implant site, it is important to avoid "tunnel vision" in concentrating on just the missing/failing tooth. The status of the adjacent dentition has to be evaluated in terms of endodontic and periodontal health as well as structural crown integrity.

More often than not, for an anterior tooth to fail or be missing, there is a high chance that the adjacent teeth will be affected by some form of pathology. Their prognosis needs to be assessed and a decision to be made as to whether they can be treated or should be included in the overall implant treatment plan. In many cases, either of the above options is clinically acceptable so it is imperative to explain both to the patient and include them in the decision-making.

The dimensions of the edentulous space need to be measured to assess the potential aesthetic result and symmetry to the contralateral tooth. Even though size differences can be acceptable when replacing missing molars or even premolars, this is rarely the case with the upper anteriors. Therefore, the options of pre-operative orthodontics, enameloplasty, use of restorative materials or accepting a diastema need to be considered and discussed with the patient.

Looking at the soft tissues, two types of gingival morphotype (tissue biotype) have been described: a) Thick flat tissue with shallow scalloped gingivae, dense fibrotic tissue and a wide band of keratinized mucosa. This type is more resistant to recession and tends to respond with pocket formation following surgery or inflammation, making it more favourable when considering the aesthetics of peri-implant tissues. b) Thin, highly scalloped periodontium with a distinct disparity between facial and interproximal gingival levels. This type is more prone to recession therefore in such cases, a further palatal and deeper placement of the implant shoulder should be considered to mask potential show-through and create a smoother emergence profile of the restoration.

Finally, the patient's lip and smile line (high – medium – low) need to be assessed as it can have dramatic implications on the overall aesthetic outcome and will ultimately guide our approach to treatment.

Once the implant site has been assessed, a decision needs to be made with regards to the type of surgical protocol to be followed. Broadly speaking there are three distinct options:

- **Delayed placement** – where the tooth/teeth have been missing for more than six months. These cases can exhibit variable degrees of bone resorption but benefit from healed sites with mature hard and soft tissues and the resolution (usually!) of any pre-existing pathology.

- **Immediate placement** – where the implant fixture is placed directly into the socket of the tooth at time of extraction. Literature has shown high success rates with this approach and has a strong appeal to patients with the clear advantage of reduced treatment times and fewer surgical appointments. It has also been suggested that by immediately inserting the implant, which acts as a tooth root, it may lead to preservation of the hard and soft tissues following extraction. On the other hand, there is potentially a higher risk of complications or a compromised aesthetic result due to a combination of:

1. Pre-existing pathology/ acute infection
2. Difficulty to achieve the ideal three-dimensional positioning of the implant (see below)
3. Traumatic manipulation of soft issues at time of extraction
4. Increased osteoclastic activity following the removal of the tooth
5. Challenging soft tissue closure over the socket.

- **Para-immediate placement** – where the implant is placed six to eight weeks following extraction. This approach allows for a soft tissue seal to develop, high osteoclastic activity to reduce and also time for any acute infection and inflammation to resolve. Nevertheless, a simultaneous bone-grafting procedure will likely be required at time of implant placement.

2. Implant positioning

The correct three-dimensional positioning of the implant shoulder is key in achieving an aesthetic and harmonious outcome. Surgical placement of the implant needs to be restorative-driven, i.e work backwards from the proposed restoration. This is achieved with the use of a preoperative wax-up (or the use of an existing tooth/ crown if satisfactory) to determine the facial profile and gingival margin of the final restoration. A simple clear surgical template can then be fabricated that highlights the position of the buccal gingival margin and will guide the placement to achieve the ideal emergence profile and long-term peri-implant hard and soft tissue support.

The implant shoulder position can be viewed in the following three dimensions: *Mesiodistal, Orofacial (labiopalatal)* and *Apicocoronal*. "Comfort" and "danger" zones can then be defined within these dimensions in relation to achieving an aesthetic outcome.

- Mesiodistal – danger zones are located next to adjacent teeth. Literature varies but general

Fig. references

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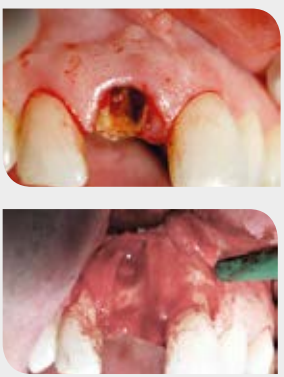

Fig 1a & 1b: Typical loss of buccal bone plate following root fracture of UR1 that was previously restored with a post and crown

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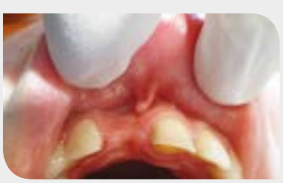

Fig 2: Buccal bone atrophy due to long-term loss of UR1.

3

Fig 3: Recession of gingival margin around UL1 implant due to lack of adequate buccal bone support

consensus is that a minimal distance of 1-1.5mm between implant and root surface and ~3mm between two implants should be maintained. Encroaching on that space can result in resorption of the interproximal alveolar crest with reduction/loss of the interproximal papillae and an asymmetrical restoration with poor embrasure form and long contact zone.

- Orofacial – the facial aspect of the implant shoulder should be approximately 1mm palatal to the point of emergence of the proposed restoration or that of the adjacent teeth (Fig 5) [8]. Too far facially and we see buccal bone loss with soft tissue recession. Too far palatal and then there are issues with the emergence profile resulting in a ridge-lap restoration, which can be un-aesthetic and difficult to maintain.

- Apicocoronal – "comfort" zone for the implant shoulder is about 1mm apical to the CEJ of the adjacent teeth (if no existing gingival recession is present!). More realistically, the same comfort zone is approximately 2mm apical to the midfacial margin of the planned restoration (Fig 6). The principle of "as shallow as possible, as deep as necessary" can be kept in mind in an effort to balance aesthetic and biologic principles. If the implant is placed too deep, it will result in undesired facial and interproximal bone loss as well as prosthetic difficulties. Too shallow of a placement can lead to visible metal margins, poor emergence profile and "square" crown morphology.

3. Aesthetic bone grafting

Can be defined as the regeneration of osseous foundation to serve aesthetic purposes (such as soft tissue support, ideal implant positioning etc.) where it is not "essential" to the stability and osseointegration of the fixture itself. The objective is to augment bone mainly in the *horizontal* direction and establish a thick facial bone wall for long-lasting soft tissue support. The GBR technique shows good results throughout the literature for this. Hard and soft tissue grafting in the *vertical* dimension appears to be more complex with less predictable results, and it is important to discuss this with the patient before the onset of treatment.

