2015

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journal of the european section
international college of dentists

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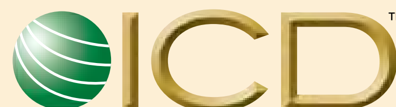

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The International College of Dentists is a leading honorary dental organisation dedicated to the recognition of outstanding professional achievement and meritorious service and the continued progress of the profession of dentistry for the benefit of all mankind.

Motto
Recognising Service as well as the Opportunity to Serve.

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- To provide a universal forum for the cultivation of cordial relations within the profession.
- To foster the growth and diffusion of dental knowledge.
- To recognise distinguished service to the profession and to the public worldwide.
- To promote post-graduate study and research in the field of oral health.
- To contribute to the advancement of the profession of dentistry internationally.
- To encourage and support projects of a humanitarian nature.
- To uphold the highest standard of professional competence and personal ethics.
- To assist in preserving the highest public perception of the profession.
- To perpetuate the history of the profession and maintain its dignity and stature.

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Editorial 4
Looking Back on Ljubljana 2014 - Frans Kroon 5
Root Canal Treatment – Maciej Zarow 9
Prosthetic Rehabilitation of Tumour Surgery in the Head and Neck Area – Katalin Nagy 14
Who Cares? Annelies Kraaijenhagen interviewed by Merryn Jongkees 18
Ten Years of the Philip Dear Foundation - Cecil Linehan 22
Prelude to the Opera – Phillip Dowell 26
Endodontocomix – Rok Jurič 28
"Standing Still Is Not an Option" Tom Feeney interviewed by Frans Kroon 30
Programme Dublin 2015 34
30 Years Let's Have Clean Teeth Tatjana Leskošek Denišlič and Matej Leskošek 36
Districts 39
European Section Officers and Regents 41
Induction Ceremony, Ljubljana, June 2014 – Joseph Kenneally 42
The European Section 2014 Inductees 43

ICDigest 2015 Volume 59

The ICDigest is published annually and is the official publication of the European Section of the International College of Dentists. All statements of opinion and supposed facts are published with the authority of the contributors under whose names the articles are published and are not necessarily to be regarded as the opinion or a policy of the European Section of the International College of Dentists. Therefore, the College, its officers, employees and editors accept no liability or responsibility whatsoever for the consequences of any inaccurate or misleading statements made by the contributors to the publication. All rights are reserved. No part of the ICDigest may be reproduced or transmitted in any form or by any means electronic or mechanical including photocopying or use of any information storage and retrieval system without written permission from the Editor. Published August 2015.

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Postmaster send address changes to:
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ISSN X1565-964

Transforming Traditions

The dual meaning in the title of this preface to your ICDigest 2015 is readily apparent – the transforming nature of the traditions we cherish. Indeed, our traditions transform us as they persuade us to embrace and carry forward the heritage of generations, using carefully crafted and respectfully honoured rites and procedures, the essence of which has crystallized by the process of time. To quote the title of an earlier editorial, they provide constancy amid change, an anchor to our values and ideals. By that same process of time, however, it is incumbent upon us to also transform our traditions, preserving their truths and richness, but refining their perspective so as to ensure they are productive rather than restrictive. It is a debt we owe to our predecessors, who ensured continuing progress by gathering and disseminating knowledge. We will not squander their legacy.

As ICD, we are going through a creative process of reinventing ourselves: gearing up for the future while conserving the best of the past. This involves change and choice, which may at times touch the very heart of our institution. Traditionally, we are an honorary organisation. Over the years, we have invited to our ranks some of the finest characters and talents in the profession, creating an immense reservoir of potential. Paradoxically however, we may find ourselves struggling to tap this potential in a way that benefits society, builds our ranks, and ensures a secure and relevant future for our college. One transformative question we could ask ourselves is: in addition to inviting successful professionals who have achieved, should we also open our doors to ambitious young colleagues who desire to serve and express a wish to join us – allowing them to stand on our shoulders, empowering them with our experience and wisdom to realise new and greater things with their specific know-how that comes with this day and age? Section President Tom Feeney, in his interview in this ICDigest, suggests additional recruitment strategies well worth your consideration. It is these and many other questions we must face as we forge our path forward.

We are going through a creative process of reinventing ourselves

Our Ljubljana meeting last year confirmed the confidence we may have in our ability to make the right choices, and reflected once again the strength and goodness we share among us. Dear East European Fellows, your kindness, etiquette, and professionalism were an inspiration to us all, and your level of excellence is amply reflected in your various contributions to this ICDigest. Importantly, in a time when societies and manners harshen, you reminded us that empathy provides power whereby we truly make a difference in the lives of people, and in so doing find fulfilment and happiness for ourselves. We will ever keep the flame of that noble ICD tradition burning – warming and enlightening our bright future.

Walter van Driel, Editor

The 59th Annual European Section Meeting

Looking Back on Ljubljana 2014

The 59th Annual Meeting of ICD Europe was held in Ljubljana, Slovenia, extremely well prepared and executed by our Fellow Ljubo Marion, Regent of District 14 since the start of the European Section's expansion into Eastern Europe, and Section President for the year 2014.

Frans Kroon

Ljubo Marion, well known and appreciated by the Board for his continuing efforts to grow the number of ICD Fellows in the Eastern Europe area, had chosen the Slovenian capital to host our Section for its Annual Meeting and Congress. Ljubljana proved to be an excellent venue for both the social and academic events: a beautiful, historic city centre, convenient for walking, with interesting, well-kept buildings from past centuries.

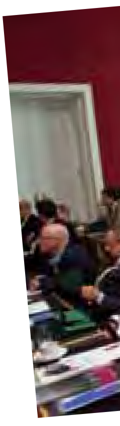
Board members arriving early to attend the Board Meeting on Thursday were in for a treat on Wednesday evening – a visit to the Presidential Palace of former President Tito. An impressive location with even more impressive furniture in the great dining hall.

Most Fellows and Inductees arrived on Thursday and gathered for a garden dinner at the Tivoli Mansion Graphic Art Centre on the outskirts of Ljubljana, an exquisite place offering a vast variety of dishes and delicatessen from the various agricultural areas of Slovenia. The atmosphere was warm and relaxing, greatly enhanced by musicians rendering both classical and local oriented music, and created an excellent setting for Inductees and Fellows to become acquainted.

The Friday was dedicated to Congress sessions and business. For the morning session, Ljubo Marion had succeeded in compiling a most informative series of lectures on the State of the Art of Dentistry in Slovenia and other parts of Eastern Europe. They provided fascinating insights into the effective results that can be achieved both in preventive and clinical dentistry, even on a low budget. Dr Marion and the lecturers deserve our praise for the outstanding quality of these presentations.

In the afternoon session, serious attention was given to the several humanitarian and educational projects of the Section. The lectures were all very worthwhile, most of which can be found in this issue of the ICDigest or on the website.

The social dimension of the Congress had been planned out very carefully also. During the day, accompanying guests were taken out on the river for an enjoyable boat trip through and around the city of Ljubljana. At dinner time, all attendees strolled through the historic city centre to reach their venue for the second social event: the splendid Theatre Hall. It was the perfect



location for the famous group picture, which obviously inspired the photographer to refine the placement of his subjects to a noble art. The evening's programme and menu were delightful, allowing participants to sample additional delicious culinary specials of the country.

The Saturday afternoon Induction Ceremony was held in another impressive structure, the prestigious Opera Theatre. Ljubo Marion and his team, supported with dignity by Past President Aris Petros Tripodakis from Greece as Master of Ceremony, had arranged a magnificent décor for an introduction film and special light show about Slovenia. The audience was then enthralled by a superb classical music performance, baritone and piano, by two 'amateur' musicians, medical academicians and friends of our President.

The Section was congratulated and honoured in the speech of Joe Kenneally, President-Elect of the ICD at Large. The Induction Ceremony for 21 new Fellows was then carried out in its traditional solemnity with short personal introductions of the Inductees by the Regents of the various Districts. The session was closed with the official installation of the Section's incoming President Tom Feeney, Regent of the Ireland District.

The Gala Dinner that night took us back to the Grand Union Hotel, where we enjoyed a charming atmosphere for a superb dinner, enlivened by the pleasant opportunity to dance. Ljubo Marion used this opportunity to thank the lecturers and the members of his organising team for their excellent contributions and support to make this Annual Meeting in Slovenia such a success.

It was finally up to the newly installed President Tom Feeney to thank and commend Ljubo Marion and his team for the superb organisation of the meeting, excellent in its contents and wonderful in the ambiance of the venues of his beloved city of Ljubljana. ■

Problems in aesthetic and restorative dentistry associated with Root Canal Treatment

Discoloured anterior teeth can have a very negative effect on patients' appearance. In the past, root canal treatments frequently used reconstructions by metal posts and crowns. Today, more conservative strategies like bleaching, fibre posts, composite restorations or minimal invasive veneers represent an alternative treatment option. On the other hand, endodontically treated teeth present impaired crown stiffness due to structural loss of hard tissues. The clinical concepts underlying the restoration of root canal treated teeth are as yet unclear and often based on empirical philosophies due to the lack of sound empirical data. The diversity of published opinions is confusing and may lead to suboptimal treatment selections. There is also emerging debate whether or not a post is necessary. The purpose of this article is to provide dental practitioners with practical guidelines for restorative therapy of root canal treated anterior teeth.

Maciej Zarow

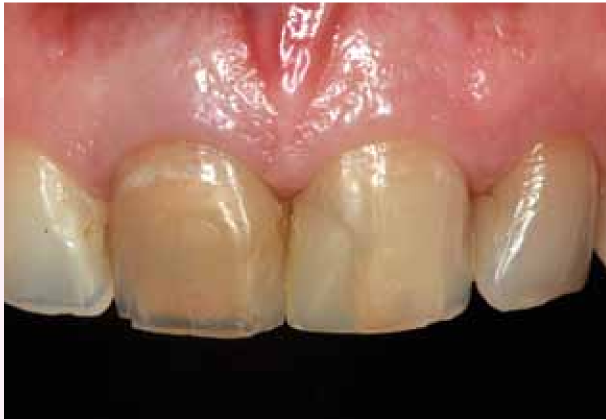
Current Status of Endodontically Treated Teeth

Root canal treated teeth are supposed to be structurally different from unrestored vital teeth. It has been suggested that endodontically treated teeth dry over time and dentin undergoes changes in collagen cross-linking. Therefore endodontically treated teeth are considered more brittle and may fracture more easily than vital teeth. Fenis et al studied more than 46,000 patients from insurance claims and reported significantly more fractures in teeth with endodontic treatment. Moreover, the teeth after root canal treatment usually represent inadequate remaining coronal structure. It is believed that it is the loss of the tooth structure from caries, trauma or both that makes endodontically teeth more susceptible to fracture. Randow and Glantz reported that teeth have a protective feedback mechanism that is lost when the pulp is removed, which may also contribute to tooth fracture. There are also other factors of mechanical weakening effects of endodontic treatment as irrigants (NaOCl, EDTA) and intracanal medications ($Ca(OH)_2$), bacterial interactions with the dentin substrates, corrosive effects of restorative materials, and negative mechanical effects through crack-inducing or crack-propagating endodontic and restorative methods and instruments, including endodontic files.