4. Soft tissue management

Pre-surgical: This includes techniques aiming to increase existing keratinised tissue such as root reduction prior to extraction followed by immediate implant placement.
At time of surgery: The objective is to minimise traumatic manipulation of the soft tissues. Parapillary incisions are preferable where possible as they have shown to reduce risk of recession/loss of the interdental papillae. Tension-free flap closure is paramount to maintain blood supply, especially in cases where a bone augmentation procedure is carried out. This is achieved by extending vertical incisions and deep periosteal slitting to freely mobilise the flap. Flapless surgery, if indicated, offers the most conservative approach with regards to the soft tissues, but detailed three-dimesional imaging +/- surgical guide for accurate positioning of implant may be necessary.
At abutment connection: The modified roll flap is a relatively simple technique to try to increase soft tissue height labially. It is carried out in cases of a two-stage healing protocol when the implant is uncovered and a healing cover or abutment + provisional restoration are fitted. Alternatively, conventional connective tissue grafts can be also performed at this stage. From the prosthetic point of view, the use of ovate pontics as provisionals can help to create an emergence profile that imitates that of the natural tooth and enhance formation of "pseudopapillae" between adjacent implants. The use of custom- milled healing abutments has also been described. These are used in sequence from smaller to larger to gradually expand the tissues and increase the band of keratinised gingivae. Finally, custom-milled zirconia abutments can offer more natural aesthetics in combination with all ceramic crowns and reduce the risk of metal show-through in case of thin gingivae coronally.

"IF THE IMPLANT IS PLACED TOO DEEP, IT WILL RESULT IN UNDESIRED FACIAL AND INTERPROXIMAL BONE LOSS"

Discussion

There is a multitude of factors to consider when planning or placing dental implant restorations in the aesthetic zone, which are well beyond the scope of this article. New materials (implant surfaces, bone and soft tissue grafts) are developed continuously with new protocols to surgical place and restore implants. In an ideal world with unlimited time and resources, every single implant case would undergo bone and soft tissue grafting with long-term provisional restorations to shape and achieve the best aesthetic outcome. In reality though, aside from the clinical factors mentioned above, the condition of the remaining dentition, finances, treatment duration, need for provisional restorations etc. play an equal role in the decision process.

Therefore it is essential to assess overall patient expectations, explain the treatment options available along with potential challenges/ complications and make a decision *with* the patient on how to approach their treatment. Full understanding of the process, outcomes and potential complications will lead to a satisfied patient as much as sound clinical skills.

Dr Michael Koukoulis, B.Dent.S (Hons) (Glasgow 2003), Pg.Cert Implant Dentistry (Warwick 2006)

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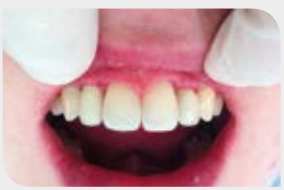


Fig 4a & 4b: UR2 and UL2 implant restorations at fit (4a) and one-year post-op (4b) showing infill of interproximal papillae.

5

Orofacial positioning of implant shoulder showing facial aspect 1mm palatal to point of emergence of adjacent teeth

6

Apicocoronal position showing implant shoulder 2mm apical to the midfacial margin of the planned restoration

Mouth guard use among children: Has the GAA policy made a difference?

Dr David Evans and Margaret O'Malley

Abstract

In 2014 the Gaelic Athletic Association (GAA) made mouth guard use mandatory. The study aimed to assess the impact of the policy on mouth guard use among school children. We replicated a 2011 study of mouth-guard use. A questionnaire was sent to parents of children attending 4th-6th class in a random sample of 25 schools across HSE West. A total of 298 questionnaires were returned for analysis. A total of 68 per cent of children were reported as wearing mouth guards (22 per cent in 2011). Mouth guard use has increased in all sports with Gaelic football experiencing the largest increase (16-87 per cent).

The main type of mouth guard used is 'boil and bite' with 2 per cent using a mouth guard from a dentist. Mouth guard use was significantly greater where schools and sports clubs that children attended had policies on mouth guard use. The number of sports accidents involving teeth reduced from 52 per cent in 2011 to 15 per cent in the current study. Rugby and Gaelic football were perceived to have the highest risk of injury to teeth if a mouth guard is not worn. The study suggests that the GAA policy has made a difference in the promotion of mouth guard use. Policies on mouth guards and their promotion need to be undertaken to increase usage in other sports and to promote the use of custom-made mouth guards.

Background

Although participation in sport plays a key role in the promotion of child health, there are risks that sports activities may lead to injuries, particularly to the teeth. Studies have found that sporting activities are linked to over a third of dental injuries (US Department of Health and Human Services, 2000). Such injuries can be very upsetting for children, requiring extensive long-term treatment. Dental injuries can be significantly reduced by wearing a mouth guard.

However, prior to 2012, the only sport in Ireland where mouth guards were mandatory was boxing. Some other sports promoted mouth guard use, but did not have mandatory regulations. The Irish Rugby Football Union, for example, advised clubs to adopt a 'no guard, no game' rule.

In 2011, we undertook a survey of mouth guard use among national schoolchildren and found that they were only worn by 22 per cent (O'Malley et al, 2012, 2015). In addition, injuries to permanent teeth represented 87 per cent of all sports injuries. Without mandatory regulations, it appeared that the majority of children, for whatever reason, were not motivated to use mouth guards. In April 2012, the Gaelic Athletic Association (GAA) made mouth guard use mandatory for all ages up to under 21 years, which was extended to adults in 2014.

This represented a significant development in the prevention of dental injury. As with any policy, it is important to determine if it has been effective in promoting mouth guard use in Gaelic football. It is also important to see if mouth guard use in other sports has increased. We therefore conducted a follow-up study to assess its impact on mouth guard use, perceptions of mouth guards in terms of reducing the risk of injury, and school and club policy.

Method

To assess changes in mouth guard use among schoolchildren since becoming mandatory for Gaelic football, we replicated our 2011 study of mouth guard use among schoolchildren. A random sample of 25 schools in HSE West (stratified by county) was selected. School principals sent parents of children in 4th-6th class a confidential self-completion questionnaire for each child attending these classes. The questionnaire sought information from the parents about their child(ren), including sporting activities, policies on mouth guards, mouth guard use, barriers to mouth guard use and history of dental trauma and treatment.

Results

Profile

A total of 298 completed questionnaires were received from 25 selected national schools. More than half (54 per cent) were boys with a mean age of 11 years (range 9 to 13 years). On average, children played two sports with Gaelic football (32 per cent), soccer (25 per cent), basketball (31 per cent) and hurling (25 per cent) being the main sports played. The respondent profile is broadly similar to our original research.

Mouth guard use

Overall, 68 per cent of children were reported as wearing mouth guards while playing sport. The corresponding figure was 22 per cent in 2011. Significantly more parents whose children wore mouth guards were aware of the GAA rules for mouth guard use for Gaelic football (83 per cent compared to 54 per cent). For those that wore mouth guards, figure 1 shows the sports where mouth guards were used. It can be seen that of the sports they played, the main sports that a mouth guard was used was for rugby (88 per cent) and Gaelic football (87 per cent). Compared to 2011, the proportion using their mouth guard for each sport has increased, with Gaelic football experiencing the largest increase (from 16 per cent to 87 per cent).

Type of mouth guard

The main type of mouth guard used was 'boil and bite' (64 per cent) with 14 per cent using other types of mouth guards and 2 per cent using a mouth guard from a dentist. This pattern is broadly similar to that found in 2011 (64 per cent, 12 per cent, and 4 per cent respectively with 19 per cent not knowing the type of mouth guard). Half (50 per cent) of parents did not know if the mouth guard from a dentist was safer while 40 per cent reported it was safer or much safer.