Recent research shows that dentin has some very effective inherent properties to inhibit crack progression (fracture toughening mechanisms) to optimally distribute local stresses and to partially repair defects, as long as a tooth is vital. On the other hand, endodontically treated anteriors often represent aesthetic problems due to discolouration of coronal structure (Figure 1, 2) and colour change of soft tissue (greyish-blue). The practitioners therefore must both reinforce the already weakened tooth and repair negative effects of discolouration.

Internal Bleaching

In terms of biomechanics and biomimetics, there is certainly no better material than the tooth itself. Thus, the less a tooth is reduced, the better the clinical long-term outcome and potential for reintervention. In case of porcelain veneers or crowns in order to mask dark colour of the tooth, dental laboratories require a certain amount of tooth reduction, which significantly reduces the mechanical and adhesive properties of restorations. For longevity of porcelain veneers, the presence of enamel is crucial. Less enamel means lower adhesion value of the porcelain veneer to the tooth structure and less predictable final veneer restoration. Therefore, instead of reducing the tooth



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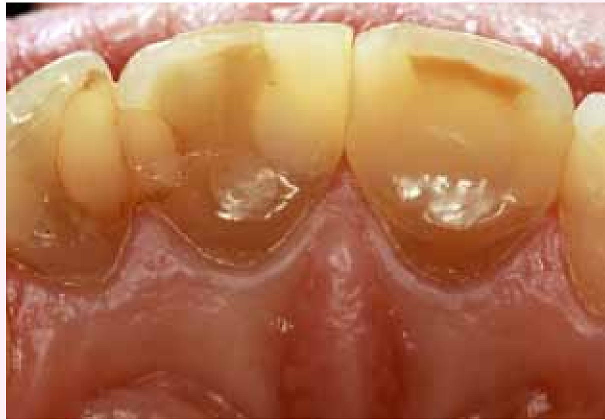

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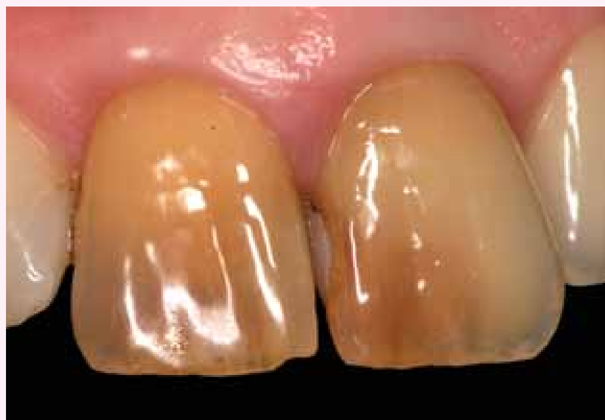
Figure 1, 2. Root canal treated anteriors are often structurally and aesthetically compromised. The example of root canal treated anteriors (teeth 11, 21, 22) in vestibular (Figure 1) and palatal (Figure 2) view.

structure we should try to change the colour as much as possible by bleaching internally. Internal bleaching is well documented in the literature. Sodium perborate[1] remains the primary choice of bleaching materials. The treatment can be successful even for teeth that received root canal treatment and were discoloured many years previously (Figure 3, 4, 5). However, careful examination of the tooth and surrounding tissues is necessary for the success of the bleaching because the outcome depends on the identification of aetiology, correct diagnosis, and proper selection of bleaching technique. The success of bleaching also requires healthy periodontal tissues, properly obturated canal and perfectly positioned barrier (glass-ionomer or phosphate cement) in order to prevent the leakage of the bleaching agent into the periapical tissues.

Today the most commonly used method is walking bleach technique. It refers to the bleaching treatment occurring between the patient's office visits. The term was first used by Nutting and Poe in 1963 and has been modified by eliminating the use of 30% aqueous solution of H_20_2, making it a very popular and safe technique. Sodium perborate powder mixed with water to thick consistency of "wet snow" should be placed in usually two treatments. If no significant improvement is observed after three attempts, the tooth should be reassessed to confirm the aetiology of discolouration and suitability of the treatment plan.

[1] *Editor's note: Council Directive 2011/84/EU recently restricted the use of sodium perborate as a bleaching product.*



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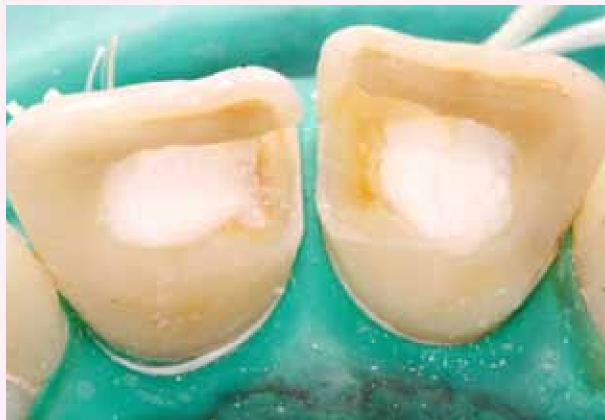

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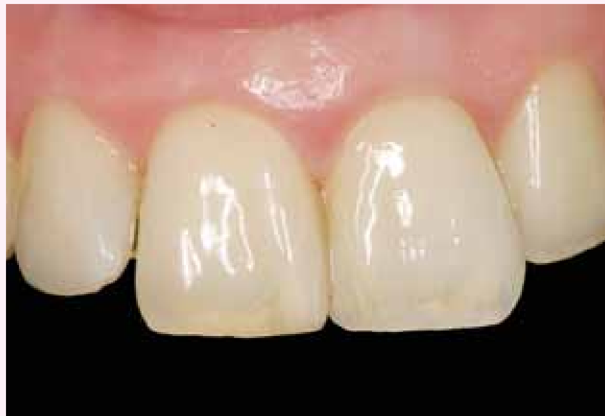

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Figure 3, 4, 5. Heavily discoloured root canal treated upper central incisors (Figure 3) were eligible for internal bleaching. After three attempts of sodium perborate placement into the pulp chamber (Figure 4), immense colour improvement could be achieved (Figure 5). Thanks to successful bleaching, only conservative treatment was performed.

Although the discolouration relapse is possible and described in the literature, usually if it happens, it does not result at the level that has been previously, before the treatment. Today we can also apply methods to reduce the risk of recurring discolouration. The first method employs a custom tray with a bleaching agent reservoir placed periodically on the buccal and palatal surface of treated teeth (recommended for one week every 6 months - applied during sleep). The second method is a mandatory suspension of the final restoration by 2 weeks in order to remove the inhibitory effect on the polymerisation of resin-based materials. More predictable bleaching results are supposedly achieved as a result of improved adhesion and reduced microleakage.

Direct Composite Resin Restorations

For root canal treated anteriors with limited loss of tooth structure, where discolouration was successfully bleached, direct composite resins can be suitable solutions. This indication is especially important for cases where asymmetrical treatments are planned (only in one side of the arch) and for relatively easy restorative procedures with limited loss of hard tissue structure (Figure 6-10).

It is important to remember that covering root canal treated anteriors with crowns does not result in significantly higher longevity versus applying conservative treatment with composite restorations.

Porcelain Veneers

In more complex cases, where symmetrical, aesthetic treatment plans are performed (e.g. 2, 4 or 6 anteriors) indirect restorations are usually preferred as a more predictable smile line can be designed. Bleaching prior to veneer treat-

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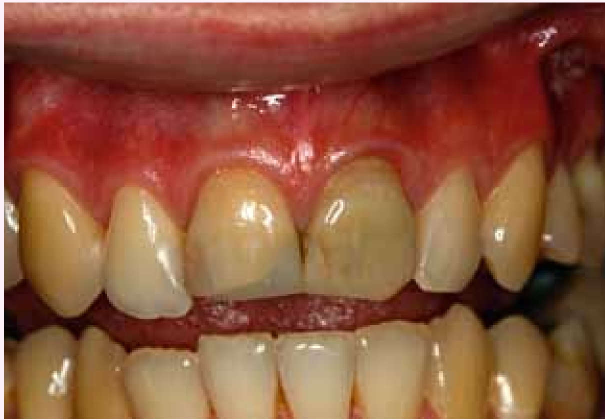
Figure 6-10. Patient was referred to the dental office in order to improve aesthetics of discoloured root canal treated tooth 22 (Figure 6, 7). The tooth was internally bleached with sodium perborate (Figure 8) and after 2 weeks adequate size of composite fibre post was tried (Figure 9) in and adhesively cemented, followed by final composite restoration (Figure 10). Thanks to successful bleaching, only conservative treatment was performed.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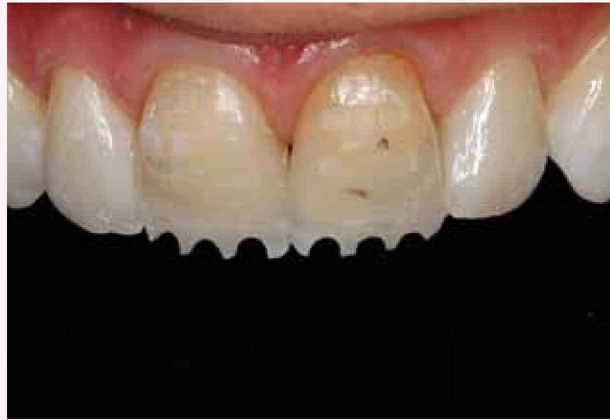
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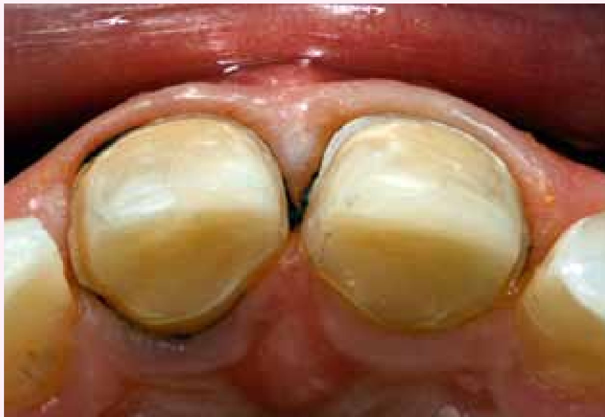
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Figure 11-16. Patient was referred to the dental practice to improve the aesthetics of two root canal treated upper central incisors (Figure 11). For endodontic reasons (previous perforation in tooth 21), internal bleaching was contraindicated and porcelain laminate veneers were planned. The neighbouring vital teeth were bleached with in-office treatment and the length of the central incisors was planned with composite mock-up. Starting from mock-up, minimal invasive veneer preparation was obtained (Figure 12, 13). At the next visit porcelain veneers were cemented under rubber dam isolation (Figure 14) with composite light curing material. Aesthetic final result, satisfaction and pleasant smile of the patient was achieved.

ment is crucial in discoloured root canal treated teeth due to the possibility of reducing the preparation (lighter shade of tooth substructure results in possibility of thinner porcelain veneer to mask the colour). Additionally, deeper preparation of the tooth often results in complete removal of enamel and decreases the porcelain veneer bond strength to the tooth structure. However in some cases, where internal bleaching is contraindicated, the porcelain veneers can be done with some compromises like more opaque porcelain or a little more space preparation for the porcelain material (Figure 11-16).

Full Porcelain Crowns

In other cases, where existing crowns must be replaced, or fractured teeth need to be restored, the full porcelain crowns are usually the only option. Also in the case of heavily discoloured teeth where internal bleaching is contraindicated or unsuccessful, and porcelain veneers would not mask the colour adequately, crowns represent a reasonable option. Today, in most cases lithium disilicate (E-max) porcelain crowns can be used providing satisfactory aesthetics and adequate transparency. However, if there is a need to cover the metal post, or if dentin is extremely dark, zirconia-based crowns represent a better option for some practitioners and their dental technicians.