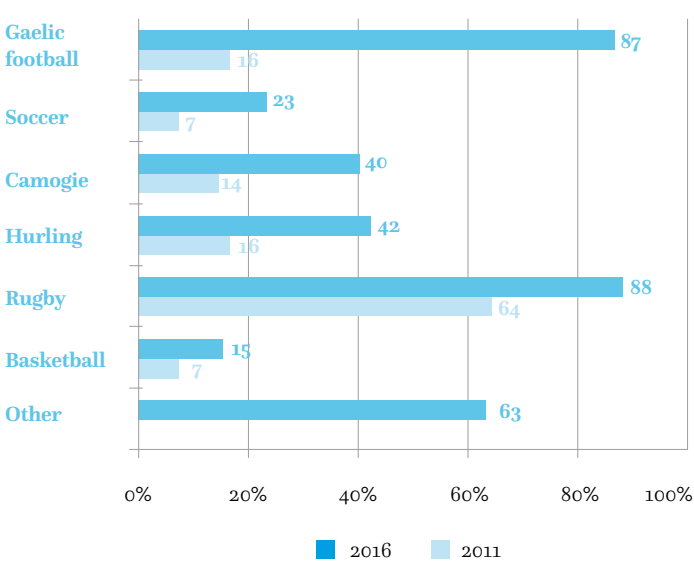
School and club mouth guard policy

Table 1 (overleaf) shows over half the parents reported (51 per cent) that their child's (children) school had a policy on mouth guards. Only 2 per cent of schools had a policy in 2011. In addition, 63 per cent reported that all or most of the sports clubs children attended had a policy on mouth guards (10 per cent in 2011). Mouth guard use was significantly greater where schools and sports clubs that children attended had policies on their use.

Dental trauma

Accidents to children during sport in the last year were reported by

Fig 1 Sports where mouth guard worn for those that use mouth guards



15 per cent of parents (10 per cent in 2011). Of these, 15 per cent involved teeth (52 per cent in 2011). Of those that had accidents involving teeth, 23 per cent were wearing a mouth guard for the last accident. All of these children (n=3) were using 'boil and bite' mouth guards. Injuries to teeth were to both permanent (63 per cent) and deciduous (80 per cent) teeth. Teeth were broken for almost a third (30 per cent) while over a quarter of parents stated that teeth were pushed out of place (27 per cent) and in need of repair. A quarter visited the dentist straight away, while half visited within one week.

Risk of injury to teeth

Parents were asked to rate the risk of injury to teeth if a mouth guard is not worn while playing a number of sports. Figure 2 shows that for each sport, parents whose children wear mouth guards give a higher risk rating. Overall the sports given the highest risk rating are rugby (86 per cent) and Gaelic football (80 per cent).

Discussion

Gaelic football, as with most team sports, involves physical contact. This increases the risk of dental injury, which can be reduced by wearing a mouth guard. Our study has found that since 2011 mouth guard use by children during sport has increased by 209 per cent. Mouth guard use for all sports has increased, but the most dramatic increase is for Gaelic football which rose by 444 per cent. Parents who are aware of the GAA mandatory mouth guard policy are more likely to report that their children use mouth guards. These findings suggest that the introduction of the policy in 2014 is promoting mouth guard use in Gaelic football with a knock-on effect on other sports. This is a positive development, particularly as Gaelic football is the most popular sport played by children in our study.

Although there has been a knock-on effect on other sports, with the exception of rugby, mouth guard use for other sports remains considerably lower. Rugby does not have a mandatory rule, but mouth guard use is strongly promoted and many clubs have mandatory rules. Parents perceive the risk of dental injury to be lower for sports that do not emphasise mouth guard use. Other sports need to consider promoting mouth guard use and also introducing mandatory rules. There is a risk of dental injury associated with all contact sports. Both soccer and basketball for example have a risk of dental

Fig 2 Risk of injury to teeth if mouth guard is not worn

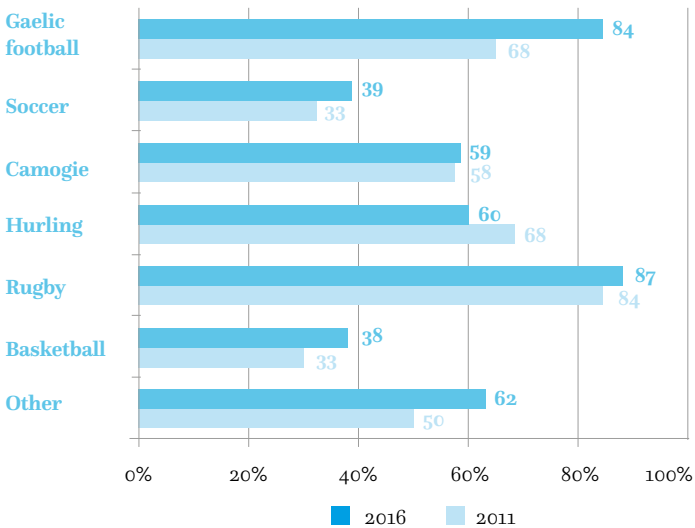


Table 1: School and club policy on mouth guards

SCHOOL AND CLUB POLICY ON MOUTH GUARDS	2011		2016	
	No.	%	No.	%
School policy	10	2	149	51
Club policy				
- all clubs	20	4	111	46.1
- most clubs	29	6	41	17
- some clubs	97	21	57	23.7
- no clubs	309	61	32	13.3

injury from other players, the ground, the ball, and posts.

Without greater promotion and regulation by sports organisations, it is unlikely that other sports will reach the usage levels achieved in Gaelic football and rugby. The importance of promotion and regulation is also demonstrated by the fact that mouth guard use was significantly greater where schools and sports clubs that children attended had policies on mouth guard use. School and club policies have significantly increased since 2011 which appears to be promoting mouth guard use. Parents of children that were in schools or clubs that had mouth guard policies were more aware of the risks of injury to teeth if mouth guards were not worn during sport. There remains considerable scope to introduce more policies, particularly in schools where half did not have a policy in place.

Customised mouth guards from the dentist are the most effective mouth guards, but disappointingly these were only used by 2 per cent of mouth guard users, with this pattern being broadly similar to that experienced in 2011. Half the parents in the study did not know if the mouth guard from a dentist was safer. Parents need to be aware of the safety benefits of customised mouth guards. The GAA do provide information on mouth guards (GAA, 2013) but they do not make recommendations in terms of the preferred type. The use of custom made mouth guards should be promoted and this should be incorporated into policies on mouth guards. As customised mouth guards are more expensive, the GAA suggest that clubs liaise with dental practitioners to enable customised mouth guards to be constructed for players in their club at reduced cost. The GAA should ensure that there are mechanisms in place to facilitate this process. All adults and children that play Gaelic football should be able to have customised mouth guards made by a dentist at a reduced cost.

Accidents involving teeth have reduced from 52 per cent to 15 per cent of all sports accidents. Although the number of accidents is small (suggesting caution in interpretation), it may be that the protection provided by mouth guards is helping to reduce dental injuries. This is also supported by the fact that anecdotal evidence suggests that the GAA have experienced a reduction in dental injury claims, and the HSE has experienced a reduction in sports related dental injury traumas. Interestingly, the three people that had a dental injury that were wearing mouth guards were wearing the 'boil and bite' type, which are less protective compared to customised mouth guards.

Conclusion

The GAA have to be heralded for introducing their mouth guard policy. Our study suggests that it is having a positive impact in terms of promoting mouth guard use among children, both in Gaelic football and other sports. We need to build on this success to increase usage in other sports and to promote the use of custom made mouth guards. Parents need to be made aware of the importance of wearing mouth guards for contact sports. This can be achieved with a combination of policy and promotion by schools, clubs, and the HSE.

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Assessment and treatment of the TMJ

Tony Spain

Anatomy and Motion Review Summary:

The temporomandibular joint (TMJ) consists of the mandibular fossa of the temporal bone and the head of the mandible.

A fibrocartilaginous articular disc separates these two structures. The articular disc and head of the mandible move anteriorly on the articular surface of the temporal bone when the mouth is opened. The head of the mandible also rotates about a transverse axis on the inferior surface of the articular disc[11]. During protraction, the head and articular disc slide anteriorly. During retraction, the head and articular disc slide posteriorly. To close the mouth the temporalis, masseter, and medial pterygoid muscles contract. The lateral pterygoid muscle protracts the mandible and the posterior fibres of the temporalis muscle retract the same structure. To open the mouth, gravity with assistance from the lateral pterygoid, suprahyoid and infrahyoid muscles is required.

Restriction of anterior gliding motion of the mandible and articular disc is the most common dysfunction. As the mouth opens in someone with a right sided TMJ restriction, the left side of the mandible and left articular disc glide anteriorly while the right side is restricted. This results in deviation of the chin to the right side (the side of restriction).

Leg length discrepancy has also been associated with TMJ pain, via pelvic torsion and the resultant functional scoliosis that terminates in the cervical spine thereby unbalancing the stomatognathic system[12]. Many of the muscles in this region act in a dynamic balancing way with the efficiency of this balancing system contributing to effective function of the mouth, throat, cervical spine and head as well as the thorax and upper extremities. Dysfunction in the TMJ can have a widespread effect on the balance of the entire area[6], thus manual therapy can be of great help in returning balance to this area.

Classification:

The approach to evaluating dysfunction at the TMJ and its associated structures can be broadly classified into three groups:

1. Dysfunctional Conditions (Most Common)

I. Altered bite malocclusion
II. Muscular imbalance
III. Capsular strain
IV. Excess chewing
V. Teeth grinding
VI. Stress
VII. Bruxism
VIII. Hypomobility
IX. Hypermobility
X. Disc displacement or adhesion
XI. Trauma to the mandible.

2 Developmental Abnormalities

I. Hypoplasia
II. Hyperplasia
III. Bony impingement of the coronoid process
IV. Chondroma
V. Eagles syndrome.

3 Intracapsular Diseases

I. Degenerative Arthritis
II. Osteochondritis
III. Rheumatoid and psoriatic arthritis
IV. Synovial chondromatosis
V. Bacterial and viral infections
VI. Metastatic tumours.

Observation, examination and diagnosis

Inspect the face, cervical and thoracic spines and jaw, looking for asymmetry and misalignment of teeth. Assess ill-fitting dentures, poorly filled teeth, raised crowns, missing or removed teeth especially molars which contribute to altered bite malocclusion. An intraoral screening, evaluating for evidence of pathology, such as swelling, cavities, and deflection of the soft palate is also recommended.

Subjectively, patients with TMJ pain generally locate their pain to the masseter muscle, preauricular

area, and/or the anterior temporalis muscle regions. The quality of pain is generally an ache, pressure, and/or dull pain and may include a background burning sensation. Episodes of sharp pain may occur, and when the pain is intensified, the primary pain quality may become a throbbing sensation.

Aggravating factors often include stress, clenching and eating, while easing factors include relaxing, applying heat to the painful area, and taking over-the-counter analgesics[1,4,5,10]. Be alert for unexplained fever suggestive of disorders that may mimic symptoms (e.g. infection, giant cell arteritis, meningitis) [2,5]. It is also important to assess from the patient if the movements are painful, if they notice a click or clonk on opening or closing their mouth and whether they grind their teeth.

Place your hands on either side of the patients head with your index fingers anterior to the external auditory meatus (area of the TMJ). Instruct the patient, "Open your mouth slowly." Normal opening should accommodate three of the patient's fingers inserted between the incisors (minimum of normal is a 40mm opening).

If not, **hypo** mobility resulting from joint dysfunction or a closed lock as a result of disc displacement should be suspected. If the patient has a restricted opening, the origin can sometimes be determined by stretching the mouth wider. This is performed by placing the index finger over the incisal edges of the mandibular incisors and the thumb over the incisal edges of the maxillary incisors and pressing the teeth apart by moving the fingers in a scissor-type motion[2]. If there is also an audible ***'clonk'*** on opening the mouth the lateral pterygoid has become shortened pulling the articular disc into a position of mechanical disadvantage, resulting in the condyle riding over the disc[9].

If opening beyond three fingers occurs, **hyper** mobility from ligament laxity (previous trauma) or capsular overstrain is likely[7]. Observe the chin (or midincisural line) for deviation from the midline while palpating the TMJs. Remember that deviation usually occurs to the side of the dysfunctional TMJ, with associated hypertonia of the temporalis, masseter and medial pterygoid muscles, also on the side of dysfunction. The minimum of normal is 7mm to the right and to the left movements, and a 6mm protrusive movement[2,5,15].

Determine if there are changes in tone, texture, and tenderness when palpating the muscles of mastication. Temporalis and

Fig. references

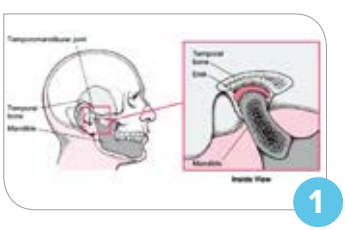

Fig 1: Anatomy of the TMJ

Fig 2: Measuring the opening mandibular range of motion

Fig 3: Palpating the anterior temporalis muscles

Fig 4: Palpating the temporomandibular joints

Fig 5: Soft tissue to temporalis

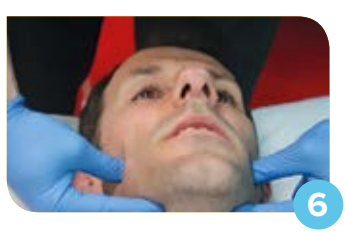

Fig 6: Soft tissue inhibition to masseter

masseter can be reached externally while the pterygoid muscles can be reached intraorally. When working intraorally it is important to explain fully to the patient what you are going to do, preferably demonstrating on a plastic skull first and ensuring you have full consent. It is also recommended that the thyroid, carotid arteries, suboccipital and postural musculature be palpated to determine whether they cause or contribute to the complaint[17,18].

If the patient's pain was not intensified or reproduced on palpation, locate and palpate the myofascial trigger points within the previous structures[19–21]. Maps that identify locations responsible for producing referred pain to the different regions of the head and face are beneficial when the true source of the pain has not been identified[19–21]. In patients with forehead pain, rule out local structures, e.g. sinuses, when identifying the source of referred pain as the cause of this initial pain. Then palpate the structures that have been found to commonly refer pain to the forehead.