Post or No Post

As ETT are often structurally compromised, root canal retained restorations were proposed to achieve sufficient anchorage of a restoration.

For many years the cast gold post and core has been regarded as the "gold standard" in post and core restorations due to its superior success rate. Alternatives to cast posts and cores have also been developed. Fibre posts present an elasticity modulus (E) closer to that of dentin (post = 20 GPa, dentin = 18 GPa) when compared to cast posts and prefabricated metallic (E = 200 GPa) and ceramic posts (E = 150 GPa), thereby absorbing and uniformly distributing stresses to the remaining root structure rather than concentrating them.

The use of prefabricated posts and custom-made buildups with composite simplifies the restorative procedure, because all steps can be completed chairside, and fair clinical success can be expected, if all adhesive procedures are followed. Fibre posts not only increase the retention of the core, but also increase the mechanical properties of a composite core, which alone may not be sufficient. The indication for placing a fibre post in anteriors remains very individual and depends on many factors. Simplifying, it can be concluded that it can be placed where more than 50% of the tooth structure is lost or the tooth is supposed to receive a crown.

Contraindications to fibre post reconstruction include the following situations:

- a lot of structure has to be removed in order to cement the post
- not enough supragingival structure remains
- the proper saliva isolation is not possible
- when ETT with limited tooth structure is planned as a bridge abutment (risk of debonding)
- teeth subjected to extensive load bearing forces.

When the ferrule of the endodontically treated teeth is lost, a fibre post should be placed only after ortho-crown or perio-crown lengthening. This decision should be based on tooth position in the arch (for molars - periodontic crown lengthening, for premolars and anteriors - orthodontic crown lengthening is preferable), aesthetic and crown/root length ratio should be considerations. If ferrule execution is not possible, a gold cast post can represent a possible alternative.

Another situation in which a gold cast could be required, is compromised ETT planned as bridge abutments.

Removing the old Post

Removing the old metal post is usually a difficult decision and should be made only in case of absolute necessity of retreatment associated with the post that is relatively easy to remove (short , thin, good quality and quantity of the root and supragingival structure). The absolute equipment requirement are: microscope, ultrasound device and experience in specialised re-endodontics .

Conclusions

For single discoloured non-vital teeth, the walking bleach technique and minimal invasive restoration should be the first choice for a treatment plan.

When supragingival tooth structure is insufficient, the orthodontic extrusion or periodontal crown lengthening should be performed in order to produce the ferrule effect. Direct composite veneers or porcelain veneers with minimal preparation are first choice in contemporary dentistry. The metal post removal can be taken into consideration for endodontic or aesthetic reasons. However, if post removal leaves the remaining tooth structure unrestorable, apical surgery may be the preferred treatment option. ■

Suggested reading available on the ICD European Section website: http://www.icd-europe.com

Maciej Zarow is an Educational Centre Dentist and runs a private practice in Krakow, Poland

Prosthetic Rehabilit Surgery in the Head

Oropharyngeal cancer is more common in developing than developed countries. The prevalence of oral cancer is particularly high among men, the eighth most common cancer type worldwide. Incidence rates for oral cancer vary in men from 1 to 10 cases per 100,000 people in many countries. In South-Central Asia, cancer of the oral cavity ranks among the three most common types of cancer. In India, the age-standardised incidence rate of oral cancer is 12.6 per 100,000 people. It is noteworthy that sharp increases in the incidence rates of oral/pharyngeal cancers have been reported for several countries and regions such as Denmark, France, Germany, Scotland, Central and Eastern Europe and to a lesser extent Australia, Japan, New Zealand and the USA.

Katalin Nagy

There is considerable epidemiological and clinical evidence to show that tobacco use and alcohol consumption represent the major risk factors for this disease. It has been difficult to distinguish the separate effects of these agents, however drinkers of alcoholic beverages tend to be smokers and vice versa. Relatively little is understood about how diet alters oral cancer. Protein-calorie malnutrition is common in patients with advanced oral squamous cell carcinoma and often results in impaired wound healing, reduced immunocompetence and decreased tolerance to chemotherapy, radiotherapy and surgery. Surgical treatment of those patients results in diminished oral food intake for extended periods of time, while radiation therapy causes severe stomatitis, mucositis and diminished salivary secretion. As might be expected, these adverse symptoms often lead to further diminishment of oral intake and to consequent weight loss. It is suspected that poor oral hygiene or compromised dentition might also increase risk.

High Mortality

Within Europe the highest rate of mortality related to oropharyngeal cancer in both genders was reported in Hungary between 1990 and 1992 (+119% in males, +294% in females). Furthermore, Hungary was ranked as number one in morbidity and also in mortality of oral cancer among European countries. This is reflected in the weighted age-standardised incidence rate laid down by the WHO GLOBOCAN 2012 survey as well [ASR-W][1]: this rate is 9.7 in Hungary versus only 6.5 in Slovakia, 5.4 in Romania and 4.2 in Austria. Among European countries, the ASR-W rate is lowest in Greece (1.6), while Hungary with 9.7 (and with a 1.12 cumulative risk) is the number one not only in Central Europe but also of the whole European region. This tendency is further substantiated by data of International Agency for Research on Cancer (IACR). The reason behind this remarkably negative ranking is not completely understood and may not be explained by simple and well-known factors such as tobacco use or excessive alcohol consumption (or a combination of these two). Undoubtedly these agents significantly impact the pathogenesis of oral cancer in the Hungarian population; however the increasing incidence of oral cancer among non-smoker and non-drinker young adults and elderly women goes against such a schematised interpretation.

In a recent (2012) global comparison of 45 countries, Hungary was shown to rank number one for oral cancer deaths among both men (10.9 per 100,000), and women

[1] This rate shows the incidence of the disease according to the standardised world population per 100,000 people and considering the uneven distribution of the disease within each age group.

ation of Tumour and Neck Area

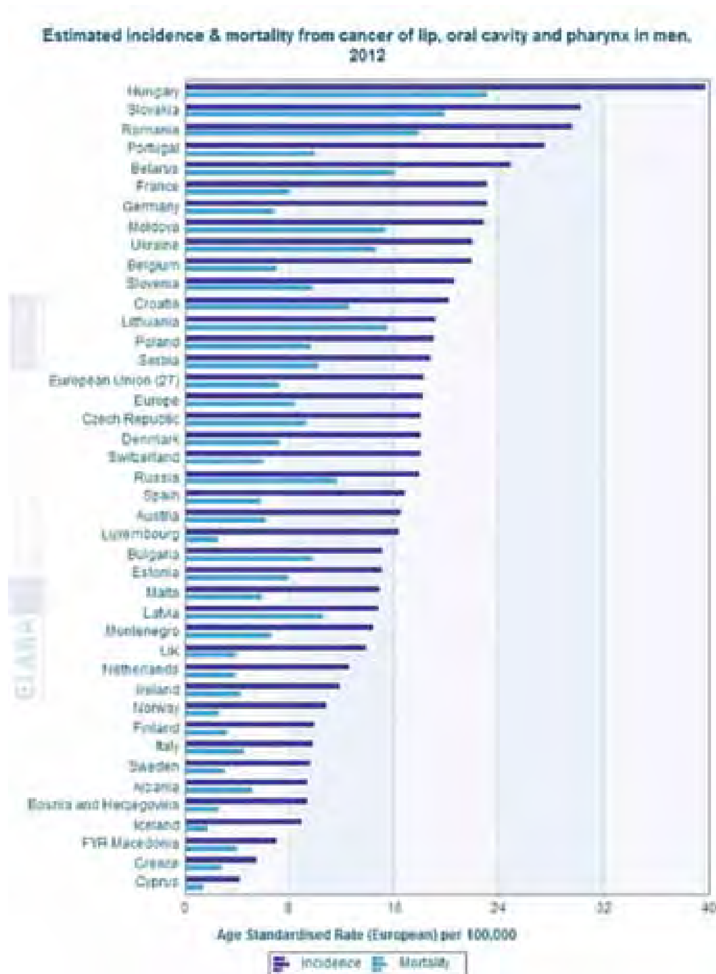


Figure 1

(1.6 per 100,000) (Figure 1). Sadly, Hungary is ranked as number one not only for European oral cancer rates. The Hungarian ASR-W rate exceeds India (7.2); even Pakistan, which is known as the most severely oral cancer-affected country, exceeds Hungary only by one tenth, which is undeniably disquieting data.

Treatments

Oral cancer can be treated surgically, with irradiation, with chemotherapy, or with a combination of these. Progress achieved in the treatment of oral cancer has made it possible to reduce posttreatment mortality and increase survival.

Managing malignant tumours involving the maxilla, mandible, tongue, and adjacent structures represents a major challenge for both the reconstructive surgeon and maxillofacial prosthodontist.

Rehabilitation is a crucial phase of cancer care and plays a very important role from the time of diagnosis. Surgical resection often creates large defects accompanied by dysfunction and disfigurement, while radiation therapy produces significant morbidity and unique tissue management problems. Currently, approximately 70% of Hungarian oral cancer patients are surgically treated, causing many of these individuals loss of teeth, portions of jaws, eyes, nose, or ears. Regrettably, prevailing social attitudes show only limited sympathy towards afflicted individuals. This state is often compounded by rejection even within the patient's immediate family. The impact of these factors alone on the quality of life may lead to socioeconomic failure, depression, and often suicide. Making maximal rehabilitative efforts is essential, not only in correcting physiologic deficits whenever possible but also in providing the necessary emotional and occupational support to help these patients return to their families and society.

Tumours that require maxillary resection create defects of the maxilla, palate, or adjacent soft tissue. They can range from small perforations of the hard or soft palate to extensive resections. Rehabilitation of these defects is best accomplished prosthodontically, with a maxillary obturator (Figures 2a-d). When fabricating the functional obturator prostheses, the main problems to be considered are compromised retention, stability and support.

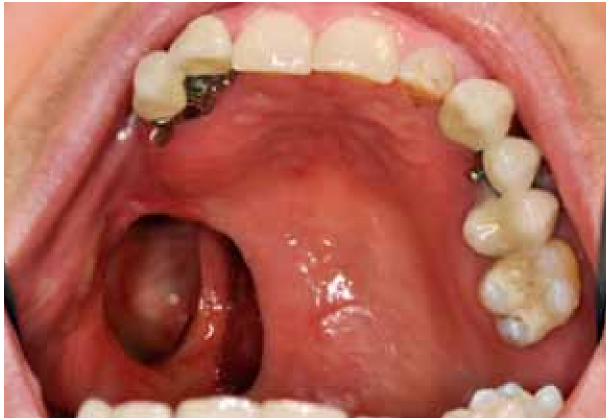
Patients operated on for malignant tumours of the mandible, present a far more difficult rehabilitation problem than patients with maxillary defects.

Advances in the reconstruction of such defects by means of microvascular free flaps have allowed the maxillofacial prosthodontist to rehabilitate these patients more effectively (Figures 3a-d).

In summary, prosthetic prognosis depends on many factors, but prosthetic appliances supported by osseointegrated implants can overcome many of the common difficulties, e.g. retention, stability, or support.

Osseointegrated implants provide an improved means of effective retention for facial prostheses.

The following patient photos (Figures 4a-f and 5a-d) are intended to show how a comfortable, well-fitting and aesthetic facial prosthesis helps to restore patients' self-confidence and allow them to return to society.

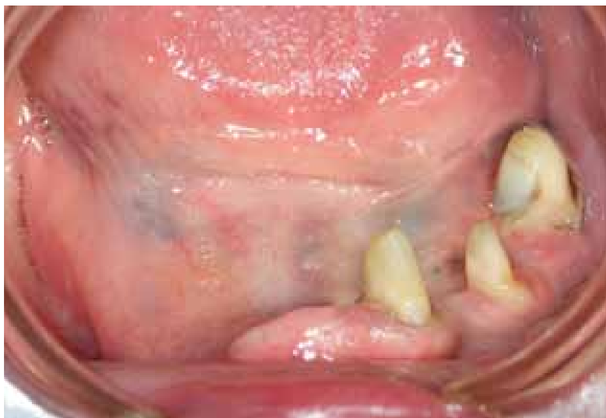


2a. Palatal defect after partial resection of the maxilla.

2b. Partial prosthesis-obturator to close the defect.

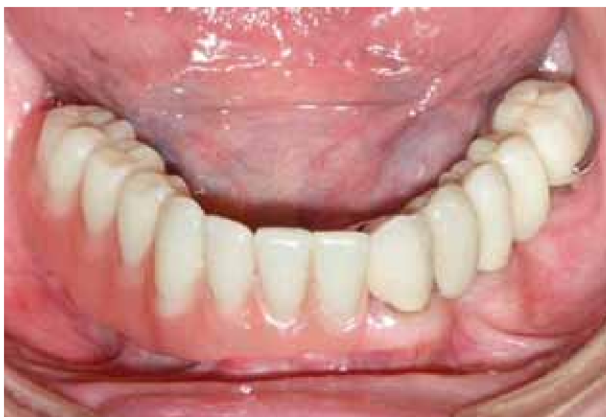
2c. The prosthesis in situ.

2d. Final aesthetic result.



3a. Preparations of remaining teeth after partial mandibular resection and reconstruction.

3b. Combined crown-bar construction to support partial prosthesis.

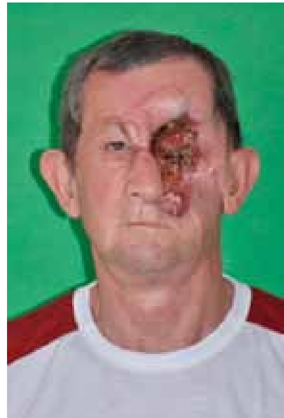


3c. Prosthesis in situ.

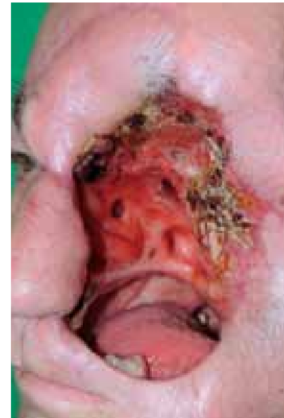
3d. Final aesthetic result.

4a. Frontal view of major facial defect after tumour resection (combined intra- and extra-oral regions, including the orbit).

4b. Lateral view of facial defect, clearly showing the intra- and extra-oral loss of bone and soft tissue structures.



4a



4b

4c. Design of facial prosthesis.

4d. Refining and colouring the prosthesis.

4e. Final result in frontal view.

4f. Lateral view in detail.

5a. Defect after orbital tumour resection in OD.

5b. Design of eye prosthesis.

5c. Final prosthesis in position.

5d. Supporting and improving aesthetic effect of glasses.

Desire, Dedication and Encouragement

Evidence of interaction between team members can most certainly be encouraging to the patient. During the prosthetic phase of treatment, focusing on tissue assessment, impression making, sculpting, mould fabrication, familiarity with materials, appreciation of colour, delivery of instructions, and patient education will ensure a satisfactory outcome. With the desire, determination, and encouragement from the restorative team to make the most of this artificial replacement, patients can have a higher quality of life and a more normalised lifestyle. ■

Suggested reading available on the ICD European Section website: http://www.icd-europe.com

Katalin Nagy is affiliated with the University of Szeged, Hungary

Supporting children in Kenya with an intellectual disability

Who Cares?

She had a captive audience as the keynote speaker at a recent Benelux District meeting in Nieuwegein, the Netherlands. Regent Walter van Driel had invited Dutch Fellow Annelies Kraaijenhagen to share her experiences as a board member of the Dutch Dental Care (DDC) Foundation, which sends self-supporting teams of dentists, oral hygienists and assistants to Kenya twice a year to provide curative and preventive services free of charge. Her 'Who Cares' presentation eloquently and impressively reminded us that a significant unmet need for dental care, particularly in children with physical and mental disabilities, continues to exist in many African nations, including Kenya.

Merryn Jongkees

So, who cares? Annelies, a retired hospital dentist and specialist in the care for people with an intellectual and/or physical disability, asks the question with dual intent – almost with indignation, expecting a high level of proactive initiative of herself and those with whom she associates; but also with tender compassion, finding deep fulfilment in treating people, both European and African, whom many other professionals may find difficult or impossible to work with.

Early Love

Annelies fondly recollects how in the early years of her career, when she had established her practice in a children's hospital in The Hague, she was invited by another ICD Fellow Elinor Bouvy to help set up a dental department in a newly built institution for people with an intellectual disability in Nootdorp, NL. Nor she, nor Elinor had any experience treating this patient group, but they started off with a determination to learn and grow. The two of them travelled extensively to study new approaches and innovations and develop techniques for complex situations (successfully so, in their travels earning a reputation for themselves as the 'Dental Divas'). Treating people with disabilities became her specialism and love of 40 years in addition to her children's hospital work. She cannot talk about it in any setting without consistently and passionately advocating the need for specialised care for these and other challenged populations in our healthcare systems.

Contagious

Around the midpoint of her career, after travelling to Africa and seeing the work of Flying Doctors there, she started to feel a desire to expand her efforts and help people on that continent, but simply saw no way forward with it in her life at the time. But in 2007 she was invited to join a field trip to Kenya by a friend, Dutch dentist Bas Donk, who in turn had been asked by his plumber, who was also his patient, to add volunteer dental services to the humanitarian projects he had been carrying out in construction in Kenya for several years. She describes her first camp experience: 'From a Dutch clinically clean dental practice setting to schools and communities in the bush is a sharp and shocking contrast. It can be overwhelming, but you are there for a purpose and just go to work. People know you are coming, so large groups will be waiting by the time you arrive. It is also physically challenging (and very hot!), but you very quickly don't feel that anymore. Relieving suffering and bringing smiles to anxious faces, it's contagious – I was completely hooked after my first trip!'

Different Mindset

Working under such different circumstances requires a totally different mindset, which can be difficult at first. 'In your regular practice, people are treated on the basis of

Box 1: DDC Statistics

Founded:	2008
Objectives:	- sponsor biannual dental camps
	- facilitate clinics aimed at autonomous local dental care
Camps to date:	35
Team members:	14-16 (dentists, oral hygienists, assistants, logistic support)
Localities in Kenya:	Ukunda region, south of Mombasa (Kwale, Lunga Lunga)
Patient contacts per camp:	1000-1100
Use of funds:	94% spent on objectives
	3% acquisition costs
	3% management/administrative support
Board members:	5
Secretarial/admin support:	4
Supervisory Board:	3
Annual budget:	€ 210.000

a long-term plan,' Annelies explains. 'In these communities, you have just one moment, and you don't know if and when people will see a dentist again. You must live in that moment, deciding to do things you would perhaps not do otherwise. That shift in mindset can be even more challenging and confronting than the primitive circumstances. You learn to deal with it, however; to me it reconfirmed the importance of prevention, which is the only effective dental health strategy there; curative and restorative approaches are not an option in most cases.'

A different mindset is also required for working with mentally challenged people. When asked what sets this apart from working with other people, she explains: 'Definitely the human factor. You have to assess cognitive and socioemotional level, optimal communication strategy, how is the person's 'tuning', when does this person feel at ease and how do I achieve that. It's all about communication, finding the best communication channel for this patient; it's a highly multifactorial approach.'

'It was very gratifying to see that I could use this approach even with a language barrier and not knowing anything of a person except a medication list. My long years of experience guided me in choosing a strategy: pick the tough ones first, who will likely not cry and scare the rest; hand them a mirror, many of them had never seen themselves before except in a puddle of water maybe; then give them a toothbrush, let them feel and handle it, show them how it works; allowing them to taste a little toothpaste, and in so doing gradually creating a relaxed atmosphere where they feel safe; then use diversion techniques as you administer anaesthesia and complete needed procedures; and then of course, reward them for success. I had stacked up before my departure on plenty of things to give away, toothbrushes, caps, pins and the likes; rewards are very important. In addition, I would gather parents and carers around me outside and give workshops on toothbrushing techniques and oral hygiene. I found this approach helped us both to achieve our immediate treatment objectives and also create goodwill that greatly helped our work on subsequent trips.'

Keeping Things Running

Thanks to previous experience from another foundation, DDC had only relatively minor start-up problems, but some issues remain, 'eg, the lack of coordination between relief organisations working in the same area, or communication or cultural barriers with local officials or workers, which can cause long hours of waiting at government institutions or irritation about different expectations. You also have to be on the look-out for infections and HIV. If there is unrest in the country which keeps tourists away, hotels are less frequently used, infections may lurk in dust or stagnant water, some of which do not manifest until after your return. So the first thing you do when you get to your room is let the shower run to make sure the water is clean again.'

Box 2: Who Car(i)es

In the DDC Who Car(i)es study, Annelies Kraaijenhagen and Professor Michiel Eijkman analysed the feasibility of an effective oral health & prevention programme in local schools in the DDC catchment area:

Pilot study in 2011 in 45 students, aged 11/12 at 3 schools

- Oral health measurement (DMFT)
- Student interviews
  - dental pain leading to missed school days
  - use of painkillers
  - availability of toothbrushes and use of toothpaste
- Head master interviews
  - perceived dental pain in students leading to missed school days
  - costs of painkillers, toothbrushes, toothpaste, income of wage earner
  - oral health education in school

Findings

- 45 students
- Mean DMFT 0.9
- DMFT increased with proximity to urbanisation
- 22 children experienced occasional dental pain
- This led to missed school days in 13 students, >10 days in 3 students
- 14 had no toothbrush (some used chewing sticks)
- 18 did not use toothpaste
- 2 head masters confirmed dental pain caused missed school days
- Toothbrush cost € 0.20, toothpaste € 0.30, daily wages € 1.50
- Two schools provided oral health education

Recommendation

DDC has sufficient logistical capability to initiate a preventive dental health strategy by

- limiting target schools to 6-8 and visiting them annually
- secondary prevention in addition to oral health programmes and fluoride toothpaste
- limiting procedures to pain control in adults
- having effect analysed every two years by neutral investigators

'Funding is obviously an important issue. Team members pay their own way, but additional running costs for each camp (instruments, transportation, materials and replacements) come to about € 3,500, so around € 21,000 for 6 camps. DDC is financially strong, thanks to an efficient organisation and network, donations and a very low-cost acquisition programme. Our most important focus is, or should be, our exit strategy – what do we leave behind, or how do we build local expertise to carry on our work without us. We complement the budget of the local organisation – two clinics that come under the CBO (Community Based Organisation) DDCK(enya) – with some € 15,000 each year, but at some point we need new blood and local initiatives so they can do it themselves. So in addition to dental skills, we would like to invest in management, business and logistics training to help our local people be the entrepreneurs that will successfully continue what we started.'