Placing gloved thumbs over the lower teeth and wrapping the fingers around the mandible externally can assess the accessory motions of the TMJ intraorally. Apply a passive stress in two directions (i) A-P (anteroposterior) glide and (ii) lateral glide. A springing end feel should be felt. Ask the patient to close their teeth quickly and sharply. A broad painfree clicking of teeth should be heard. If pain or only a single strike is heard, a tooth abscess or malocclusion is indicated [12].

Treatment approaches

The best theory for TMJ dysfunction appears to best target patients and their contributing factors and correlates treatment strategies with their daily variations in symptoms [15-16]. Those that awake with pain that only last minutes to hours implies that nocturnal factors are the primary contributors to these symptoms[2,3,5,13-14]. Those whose symptoms develop later in the day suggest that daytime factors are the primary contributors (e.g., daytime muscle tensing or clenching habits). Patients who report that they awake with TMJ pain that never goes away suggests that both nocturnal and daytime factors are contributing to their symptoms.

Improving sleep positions, wearing occlusal orthotics at night, relaxation prior to sleep and medications that decrease electromyelographic activity have been shown to be beneficial for symptoms that patients awake with. Occlusal orthotics are splints made to cover the occlusal surfaces of mandibular or maxillary teeth and should ideally be worn only at night and possibly for a few hours during the day when the habit of heavy clenching activity has not yet broken.

Relaxation, stress management, orthotics and medications have shown to be beneficial for daytime TMJ symptoms.

NSAIDs and/or steroids, physiotherapy modalities (heat, ice, ultrasound), jaw-stretching, head and neck posture exercises and cervical manual therapies appear beneficial for both awaking and daytime TMJ symptoms.

It is important to decide which therapies have the greatest potential to provide the most cost-effective, long-term symptom relief. It is recommended that the least invasive procedures be used first.

Current best evidence in physiotherapy treatment

The evidence supporting the following is limited however treatments should include

- manual techniques (i.e., stretching, mobilisations, and manipulations of the TMJ and cervical spine)
- exercise instruction (i.e., self stretching and mobility strategies for the TMJ and cervical spine)
- patient education (i.e., postural instruction, relaxation techniques, and parafunctional awareness) and
- modalities that improve tissue health.
- Postural training, manual therapy and exercise, have all demonstrated significant benefit[17] with a systematic review concluding that "active and passive oral exercises and exercises to improve posture are effective interventions to reduce symptoms associated with TMJ"[17]. A second systematic review concluded that active exercise and manual mobilisations may be effective as well as postural training in combination with other interventions[18].

An additional study compared four treatment strategies for TMJ close-lock: medical management (education, counseling, self-help, and NSAIDS); rehabilitation (occlusal orthotic, physical therapy, and cognitive-behavioral therapy); arthroscopy with post-operative rehabilitation; and arthroplasty with post-operative rehabilitation (i.e., physiotherapy). The results demonstrated that "the four treatment strategies did not differ in magnitude or timing of improved function or pain relief [20]. Since the four treatment strategies had similar efficacy, the most cost-effective and conservative methods should be explored prior to progression to more costly, invasive procedures.

One study suggested that osteopathic manipulative treatment can induce changes in the stomatognathic dynamics, offering

a valid support in the clinical approach to TMJ [19]. The use of a variety of structural osteopathic techniques used to treat TMJ dysfunction is discussed here.

Manipulative techniques to the TMJ:

Soft tissue to temporalis muscle
Procedure:
1) Ask the patient to lie in a supine position. Ensure the head and neck are supported with a pillow.
2) The therapist should stand at the head of the table.
3) Locate the zygomatic arch and place your finger pads 2-3 cm superior to the arch and ask the patient to clench and relax their jaw. The temporalis muscle should be felt to contract.
4) By continuing this, you should be able to locate the attachment area of the temporalis.
5) Using re-enforced thumbs, cross-fibre the wide origin of temporalis until you feel the muscles softening and a change in tissue tone.

Soft Tissue to Masseter
Procedure:
1) Ask the patient to lie in a supine position. Ensure the head and neck are supported with a pillow.
2) The therapist should stand at the head of the table.
3) Locate the zygomatic arch and angle of the mandible and place your thumbs between them.
4) Ask the patient to clench and relax their jaw. The masseter muscle should be felt to contract.
5) Once this muscle has been identified, cross-fibre can be carried out until you feel the muscles softening and a change in tissue tone.

Isolytic muscle energy technique:

Muscle energy technique to lateral pterygoids
Procedure:
1) Ask the patient to lie in a supine position. Ensure the head and neck are supported with a pillow.
2) The therapist should stand at the side of the table and should support the patients forehead with one hand whilst the other hand is placed palm side against the middle of the patient's mandible for patient comfort.
3) Ask the patient to open their mouth. The therapist should resist this action for between three to five seconds. Repeat three times. Care should be taken not to force the mouth shut.
4) Re assess muscle tone and check for reduction in mandibular deviation.

Intra-oral techniques

Soft tissue inhibition to lateral pterygoids and medial pterygoids
Procedure:
1) Ask the patient to lie in a supine position.
2) The therapist should stand at the head of the table.
3) Instruct the patient to open their mouth.
4) Using a gloved hand, the pterygoids can be palpated intraorally by the index finger following the molars to the back of the mouth and beyond onto the buccal mucosa, to the medial aspect of the TMJ, just proximal to the tonsils.
5) The lateral pterygoid should be felt more by the tip of the extended index finger. Ask the patient to 'open wide'. You should feel lateral pterygoid contract. Then turn the index finger 90 degrees and flex the distal interphalangeal joint, which should make contact with the medial pterygoid.
6) Inhibition to either muscle can be carried out as necessary but ensure patient comfort

High-velocity thrust (low amplitude)
Assume the patient has a right TMJ restriction. The chin deviates to the right as the mouth is opened. Presume soft tissue preparation has been carried out.
Procedure:

Fig. references

Fig 7: Muscle energy technique to lateral pterygoids

Fig 8: Soft tissue inhibition to lateral pterygoids

Fig 9: High-velocity thrust (low amplitude)

1) Ask the patient to lie in a supine position. Ensure the head and neck are supported with a pillow.
2) The therapist should stand at the head of the table.
3) Rotate the cervical spine to end range of left rotation.
4) Palpate the left TMJ with the finger pads of the index and middle fingers of the left hand. Maintain slight flexion of the cervical spine.
5) Place the medial border of the right hand along the raised border of the mandible and add slight compression.
6) Instruct the patient to "open your mouth slowly".
7) As movement of the mandible is sensed via proprioception of the left hand, a high-velocity thrust (low amplitude) is delivered by the right hand laterally and obliquely towards the side of the couch.
8) This will gap the right TMJ restriction.
9) Re-evaluate motion at the TMJ.

Conclusion

Symptoms emanating from the TMJ and its associated structures are quite common and are frequently sources of considerable functional disability. It is important to consider the structure and functional inter-relation between the structures of the head, neck, TMJ and the body as a whole. More accurate diagnosis of mechanical, pathological and somatic dysfunctions and the implementation of appropriate treatment and management plan is imperative. It is important to rule out disorders that mimic TMJ symptoms, to identify non-TMJ disorders that may negatively impact the patient's TMJ symptoms, and to offer therapies that will provide the most cost-effective, long-term symptom relief. Patient education about the source of their problem and tips to prevent future re-occurrence are essential.