Box 3: Anthropological Perspective

Follow-up study to Who Car(i)es: Cultural and Socioeconomic Factors Impacting Oral Health of the Children in the Kwale District, Targeted by DDC, by Alice Grasveld, 2014

Background

- Western dental humanitarian work in developing countries is frequently unsustainable and may damage local health systems (Van Palenstein Helderman et al. 2012)
- Cultural differences between medical professionals and patients may cause confusion and noncompliance

Questions

- How do people perceive disease and how does this impact their behaviour?
- How do people influence their own health and that of others?
- What cultural and socioeconomic factors impact behaviour, health and healthcare in specific settings?

Domains

- Living conditions
- Diet
- Traditional mouth rituals
- Influence of religion
- Traditional oral health methods
- Aesthetic perception of mouth/teeth

Conclusions

- Sustainability of dental development projects is increased by taking into account local social structures and cultural context. Perceptions driving behaviour must be understood before behavioural change can be initiated
- Development work is more effective when supported and advocated by prominent local members of society

Recommendations

- Involve parents and prominent community members in education/instructions
- Link with religious practices and use chewing stick
- Dietary education
- Win trust of population by using Community Oral Health Officers (COHOs)
- Take time to explain treatment and discuss anaesthesia where possible
- Study traditional oral health methods

ICD Involvement

When asked how ICD could support projects like DDC, Annelies has outspoken opinions: 'There is much good ICD could do here, eg, take inventory of ongoing projects in Kenya and identify duplication, help realign projects to avoid duplication and optimise use of resources. ICD could also be of great help in communication and negotiation with local authorities; this is what I personally find the most challenging aspect of our work there – where do local authorities stand in their commitment to dental and health plans, what is the agenda of the person at the other side of the desk, how do we achieve transparency in mutual expectations, how do we find the local people who are willing and able to support and achieve our objectives? How do we help mobilise commitment of local authorities to oral health? I would love to be part of an ICD task force to study such issues and help improve our current processes. Local doors don't open easily; we need to think out of the box rather than by the book to find creative solutions. Also, we need to understand how the local people think, suggesting a combined anthropological/scientific approach.' [See also Box 2, Who Car(i)es, and Box 3, Anthropological Perspective.]

Fanning the Flame

Annelies' dedication illustrates that you do not necessarily require the strength of youth to serve under rigorous circumstances and make a difference. Many ICD Fellows may find inspiration in her and other Fellows' stories and want to follow in their footsteps, but feel unsure how to proceed. The DDC website (English available) is an excellent tool which may serve as a template for similar initiatives: www.dutchdentalcare.nl ■

Established in 2005 by the European Section of the Interna

Ten Years of the Philip

The European Section of The International College of Dentists established the Philip Dear Foundation at the annual meeting in Stockholm in the year 2005 to commemorate the 50th Anniversary of the founding of the Section as an autonomous unit in 1955 and in particular to commemorate Philip Dear, considered by many to be one of the key Founding Fathers of the European Section.

Cecil Linehan

History of the Establishment of the Foundation

Announcing the establishment of the foundation, Dr B. David Glynn, MICD, European President 1985 and World President 1999 said:

'This is a charitable fund for educational purposes which the European Section is establishing to celebrate its 50th anniversary. Through the Foundation, the European Section seeks to support continuing dental education programmes, oral health-related projects and programmes which encourage the expansion, development and cohesion of the European Section of the ICD.'

Dr Glynn went on to say that the Foundation would be funded in three ways:

- a grant of € 5000 annually to be provided by the Treasurer of the European Section;
- Fellows' contributions from the General Funds to be added as a percentage of the annual dues;
- donations and bequests from Fellows, either in their own name or to remember a loved one.

History of the Name of the Foundation

At the 51st Meeting of the European Section of the ICD in Genoa in June 2006 a special welcome was given to a very special Fellow: Dr William Fitting. Dr Fitting was the first Fellow inducted into the newly founded European Section in 1956 in London by Dr Philip Dear, the European Section's first President. Dr Fitting's grandfather, also Dr William Fitting, studied dentistry in Geneva and later went to the University of Pennsylvania in Philadelphia to obtain his DDS.

There grandfather Fitting met Philip Dear (originally from Australia, also studying in the UP), and later invited Dear to join him in his practice in Lausanne, until his two sons, Edouard (the present Dr Fitting's father) and Louis, graduated as dentists. At that stage it was expected that Philip Dear would return to Australia, but this never happened. Dear stayed on in Lausanne for many years and later moved to Monaco.

Caring by sharing through the Philip Dear Foundation

When Philip Dear activated the European Section of the ICD in London in 1956, he invited 'our' William Fitting to be its first Inductee – 'probably', said Dr Fitting in Genoa, *'as a means of expressing his gratitude to my grandfather, because strictly, being non-Swiss, Philip Dear was not entitled to practice in Switzerland'.*

In relation to the Philip Dear Foundation, Dr William Fitting said in July 2006 in a letter to me, at that time the Editor of the ICDigest:

'I think that it is a very good idea to create something in his name, something to promote good dentistry around the world. It is renewing the programme of postgraduate courses I established when I stepped down from the post of Treasurer of the ICD. The Board then asked me to set up these European Section ICD postgraduate courses and I was pleased to take the initiative in doing so, as prior to this, some of my young colleagues were laughing at me and saying: "What are you doing with all these old gentlemen meeting once a year just for banqueting?"
'The ICD postgraduate courses were delivered by excellent

tional College of Dentists

Dear Foundation

Speakers at the Odessa International Meeting, October 2005, supported by European Section of ICD. From left: Dr Ioannis Fakitsas, Mrs. Fakitsas, Dr Jan van Hoeve, Tania and Paul Becker.

lecturers from Europe and the US, and opened to non-Fellows at a very low price. Rapidly, the opinion of the profession changed in favour of the ICD. I saw that change for many years until I was elected President in 1988. Later so many courses had proliferated that the Board decided to give them up.'

Present Charitable Status of the Foundation.

In the first ten years a considerable number of projects, both humanitarian and educational, have been developed and supported by the Philip Dear Foundation from the modest initial financial sources as mentioned above.
Recently the Treasurer of the Board of Regents of the Section has improved the Charitable Status of the Foundation by arranging through a Notary that all gifts are tax deductible in all (at least all European) Countries.

Projects the Foundation has supported in its First Ten Years

2005: Dr Jan van Hoeve of the Netherlands and Dr Ioannis Fakitsas of Greece addressed 300 paediatric dentists and orthodontists from Albania, Moldova, Belarus, Russia and Ukraine at the first International Meeting in the Academy of Medical Sciences, Odessa (AMSO), Ukraine on 'The Vital Problems of Children's Dentistry and Orthodontia.'

2006: Professor Peter Mossey, Chair of Craniofacial Development and Dento-Facial Orthopaedics at the University of Dundee and Director of the World Health Organization (WHO) collaborating centre for public health issues on congenital anomalies addressed the Second International Meeting in the AMSO, Odessa, Ukraine. Professor Mossey spoke on the 'The Challenge of Craniofacial Anomalies in the Developing World'.

2007: Dr Jan van Hoeve visited Odessa again to give a Masterclass on Periodontology, and Dr Lisa Papagiannoulis of Greece gave a master class to Paediatric Dentists. The funding of a sterilisation unit for Dr Becker for his dental work with children in orphanages in Odessa was also approved.

2008: Dr Sabine Maréchaux, FICD Switzerland, volunteered to visit the dental school in Odessa where she gave lectures on 'Patient Management, Trauma in the Primary and Secondary Dentition and Endodontics in Children'. Dr Maréchaux later arranged to have much-needed materials sent to the dental school in Odessa.

2009: Dr Van Hoeve delivered in Odessa a lecture entitled 'The Importance of Oral Hygiene in Daily Practice' at the Third International Conference on Scientific and Practical Aspects of Individual and Professional Hygiene of the Oral Cavity in Children and Adults.

Through our relationship with the Academy, the Philip Dear Foundation enabled free treatment to be provided for 200 children at the state orphanage in Odessa. The professors performed many procedures, and supervised local fifth-year dental students while they provided chair time at the orphanage as part of their training. This effort was greatly assisted by the cooperation of the ICD American Section. Professor Howard D. Strassler of the University of Maryland provided the majority of dental restorative materials for the orphans.

The Israel, Malta and Baltic States District received a grant of $ 600 per year for three years to send an outstanding student to the IADR Annual Conference where the chosen student is given the opportunity to present his/her paper.

2012 and ongoing: Professor Corrado Paganelli, Chief Dental Officer of Italy, Dean of Brescia Dental School and ICD Regent, volunteered his time to share with educators and students the lessons that can be learnt from mistakes made in Orthodontics.

Examples of Current and Completed Projects

Dr Miguel Pavão, FICD Portugal, founded the NGO Mundo a Sorrir (MAS) and has been extremely active in humanitarian projects in Portugal, Cape Verde, Gambia, and more recently in Mozambique. With other partners, he has received funding from the Philip Dear Foundation for the following initiatives:

Smiles Door to Door – 2012/2013 This project provides oral health care to seniors in nursing homes and day centres in Porto, Portugal. The Philip Dear Foundation has also paid for portable x-ray machine and consumable medical and dental materials.

Healthy Smiles S. Tomé and Principe – 2014 This project was aimed at 1500 six to ten-year-old children, educating them and their parents on oral health and nutrition. The project was extended to six different districts on the island, instructing hundreds of teachers in preventive oral health screening, providing fluoride to thousands of children, and delivering lectures to health professionals.

Smiling Fogo at Cape Verde – September to December 2015 This project aims to improve the oral health of children, teenagers and adults from the underprivileged community in Sao Vicente island of Cape Verde by opening a Dental Social Clinic in São Vicente Island, performing dental treatments to vulnerable and poor children and raising oral health awareness for hundreds of teachers and thousands of children.

Smiles for Mozambique – 2015-2016 (pilot) Mozambique has around 25 million people with a life expectancy of 49 to 53 years. There are only 0.26 physicians to 10,000 people (WHO 2008). This project aims to get to know the oral health care system and the dental needs of the population and promote oral health among children from schools and local communities in Mozambique.

Restoring Smiles in Guinea Bissau – 2015-2016 (pilot) MAS have been working in Guinea Bissau since 2005, where it set up a dental clinic in 2008. However, reports on the work there showed that the most frequently performed treatments were extractions due to no other options for treatment. As there is no operating dental laboratory in Guinea Bissau, the edentulous have to travel to neighbouring countries to have dentures fitted, something they can ill afford. This project will complement the objectives and actions of the current MAS project for promotion of oral health and dental care in Guinea Bissau. The main goals of this project are:

- To restore the masticatory function and oral aesthetics of edentulous patients.
- To set up the first fully equipped dental laboratory in Guinea Bissau to produce removable dentures to the population in need.
- To send dental technicians as volunteers to conduct on-site prosthetics treatments and give training to a Guinean to pursue the profession in the long term in order to make the project sustainable.

Dr Vincente Lozana, FICD Spain, Professor of Odonto-Stomatology of the University of Barcelona works with the Dalit rural communities in Anantapur, in Andhra Pradesh, India. The Anantapur region in South India is one of the most disadvantaged rural areas of the country. 95% of the patients are Dalit, or untouchables, a discriminated community in India. Over two million people are treated every year. Professor Lozano assists the most disadvantaged patients and works for better education of local specialists supported by the Faculty of Dentistry of the University of Barcelona, a centre affiliated with the NGO, Dentistes Sans Frontières which Dr Lozano supports in Nicaragua, Honduras, Haiti, and in the Dominican Republic as well as in India.

The three FICDs in this article, Dr Pavão, Dr Farr (next page) and Dr Lozano all have access also to other sources of funding besides the Philip Dear Foundation and this is a great help to all concerned. There are several other European FICDs involved in humanitarian projects all over the world, some having started before the Philip Dear Foundation was established, others through funding they raise themselves. The European Section salutes them, each and every one.

The liaison between Odessa and ICD Europe originally came through Dr Paul Becker, an FICD from the USA domiciled in Odessa from the early 2000s to 2011. A great deal more work was done with the AMSO and its dental Director, Dr Oksana Denga (now an FICD) with the primary intention of helping her to establish a school for dental hygienists operated through long-distance learning. FICD Professor Patricia Reynolds of King's College, London leads the field in this area and several meetings of the Flexible Learning Advisory Group (FLAG)[1] of the European Section of ICD worked very hard from 2007 – 2011 with this purpose in mind. But sadly for family reasons and at very short notice, Dr Becker had to return to the USA in 2011. Without an ICD presence on the ground in Ukraine, it was impossible to continue the development of the distance learning school for dental hygienists.

[1] Flexible Learning Advisory Group Members: Kate Fabricant, Russia & Switzerland; Phillip Dowell, England; Frans Kroon, the Netherlands; Ken Eaton, England; Isobel Madden, Scotland; Hubert Newman, England; Corrado Pagannelli, Italy; Dov Sydney, Israel; Richard Vaughan, England; Walter van Driel, the Netherlands.

A fully functional dental clinic has been set up in a remote village in the Philippines with support and funding from the Philip Dear Foundation.

The Philip Dear Foundation sponsored travel and subsistence for Dr Oksana Denga and a senior colleague from Odessa to attend a conference on distance learning in Brescia, Italy, led by FICD Professor Pat Reynolds, King's College London; FICD Professor Corrado Paganelli; and FICD Kate Fabricant from Russia now domiciled in Switzerland. The purpose of the visit was to give these two dentists from Ukraine further help in endeavouring to establish a long-distance learning school for Hygienists in Odessa.

A new dental clinic was founded in Gawad Kalinga (GK) Hope Village in Talisay, Negros Occidental, the Philippines. This was the achievement of FICD Dr Hani Farr from Vienna, supported by good friends living in Vienna originally from Negros Occidental. Dr Hani Farr had previously conducted and set up dental clinics in Mexico and the Dominican Republic. Buoyed by the success of these missions, he wanted to conduct a similar mission in Asia, confident that ICD European Section would back his efforts. Dr Farr picked Gawad Kalinga (GK) Hope Village in Talisay, Negros Occidental. It was remote but still accessible; there were no dental clinics for miles and miles around; and the community had a high number of indigent families that would benefit directly from a dental clinic. And so a dental clinic 'for the poorest of the poor' was successfully set up with the support of ICD Europe.

Applications to the Philip Dear Foundation

Application forms are available for download from the web site of the European Section:
http://www.icd-europe.com/the-philip-dear-foundation
All applications for funding go to the Projects and Funding Committee and are assessed for simplicity, suitability, sustainability, serviced by local contact and supported by a written protocol.

On their advice a final agreement will be given by the Board of Regents.

Presently the Members of the Projects and Funding Committee are:
- Dr Gil Alcoforado , Chairman
- Dr Argirios Pissiotis, Registrar of the European Section
- Dr Henk Donker, Treasurer of the European Section

All e-mail addresses are on the Application Form.

Can You Do Something? Yes You Can!!!

I hope that having read this account of the work of the Philip Dear Foundation in its ten short years, you may be inspired to become involved in a humanitarian or educational project in your area. You can volunteer to help in some of the projects in this article; you can give a special donation to the Philip Dear Foundation – just because you want to support its work, or in lieu of presents on birthdays and anniversaries, or in the memory of a loved one.

The European Section salutes all Fellows involved in humanitarian work, wherever it may be in the world

And remember, charity sometimes has to start at home. With so many developed countries cutting back on dental health service systems, there is practically no country where children, vulnerable adults and the elderly are not in need of accessible dental care.

Prelude to the Opera

For me this ICD year started with a journey to Boston USA for an executive meeting held at Tufts Dental school and organized by President Joe Kenneally. We were hosted for dinner by the local district and had a significant battle with the sheer volume of snow that covered New England in a white blanket. The executive meeting deals with similar issues to our section meetings but is more global in its remit. What is particularly striking is the passion and commitment that the Officers demonstrate and their enthusiasm for making the College fit for purpose in the 21st Century. I was very fortunate to spend a couple of days at Joe and Lisa's house in Kennebunk, about an hour's drive north of Boston on the eastern seaboard, a beautiful area peppered with the traditional pastel coloured clapperboard houses so redolent of New England.

Phillip Dowell

The next ICD trip coincided with a holiday to South Africa and entailed a visit to the Dean of the largest dental school in Africa at the University of the Western Cape. There are two campuses for the school which is modern and has an excellent training programme.
The Dean, Professor Yusuf Osman gave me a guided tour and more importantly agreed to help found a new region in Southern Africa, offering the use of the dental school for the first induction ceremony to be carried out early next year.

After South Africa and a journey back home, a short time for repacking in order to travel via Portugal to Sao Tome and Principe, an island country near the equator off the coast of Gabon, West Africa. This was a volunteering experience on behalf of an ICD Philip Dear Fund project organized by Fellow Miguel Pavão and his NGO Mundo o Sorrir or Smiling World. I was accompanied by European chair of Projects Prof. Gil Alcoforado and two other volunteers and during the week we saw hundreds of children, mostly between 6-10 years of age, gave them preventive advice, oral hygiene instruction and fluoride treatment and organized treatment that was required. The amazing demographic was that over 43% of the population is under 14 years old and there is very little in the way of a dental infrastructure set up. The work carried out by the NGO and its volunteers is incredibly worthwhile and it was a very humbling experience to view it first hand and to be a part of it. I certainly intend to do more volunteering and highly recommend it to Fellows with a similar interest.
Following Africa I was called on to carry out the induction ceremony for section X111 China on behalf of President Kenneally whose son was graduating from College that same weekend. The dental school in Chengdu, the capital of Sichuan province, is a state-of-the-art modern school with excellent facilities including a 360 bed hospital. It is a regional centre for cleft palate, trauma and oral cancer and has an equally impressive research block with scientists from multi-disciplinary areas. I was joined in Chengdu by Prof. Raghu Puttiah who is Professor of oral and diagnostic sciences and infection control at Baylor Dental School, University of Texas. Raghu is the Director of the newly formed Dental Safety Program (DSP), an educational initiative of the College, founded following the ICD Memorandum of Understanding with the Organization for Safety, Asepsis and Prevention (OSAP). We gave a half day symposium on infection control which included types of infection, virulence, personal protective equipment, germicides, hand washing and cleaning of dental lines. The DSP project will be rolled out to other sections and

regions and will include a two-day "Train the Trainer" programme which will be given for the first time in India early next year.

As you can see, even as President-Elect of the ICD there is a lot to do and much still needs to be accomplished. I am very much looking forward to seeing many of you in Dublin in October. It promises to be a first class meeting as European President Tom Feeney has put together a very exciting programme and of course Europe is hosting the International Council.
After my induction as International President in Dublin I will be carrying out induction ceremonies in Washington DC, Mexico City and Mumbai, India before year's end.
With all this in mind there are no prizes for guessing the theme of my Presidency.

It will be "Internationalism", but more about that later!

A novel comic book explaining endodontic procedures to patients

Endodontocomix

Endodontology has made tremendous progress in terms of improving the standard of care over the last two decades. Operating microscope, electronic apex locator, nickel-titanium shaping systems, ultrasonic instruments, and biocompatible obturation materials have made endodontic treatment more predictive and successful than ever. Nevertheless, patients still perceive endodontic procedures as painful.

Rok Jurič

It is well known that apprehension correlates significantly to postinstrumentation endodontic pain. Distraction from tension and stress over the upcoming procedure is why magazines and other light reading materials are often made available in the waiting rooms of contemporary dental practices.

Informed consent should be obtained from patients before any endodontic procedure is started. Treatment plan, alternative treatment approaches and treatment consequences should be explained to patients in a direct and tactful way so they fully understand all conditions, risks, side effects and the prognosis of treatment.

Combining light reading with learning about the endodontic procedure in a comic strip can be an effective strategy to help patients overcome their tension and confront the dreaded theme in a way that might both comfort them and provide useful information about their condition. As the most direct and popular printed medium, the comic strip has had well documented educational objectives from the very beginning when the first comic strip The Yellow Kid, presented by Richard F. Outcault, was published in The New York World in 1895.

Endodontocomix is a novel comic booklet explaining endodontology to patients in a humorous, exaggerated and caricatured way. Comic artist Cyril Horjak, known in the world of comics as Dr Horowitz, explains in autobiographic style his experience with root canal treatment.

In Part One of Endodontocomix, Cyril experiences pain in his lower first molar. His dentist Dr Greta Percha briefly explains to him the anatomy of the tooth and aetiology of caries and periapical granuloma (Figure 1). Step by step readers can follow her primary endodontic treatment of Cyril's lower molar from the access cavity opening and rubber dam placement through chemomechanical instrumentation of the root canal system to the intracanal medicament placement and final obturation of the root canal system in the following session. All the necessary instructions about posttreatment sensitivity and cleaning and chewing during and after the endodontic treatment are clearly explained.

Part Two of Endodontocomix focuses on a difficult endodontic treatment, where additional instruments are needed – operating microscope, ultrasonic instruments, rotary Ni-Ti files, etc. Dr Percha refers Cyril to the endodontic clinic where Dr Rootman, specialist in endodontology, treats the most challenging endodontic patients. Dr Rootman explains to Cyril the difference between endodontic procedures performed by a regular dentist and by an endodontist (Figure 2). Through treatment of Cyril's upper molar, which has severely curved and obliterated canals, readers are introduced to modern endodontic practice – the purpose of the various instruments, passive ultrasonic irrigation and warm gutta-percha obturation technique are explained in a funny yet highly informative way. At the end of Part Two, the prognosis of endodontic treatment is briefly explained as well as endodontic microsurgery; apicoectomy, hemisection or implant placement are clearly outlined.