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Avoiding Failures in Aesthetic and Everyday Dentistry

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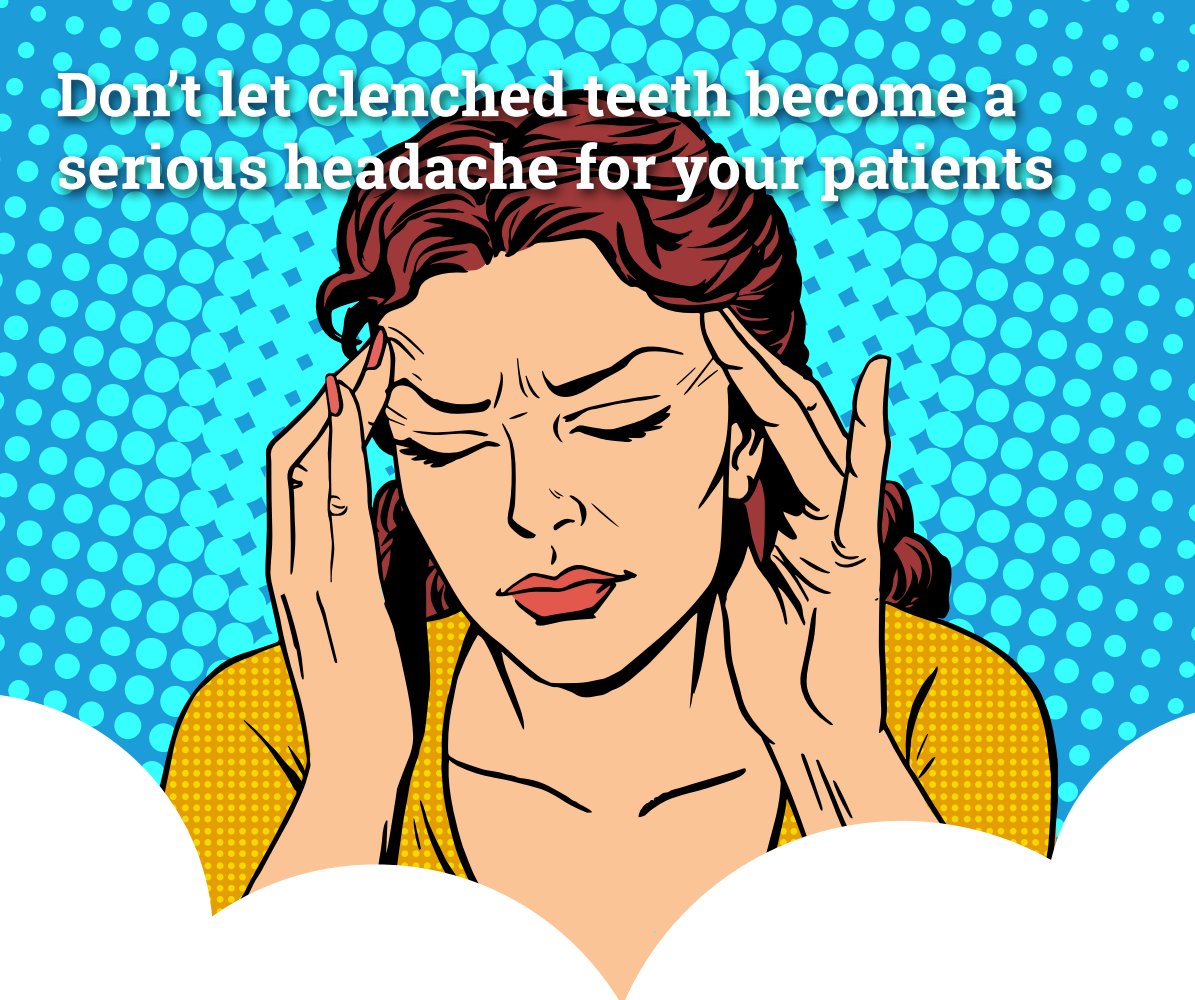

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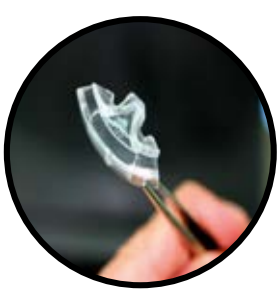

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Leadership – and how to get it right

The most successful leaders are those who acknowledge that they are lacking in some areas and work hard at developing themselves

Alun K Rees

A quick Google search of "Leadership" will come up with more than 50 million results. Yet in spite of all the learned articles, books and research, it is still done badly. From governments to corner shops, problems are caused, opportunities missed and ultimately inefficient results come from poor leadership.

Dentistry is no exception. My experience as a coach has shown me leadership styles that vary from the autocratic, "My way or the highway!" right through to the submissive, "the meek will inherit the earth – if the others don't mind".

I think that one of the main problems is that leadership is perceived as a thing that can be learned from a book, that a style can be copied slavishly and that by doing what appears to work for someone else will succeed for you. Difficulties arise when there is no variation in style, resulting in little or no flexibility.

In fact, there are many styles of leadership and it is important to use the most appropriate in any given situation. Writing in the *Harvard Business Review*, Daniel Goleman quotes the work of Hay/McBer who liken the leadership skills required for success to the different clubs in a golf pro's bag. As the pro goes around a course they choose the most appropriate club for the shot. Sometimes they need to ponder the shot, but usually the choice is automatic and that's how good leaders work.

The six styles and their brief statements are:

Coercive leaders who demand immediate compliance. "Do what I say."

Authoritative leaders who mobilise people toward a vision. "Come with me."

Affiliative leaders who create emotional bonds and harmony. "People come first."

Democratic leaders who build consensus through participation. "What do you think?"

Pacesetting leaders who expect excellence and self-direction. "Do as I do, now."

Coaching leaders who develop people for the future. "Try this."

The most successful leaders are those who acknowledge that they are lacking in some areas and work hard at developing themselves. They have analysed their style or styles, observed what works for others, considered their approach and evolved how they lead into something that is appropriate for the situation, the individuals and the challenges that

Alun K Rees BDS is The Dental Business Coach. An experienced dental practice owner who changed career he now works as a coach, consultant, trouble-shooter, analyst, speaker, writer & broadcaster. He brings the wisdom gained from his and others' successes to help his clients achieve the rewards their work and dedication deserve.

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they or the business generally are facing.

In order to succeed, Goleman tells us, we need to have highly developed "Emotional Intelligence". This he defines as the ability to manage ourselves and our relationships effectively. He describes the four fundamental capabilities as self-awareness, self-management, social awareness, and social skill. Each capability, in turn, is composed of specific sets of competencies.

In any organisation, large or small it is important that those "at the top" develop leadership qualities in everyone within the group.

This does not result, as some resistant dental practice owners have told me, in too many chiefs and not enough Indians, rather it grows within individuals a sense of self and responsibility. It is a role of leaders to identify the traits in others that can be developed and also those that are absent or dormant and should be awakened. Every individual needs to have the knowledge of themselves to understand their role or roles and appreciate the roles of other team members.