Comic strips would seem to be a perfect medium to inform patients about medical procedures which could be difficult to understand when they are explained using only words. Also, while videos or photographs of surgical procedures are very informative, patients may have problems viewing blood and human tissue. Comic strips have both the informative power of photographs or videos, and also clear language expression without overly vivid representations of the procedure which could distract patients from the reading. The autobiographic story of Cyril, who is a busy comic artist, husband and a father in his mid-thirties, is highly credible and most readers will be able to identify

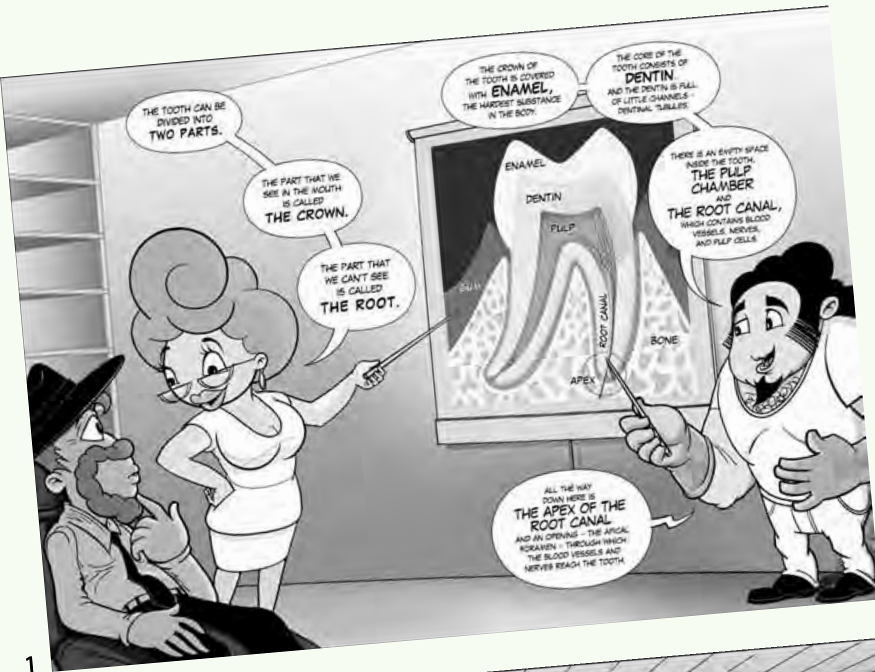


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Figure 1: Dr Greta Percha briefly explains to him the anatomy of the tooth.

Figure 2: Dr Rootman explains to Cyril the difference between endodontic procedures performed by a regular dentist and by an endodontist.

Figure 3: "Did you know" section presenting some interesting facts about dentistry and teeth.

with him. This is why his everyday family life is depicted and smartly incorporated into the story of his toothaches.

A simple quiz is added at the end of the booklet to summarise the endodontologic knowledge obtained; a "Did you know" section presenting some interesting facts about dentistry and teeth (Figure 3) is placed between the two chapters to relax readers from the demanding medical topic.

Most dental offices in Slovenia are supplied with a copy of the Slovene edition of Endodontocomix, and patients find it a very informative and funny way to learn about the procedure they are about to undergo. Many copies are also sold to primary and secondary school libraries, where Endodontocomix is a supplemental tool in teaching about oral health and teeth.

Endodontocomix is a 80 black-and-white pages booklet first published in 2014 in the Slovene language under the name Endodontostrip. Its English edition was published on the occasion of the 59th International College of Dentists - European Section meeting in Ljubljana, Slovenia in June 2014. Endodontocomix has also been translated into Dutch and donated to Netherlands dentists by the Dutch Endodontology Association NVvE. The story was co-written by Rok Jurič, DMD, endodontist, and Cyril Horjak, and drawings and grayscales were made by Dr Horowitz, popular Slovene comic artist. ■

Suggested reading available on the ICD European Section website: http://www.icd-europe.com

Rok Jurič is a specialist in endodontology in Ljubljana, Slovenia.

“Standing Still Is Not an Option”

Tom Feeney, European Section President, interviewed by Frans Kroon

You have a long track record of activity in ICD Europe. How do you look back on your membership?
I was inducted at Heinz Lassig’s meeting in Munich in 2001 and I have had the pleasure of attending every Annual Meeting since then. I took in 2007 over from Frank Shields as Irish Regent. This has given me many opportunities to meet with colleagues and to experience first-hand the unique fellowship and bond that Fellows of the ICD share. Through the Annual Meetings I have also been lucky enough to visit many European cities and experience the splendour, the character and the charm of each, not to mention the magnificent welcome and hospitality always on offer. On the business side, I have observed over many years the sterling efforts at Board level to position the ICD as a force for positive engagement, be it either in the area of standards, humanitarian activity, service to our fellow dentists in emerging countries or whatever. I am particularly pleased that in recent years more of our technically skilled and positively motivated colleagues have been channelling their talents into the humanitarian area, which opens up many exciting opportunities for the future.

You succeeded - in some way also - Joe Lemasney as Ireland Regent and served as Vice-Regent; Joe is now Past-President of ICD Europe and has served as International Councillor for many years. The Irish contribution to ICD may be termed substantial.
I think for a small country we regularly punch above our weight. As a Celtic people we are often considered to have the Celtic attributes of being charming but also unreliable! Perhaps in the modern era we have got rid of some of that unreliability, and are now using to good effect our natural ability to easily interact with people. Joe Lemasney of course has been an outstanding servant to his profession, to Irish and international dentistry and of course to the International College itself. Likewise Frank Shields, who took up the baton after Joe’s term as Regent and served for several years ahead of my taking over. Frank certainly made his mark, not least of all for his skills as a raconteur and for his wonderful ability with words.

We built a ‘team spirit’ in Ireland

Your wife Joan has shown in many ways that she shares your deep commitment to ICD Europe, and she has always been very supportive of your travels to European meetings. In a Board of Regent Meeting you reported openly about her severe illness for which she had to undergo surgery. We trust she is recovering well?
Yes, she is recovering well and my personal thanks to everybody for their support and good wishes. Joan has been with me at all but one European Section Annual Meeting since my induction in 2001. She is very comfortable in international settings and greatly enjoys meeting people from different countries and different backgrounds and has been a great support to me at European meetings.

The Irish District seems to be characterised by constancy, with good attendance at international events and local District meetings. In a time where growth is much discussed and needed, what would you say is an 'optimal' size of your own district?
I think Ireland has the advantage of being a small country so while everybody doesn't quite know everybody else it often feels that way! Therefore it is easier to build a 'team spirit'. As you will see from the list of Fellows per 1,000 registered dentists (ratio table) from each European District, Ireland has a higher ratio than any other District, and much higher than the Districts at the other end of the scale. What is the optimal size? This is hard to say but what I can safely say is that despite the high ratio each of the Fellows in the Irish District is richly deserving of the honour of Fellowship and at our present numbers there is no fear of dilution. If we extrapolate that concept to other Districts there has to be a huge untapped potential out there just waiting to be inducted. I think it is reasonable to conclude that other Districts could get their ratios up significantly without any risk of lowering the member quality.

The European Section has been able to compensate for loss of membership due to old age or death, but growth is moderate at best. How 'healthy' is our current membership (500-600); should young blood be brought in, and is it to be found in Ireland?
Our discussions at Board of Regents meetings over recent years have centred very much on the topic of membership and how we desperately need to bring more members into the College. These should be younger and we also need more female Fellows. This raises many questions. These include how to make the College appeal to younger members, how to attract more Fellows from the Eastern countries, the financial implications of not increasing our membership, the representation implications at International Council level of not increasing our membership and many more. In my opinion, considering the total number of registered dentists in the greater European area and the undoubted number of dentists in that grouping deserving of Fellowship, we are way below the numbers we potentially can achieve. In short, unless we can substantially increase our European Section numbers in the relatively near future, we are going to stagnate as an organisation and lack that vital energy that new blood can give us.

We currently have relatively high representation in the College at Large Board. In the upcoming restructuring, representation will be more strongly linked to Section size. If we are to maintain the same number of International Councillors (3), the Section would have to triple in size over the next five years! How realistic is this, and how do you reconcile it with ICD Europe's focus on quality rather than numbers?
As I mentioned above, we desperately need to grow as a section. If we don't, we will stagnate and as the question

There is a huge untapped potential out there just waiting to be inducted

implies our representation on International Council will suffer badly. If we go back again to the Ratio Table there is a vast untapped potential in many of the larger countries so the problem is not lack of raw material. The starting point is that the raw material is there and the quality is there. The problem is very simple – we are not tapping into the existing potential. The real question is how do we take advantage of this pool of talent? We can either go about it in a well meaning 'laissez faire' way or we can approach the problem in a systematic professional manner. If the European Section was to double in size over 10 years this would mean an excess of Fellows in to Fellows out of 50 per year. Assuming we lose 30 Fellows per year, we then need 80 new Fellows per year over 10 years. This would mean serious changes to the way we run our Annual Meetings and in particular our Induction Ceremonies. Either we are prepared to bite that bullet and systematically and methodically address the numbers question (see also Recruitment box at end of interview), or we can go on talking indefinitely about the problem in general and abstract terms and be in exactly the same situation, or probably worse, in 5 and 10 years time!

As in 2003, Dublin is the venue for our 2015 meeting. Have your considered other Irish locations to reach colleagues elsewhere in the country? Or was your choice primarily driven by Dublin's international accessibility and allure as the capital?
Yes, I did consider other venues. However, the first priority for any venue is international accessibility. If a place is difficult to get to, that will immediately put people off. The benefits of a one flight only link are massive. Having researched the appeal of other venues, the overwhelming professional advice I was given was that Dublin as a venue as opposed to another Irish city regularly increases numbers by up to 50%, so the choice was easy to make. The Sunday tour to Belfast and the Titanic Museum is one not to be missed. The recent centenary of the Titanic disaster has generated new interest and the exhibition is an absolutely stunning one that will fascinate visitors for many hours. Of course, there are other Irish cities and the beautiful landscape that have great tourist appeal and people coming to the meeting should perhaps consider spending a few extra days in the country to visit these places.

What in your opinion is the significance of the European Section hosting the International Council this year? Is it functional, an honour, or simply an additional logistic burden? How 'connected' are Ireland and the USA?

Having the International Council coming to Europe for its Annual Meeting is first of all a fantastic opportunity for the worldwide College to come together and share fellowship. It is of course a great honour for Europe and a great honour for Ireland and for Dublin to be hosting the meeting. It is also a great opportunity for the European Section to showcase the professional way the Section goes about its business. The added interest is that the current International President of ICD is Joe Kenneally who will be coming 'home' to Ireland from where his grandparents emigrated two generations ago. The ties between Ireland and the USA go back a long way. For many people on the west coast of Ireland, their next village was traditionally in America, so from the latter half of the 19th century up to the present many millions of Irish people emigrated to that vast country. An astonishing fact is that 36 million Americans now claim Irish as their primary ethnicity, so it goes without saying that the connection between the two countries is enormous.

You yourself have been very active in another European association (Dental Liaison), with a high commitment to the quality of dental (postgraduate) education. How vital is this to the quality of dental care? And how important is it to ICD, which shares this commitment but does not have similar governmental connections?

I was involved for many years with the Council of European Dentists (formerly Dental Liaison and EU DLC). The role of the Council of European Dentists (CED) was to act as the interface between the practising profession and the European institutions. At certain times the CED lobbied the institutions for improvement in delivery of dental care throughout Europe and at other times the Commission or other institution came to the CED seeking feedback and advice on problems of the day. The underlying objective was to promote the highest standards of dentistry and of dental care by working with and supporting the European institutions in a range of areas including ensuring that education was of the highest standard.

The CED in its work today monitors EU political and legislative developments which have an impact on the dental profession. It also has many other functions including issuing policy statements and draft amendments to proposed EU legislation so as to ensure that the views of European dentists are reflected in all EU decisions affecting them. By doing this it supports them in understanding the effects and implementation of EU legislation, especially those members from the new Member States and EU accession countries. The ICD is a College made up of dentists who have excelled in one form or another as members of the profession. It is not a formal political body so it cannot have the same influence. However by its core values of serving and recognising service, the ICD is a force for high quality in all areas of professional life.