> "MY EXPERIENCE HAS SHOWN ME THAT MANY PROBLEMS IN DENTISTRY COMMUNICATION, DISCIPLINE, AND EFFECTIVENESS ARISE FROM THE STANDARD BEARERS OF THE LEADERSHIP LETTING THEMSELVES SLIDE INTO BAD HABITS"

Leaders in any organisation set the tone, establish and maintain the culture and are visible signs of the business's core values. This is easy to forget – especially when new to a job and the temptation to take the path of least resistance and let standards slip can be attractive.

My experience has shown me that many problems in dentistry communication, discipline, and effectiveness arise from the standard bearers of the leadership letting themselves slide into bad habits. Successful people have successful habits, Dan Sullivan tells us, and there is a need for everyone to say, "It's showtime!" to themselves every morning.

Roger Levin recently wrote of the four bad habits that undermine leaders in dentistry and I can only agree.

1) Procrastination – the urge to put off relatively small things can be tempting, especially in a busy practice. Yet the small things grow into big ones, and will weigh you down if there is not a timetable and a deadline for dealing with them.

2) Impulsiveness – team members hate the announcements that start, "we're going to make a few changes". People need to understand the reasons for change, the benefits for them and want to feel consulted. Railroading through a change in policy, procedure or protocols will only provoke resistance and promote unease.

3) Complacency – everything changes. Acknowledge it, be aware of your own comfort zone and know how you resist new ideas. The late adopters and laggards in any walk of life are usually left wondering what happened as their businesses struggle and are left behind.

4) Not sticking to your word – your team members rely on you to do what you have said that you will. Failure to complete or to follow through means you have broken your bond and let them down. If you cannot be trusted how can you expect to get the best from them? Consistency is everything.

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Lorraine McFadden, Senior Dental Nurse, Chorlton Private Dental Practice

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How to stop a practice meeting being a **total waste of time**

Being unprepared and having haphazard, unproductive gatherings of your team can cost you dear. What's on your agenda?

Richard Pearce

Richard Pearce spent some of his early years living in Ballymahon and now lives in Northern Ireland. Following a business career in various sectors and an MBA, he joined his dentist wife in dentistry. Richard combines his wide commercial experience with being attuned to what it is like for an associate dentist, a practice owner and a practice manager. His unique perspective ensures he can assist a practice owner with every area of the practice to create a more profitable practice and to achieve their smart objectives.

Have you ever worked out the cost of stopping production in your practice for one hour and having all staff attend a meeting? Let's consider a three-chair practice (so three dentists who gross £150/hour and three nurses, two receptionists on £10/hour and a PM on £15/hour).

That's, £450 in 'lost' treatment time and £65 in staff costs. This should concentrate our minds that we had better make very good use of this 'face time' with all the staff.

How many practice meetings have an agenda, produce minutes at the end with actionable steps and everyone leaves feeling motivated and understanding what changes/improvements will directly flow from the meeting? Very few, I would suggest. Many organisations have now realised how wasteful a meeting can be and do things such as make it a 'standing only' meeting. This is supposed to make it sufficiently uncomfortable that no-one wants it to last too long and so only make meaningful contributions!

However, the best practices (in my experience) have learnt how to hold regular, productive meetings. This article aims to explain how you too could realise this outcome.

Many businesses hold board meetings. Normally, they are held to allow non-executives (representing shareholders), to engage with executives in the business. They review performance, they help shape strategy, they hold people to account and most importantly they want implementation. There is no reason why a practice cannot follow this 'model' and if done well, will have a positive impact on practice performance.

A key element of a board meeting is the attendance by individuals who do not work in the business on a day-to-day basis. Practices easily suffer from 'group think'. It becomes accepted that; this or that won't work, he or she won't accept/do this, this is the way we've always done this/why change. Having an 'external' board member can be difficult for a practice to engineer, but that's perhaps where a dental business consultant could be useful (I would say that wouldn't I?)

What are the steps needed to ensure positive outcomes?

Have the right people there. The principal, PM and business consultant works for many. Short

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> “PRACTICES, TO VARYING DEGREES, STRUGGLE TO IMPLEMENT. HAVING TO EXPLAIN TO A MEETING WHY AN ACTION HASN’T BEEN COMPLETED CAN CONCENTRATE MINDS AND FORCE ACTION”

slots are given for the lead nurse, head receptionist and compliance manager to join the meeting and present a short report on progress, issues that they have and future actions they are implementing.

Get the timing right. Second Tuesday of the month, 11-1pm, with lunch provided (and some slippage time into the lunch period), works for some. This also gives time for the monthly report to be completed, for the previous month.

Get the meeting pack out in advance of the meeting (say three working days before). This allows everyone to read what’s happened and have questions/thoughts/suggestions ready. Small suggestion – have the financials on yellow paper. You will definitely want the monthly and quarterly P&L available, so make sure everyone can find it.

Have the agenda at the front – here is a suggestion:

- Minutes of last meeting with action points
- Financials – P&L, balance sheet
- Operational Report – average daily yields (ADYs) for each clinician, new patients (source and by clinician), FTAs, treatment conversion rates
- Compliance
- HR – staffing, recruitment, training, disciplinary
- Marketing – what worked, what didn’t, how much each cost, what’s planned, input required
- Equipment/IT/premises
- Reception – Head receptionist report
- Clinical – Lead nurse report
- Any other business.

Conduct of the meeting

A ‘chairman’ is a good idea. A degree of formality helps. Practices, to varying degrees, struggle to implement. Having to explain to a meeting why an action hasn’t been completed can concentrate minds and force action.

The agreed actions must be written down **and who will action, clearly identified**. Actions must have ‘complete by’ dates. This allows you to see how effectively actions are implemented.

Waffle and twaddle

Be specific about an action. “We should certainly look at our prices”, is pointless waffle. “A competitor pricing review of three practices will be completed by 20 July with our own analysis of gross margin on treatment codes. Then a proposed new price list will be provided for the next meeting, by Jayne, the PM, having discussed it with the Principal, one week before the meeting” is more specific.

Minutes

As short as possible, **with actions by who**, highlighted and within two days of the meeting. Minutes are crucial and without them the content and actions from the meeting will be largely forgotten.

In conclusion, the most successful practices know that meetings can be a total waste of time. Therefore, they prepare, have structure, have the right people there (even if only for a short time) and want to see actions and results flow from them. If you want an external representative on your ‘board’, just give me a call.

KIN HYGIENIST OF THE YEAR

Kin Dental Hygienist of the Year is a competition that recognises the hard work, dedication and professionalism of Dental Hygienists in Ireland. Since its inception, the KDHY has been growing in popularity and prestige every year.

We get to hear from patients themselves just what a fantastic job dental hygienists are doing all over the country. The care, attention and professionalism offered to their patients in the important matter of oral health are always the common thread in the comments we receive.

The competition is organised each year by Pamex Limited, the Mayo-based healthcare company. As owner and Managing Director Tom Murphy said: "Pamex is delighted to be involved with such a worthwhile competition and we hope to do so for many more years to come.

"At Pamex, we aim to source products that make life more comfortable for people, and with our Kin Dental products, we are proud to support the competition to nominate the Kin Dental Hygienist of the Year.

"Its aim is to give recognition to those dental hygienists who make their patients feel at ease, who always give professional advice and who go above and beyond for their patients and for their practice".

Pamex invites patients to nominate their hygienist for the award of Kin Dental Hygienist of the Year.

All nominations received are scrutinised by an expert judging panel and the selected finalists are then invited to compile a patient information leaflet.

The leaflets are then judged by the same panel and ultimately a winner is chosen. The prize on offer is a €1,000 educational bursary sponsored by Pamex Ltd., a trophy and a certificate.

> **"IT'S ENCOURAGING TO SEE A COMPANY WILLING TO INVEST SIGNIFICANTLY TO DRIVE DENTAL INNOVATION"**

If you think you have what it takes to be Kin Dental Hygienist of the Year for 2018, ask your patients to log on to www.kindentalhygienist.ie to nominate you today!

Closing date is 31 July 31. Check us out on Facebook – Kin Dental Hygienist of the Year, proudly sponsored by Pamex Limited and Kin Dental, the Professionals' Choice.

Last year's winner Gillian Shannon

KIN

Dental Hygienist of the Year

Congratulations to our 2017 winner of
Kin Dental Hygienist of the year

Gillian Shannon

Her patient leaflet on **"How to care for baby and toddlers teeth"** caught the eye of the judges for its appealing design, health literacy, and overall content. **Gillian received an educational bursary for €1000**, winner's trophy, certificate and badge.

Could you be the next Kin Dental Hygienist of the Year 2018?

Contact your Pamex Ltd representative to ensure you have the nomination poster up in your surgery:

South of Ireland • Contact Sophie on 087 4444 928
West of Ireland • Contact Pamela on 087 4444 947
East of Ireland • Contact Annmarie on 087 9235 523

Closing date for nominations is **31st of August 2018**

Alternatively, nominate your Hygienist and you could win one of three breaks in the fabulous Doyle Collection of hotels.

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Best of luck to this year's entrants

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– Dr Paul Howlett, May 2018

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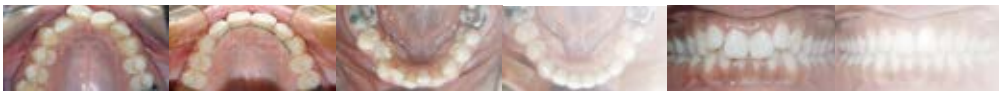

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Strong teeth make strong kids

Shocking research findings have revealed that 23 per cent of five-year-olds and nearly half (46 per cent) of eight-year-olds in the UK have obvious tooth decay in their primary teeth. It was also found that, sadly, 35 per cent of 12-year-old children are too embarrassed to smile or laugh due to the condition of their teeth.

Oral-B is on a mission to support UK parents / carers adopt appropriate home-based oral health behaviours to reduce the number of children with toothache and dental problems – all through its #StrongTeethMakeKids campaign. Oral health experts from Oral-B and the University of Leeds, have now launched a research and education programme to give dental professionals and parents the right support to prevent these dental health issues.

Oral-B's programme aims to educate parents on how they can help their children develop the right habits, as well as lay down a strong foundation for good oral health – for a healthy and confident smile for life.

BUPA DENTAL CARE REVEALS NORTHERN IRELAND'S BEST AND WORSE DENTAL HABITS

New research has found that over 90,000 people in Northern Ireland haven't been for a check-up at the dentist in more than 10 years.

Bupa Dental Care has released a comprehensive new study that looks at dental habits of residents in the region – with some surprising results revealed.

While 70 per cent of people in Northern Ireland brush their teeth twice a day, half have never flossed in their life, and 45 per cent revealed they have never been to a hygienist appointment.

Eighty-five per cent of respondents admitted having had fillings done during their lifetime, equating to over 1.5 million people, while three in four have had a tooth extracted.

Kevin Terry, dentist at Bupa Dental Care Lisburn, said: "These figures reveal a shocking truth. People in Northern Ireland are missing appointments and even skipping brushing – but good dental care doesn't have to be a chore."

The research also found that people in Northern Ireland are reluctant to visit the dentist mainly due to a previous bad experience (30 per cent), fear of the dentist (25 per cent) and lack of time (25 per cent).

Kevin continued: "As dentists, we need to educate people in how easy it is to maintain a good oral health regime. Appointments can be booked weeks, even months in advance, allowing them to manage their schedule and plan ahead.

"In addition, our dentists are trained to help nervous patients overcome their fear and will do their best to make everyone feel comfortable in the practice, from the moment they walk in until they leave. Again it's vital that we're communicating this and highlighting the different techniques we can offer, to ensure we're reaching people who are otherwise deterred from visiting."

"It's really important that we help people support their oral health, which is why we're looking to expand our presence in both Northern Ireland and the Republic of Ireland."

Bupa has 21 Bupa Dental practices in Northern Ireland, and 24 practices in the Republic of Ireland under the Smiles Dental brand. It is currently looking to acquire quality dental practices throughout Ireland.

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In addition to excellent flexural strength, it also possesses outstanding fracture toughness that ensures long-term stability of semi-permanent restorations. Very hard, with a Barcol hardness of 54, in-vitro studies have confirmed its high mechanical strength. Standardised chewing and wear simulations of masticatory behaviour with artificial aging verified a lifespan of up to five years for LuxaCrown.*

Its unique indication as a semi-permanent crown and bridge material with outstanding wear allows for a wide range of indications. It can be used to protect the remaining tooth as well as to restore the anatomical form and masticatory function. LuxaCrown is recommended, too, if long-term observation of treatment success is necessary, when bridging the gap for healing phases and in difficult restoration situations.

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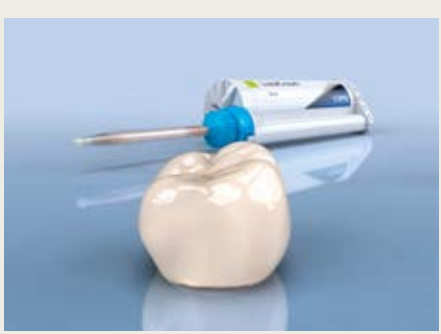
Highly aesthetic, it is specifically formulated for optimal transparency so that it is invisible underneath a restoration and never impacts upon its shade. This makes it the ideal choice for posterior and anterior restorations. Its innovative formulation enables the clinician to easily detect excess cement, even below the gingival margin, and remove it in one piece.

TempoCem ID has a high bond strength, which is designed to prevent leakage, but still allows it to be removed easily. Peroxide, methyl methacrylate and eugenol-free, it flows and mixes easily for ideal handling and without sticking to instruments. It has an optimal consistency for solid and complete seating of the restoration.Radio-opaque, TempoCem ID is supplied in a pack with a 5ml Smartmix 4:1 syringe and 10 Smartmix Tips.

Perfect for long-lasting restorations using TempoCem ID enables clinicians to see their aesthetic worries vanish before their eyes!

*In vitro study of LuxaCrown; N. Albrecht, S. Duy, Germany , FEB 2016

For further information contact your local dental dealer or DMG Dental Products (UK) Ltd on 01656 789401, email info@dmg-dental.co.uk or visit www.dmg-dental.com



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With GM, Neodent® have refined and cleverly taken the best bits of their implant offering and created an outstanding new addition to their range with superb results.

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Ian Creighton, Implant Product Sales Manager, Quintess Denta, with Neodent customer Dr Peter Doherty, 3 Dental Dublin

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*In vitro study of LuxaCrown; N. Albrecht, S. Duy, Germany, FEB 2016