You work at the Blackrock Clinic, renowned for its success in implantology. How important would you say this is to (dental) health in general, or is it something for the Happy Few in Ireland?

My clinic is situated close to the Blackrock Clinic from where David Harris, one of our Irish Fellows, has been at the forefront of implant dentistry for many years. Certainly, in my practising lifetime the ability to predictably place implants and so restore missing teeth has been the greatest advance in dentistry. Up to relatively recently we were probably somewhat over-conservative in choosing cases, and we also probably over-engineered cases to reduce risk of failure. In more recent times the pendulum has swung the other way with implant placement by general dentists now commonplace.

While the cost has fallen, implant treatment fees are still high. I feel however that over the coming years these will fall further as more dentists develop the necessary surgical skills and more laboratories come up with ways to reduce their own costs, and so put implant treatment within the financial reach of more people.

As regards the importance of implantology to dental health in general, I think this cannot be underestimated. Whereas in years past teeth could only be permanently replaced by bridges (and not at all if there were no abutment teeth) this resulted in regular compromising of perfectly good teeth. The arrival of the predictably successful implant treatment modality has changed this situation utterly and for the great benefit of our patients and their dental health.

How do you feel about the (increasing) focus on humanitarian projects in the ICD at Large and in Europe/Ireland in particular? Could you see projects starting in your own country?

In any successful business or enterprise, standing still is not an option! For the College to grow it has to look to develop and expand on its core beliefs and focus. The humanitarian area has always been very important to the European Section and in recent times there has indeed been more focus on this area.

For me, Section Fellows are not one homogeneous grouping. There is room in the College for several different strands. Some Fellows are happy to see the College simply as a place to meet, interact and socialise with colleagues of like mind, while others feel that there is a need for the College to develop in new directions. I feel at this stage there is a significant cohort of Fellows within the Section who are prepared to give more time and attention to the humanitarian aspect of our activities not only because of their own interest but also to make the College more relevant to prospective new Fellows. This year for the first time at the European Section Annual Meeting in Dublin we will hold a Saturday morning open workshop on Volunteerism, which links perfectly to our humanitarian ethos. The workshop will be open to all dentists and dental students and will also serve as a way to promote the humanitarian mission of the ICD, and indeed ICD itself.

Is there anything you would like to add?

The ICD motto sums up what ICD is all about – "recognising service and the opportunity to serve". To successfully carry this ethos into the future there are two immediate challenges that we face. The first is increasing our numbers substantially from the current low base. The other related challenge is how to get our colleagues in the East to engage with the College. Clearly the cost of engagement, especially for dentists in the public service in the countries of Central and Eastern Europe is a major barrier. I would like to see the Board of the European Section develop some creative solutions to deal with this barrier. Having said that, cost is not the only barrier. I feel that relevance or rather lack of it is an even bigger barrier and the challenge to all of us is to make the College more relevant and attractive to our colleagues in Eastern countries. If they don't see value in what the College is offering, then all the hard hours of trying to expand into the East will have been largely in vain. This is a big challenge for all of us but I am certain that we have enough creative and committed Fellows within our College to successfully confront it. ■

RECRUITMENT – Achieving a Positive Relationship Between Gain and Loss

The lack of numbers is probably the biggest problem the ICD faces at the present time. It has been proven in the smaller countries that higher numbers of Fellows doesn't necessarily lessen quality. There is therefore ample scope especially in the bigger countries to increase numbers without any risk to quality. Many suggestions have been made as to how the numbers problem might be tackled but in my opinion the whole question boils down to two fundamental points:

1) We need to promote ICD as being both prestigious and worthwhile and thus create a demand.
2) We as Regents just need to work harder to identify worthy colleagues!

How do we do this? Taking point 1 first, we are a voluntary organisation where Fellows have busy day-time jobs so as an organisation we lack the time and the expertise to market ourselves effectively. Of course, as individuals and as an organisation we should actively seek out promotional opportunities but the effect of this is never likely to be as great as we would like or need. What is really required is professional advice on how to plan and deliver a promotional strategy with probable payment of a 'project manager' to implement that strategy. This will cost us money but we may have to 'speculate to accumulate'.

In point 2, I mentioned the need to be more active in identifying worthy colleagues. To do this we need to spread the organisational load, particularly in the larger Districts. I think we can safely say that a Regent is never likely to know many dentists outside of his/her own region. So, for example, if a large District could appoint a number of Vice Regents – spread geographically – then each one could target worthy dentists in his/her area. The current system of one Regent per District regardless of size (with minor exceptions) is likely to have resulted in a concentration of Fellows close to where that Regent is situated, leaving much of that District unrepresented.

So to sum up, we need to develop a strategy to achieve a far more positive relationship between annual gains versus annual losses. Above I have suggested a twin track approach that can be added to those views already expressed around the Board table, and hopefully we can start to make progress in the very near future.

International College of Dentists

European Section

60th Annual Meeting European Section
International Council Meeting
Dublin, Ireland
7-11 October 2015

WELCOME

Dear Fellows and Guests,

It is my great pleasure to welcome you to Dublin for this joint meeting of the International Council and the European Section of ICD. This will be a great event, a gathering which will bring together Fellows from around the world to meet for the purposes of both business and pleasure!

Dublin is one of Europe's oldest cities. As well as retaining its historical and cultural charms, it offers trendy bars, elegant restaurants and stylish, cosmopolitan shops and hotels – ideal for creating a vibrant atmosphere in which to hold a meeting like ours. The city has a rich cultural history and is the birthplace of James Joyce, Oscar Wilde and Nobel Prize for Literature winners William Butler Yeats, George Bernard Shaw and Samuel Beckett. As one of the literary capitals of the world it was designated UNESCO City of Literature in 2010.

Of course there is much more to Ireland than just Dublin. The second biggest city on the island is Belfast and it too has a rich tradition and is a must see for colleagues coming from overseas and intending to see more of the country.

Ireland has a long established reputation as a country that knows how to give a 'cead mile failte' (100 thousand welcomes) to its guests and I can promise you plenty more of the same when you come to Dublin in 2015 for the 60th Annual Meeting of the European Section.

Tom Feeney
European Section President

ICD European Section 2015
complete overview of the programme on www.icd-europe.com

SCIENTIFIC AND SOCIAL PROGRAMME

Wednesday 7th October
Golf Tournament, Portmarnock Golf Club
Regents Dinner, Cliff Townhouse Restaurant

Thursday 8th October
Board of Regents Meeting, Royal College of Physicians of Ireland
Executive Committee International Council, Royal College of Physicians of Ireland
Welcome Reception of Fellows and Guests, Trinity College Dublin

Friday 9th October
Scientific Day "Learning Without Limits", Royal College of Surgeons in Ireland
Accompanying Persons Tour
Irish Cultural Evening and Dinner, Jameson's Distillery

Saturday 10th October
General Session International Council, The Shelbourne Hotel
Induction Ceremony, Trinity College Dublin
Gala Dinner, Royal Hospital Kilmainham

Sunday 11th October
Optional Post Conference Tour, Belfast City Tour

Conference Hotels
Shelbourne Hotel - official conference hotel
Westbury Hotel
Stephens Green Hotel
Cliff Townhouse

Contact Details
Organising Secretariat
Keynote PCO
Office 26, Angelsea House, 63 Carysfort Avenue
Blackrock, Co Dublin Ireland

Unique tooth brushing competition among Slovenian sch

30 Years Let's Have

35 years ago, 70% of Slovenian school children aged 6-14 years did not clean their teeth regularly and according to recommendations. Motivation among parents to serve as role models to their children and instil healthy dental habits from an early age was lacking, leaving the care for their children's teeth to kindergartens and elementary schools.

Tatjana Leskošek Denišlič and Matej Leskošek

The competition takes form: letters to parents explaining the nature and purpose of the competition and soliciting their support.

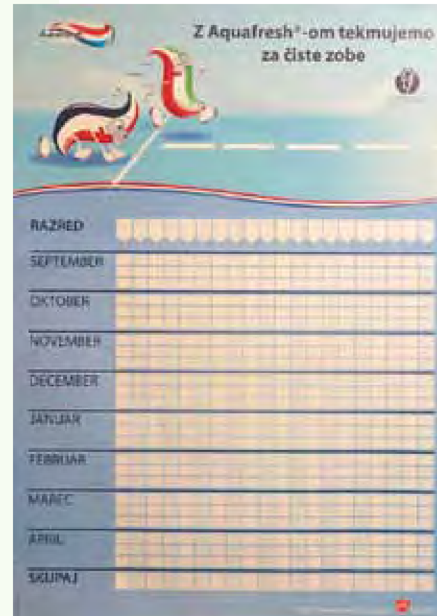
This suboptimal situation inspired us to take action, and we started looking for ideas in our homes and our workplaces where we treat the children. After a series of discussions with representatives of our Community Health Centre in Ljubljana and school management, we decided that a tooth brushing competition could serve as a friendly strategy to motivate our young patients to improve their oral hygiene habits and reduce painful caries interventions. The first competition round started in 1979 in one elementary school where the author was employed. The positive response encouraged her to invite other colleagues by submitting a letter to the Slovenian dental journal Zobozdravstveni vestnik.

As part of the competition, three mornings each month, our nurses and doctors came in unannounced and distributed disclosing tablets (without erythrosine) to five randomly selected children in each participating class. The pupils whose teeth were clean earned a point for the class. The score was recorded on the special board hanging in a conspicuous place in the school building.

This approach promotes children's natural delight in competition, but they do expect rewards for success. So to provide incentive, a local pharmaceutical company made awards available for the winners. This company proved to be a very supportive partner in our project, continuing their donations for 25 years.

ool children

Clean Teeth



Special board for points

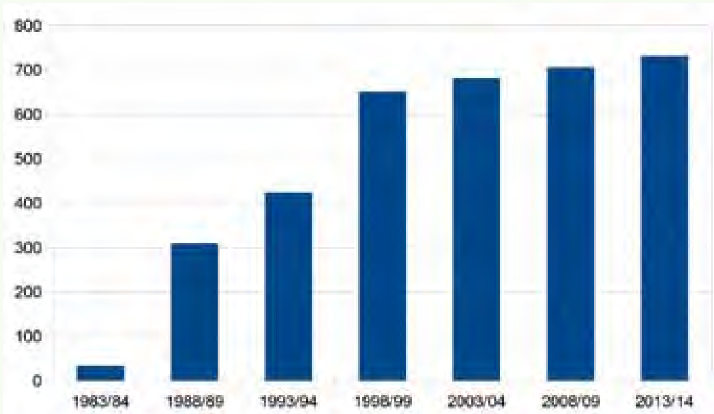


Diagram of participating schools 1983 – 2013

Increasing Participation

During the first 4 years, the competition ran in one school only. However, things started moving: By 1983, 34 schools participated. Ten years later, in 1993, this number had skyrocketed to 424 schools; another ten years later, in 2003, 681 schools; and again ten years later, in 2013, 732 schools – 98% of all regular schools in Slovenia, and including schools and institutions for children with special needs (100% of all special needs schools).

Yearly Ceremony

A project of this scope and magnitude deserves a fitting closing ceremony each year. After modest beginnings, the ceremony is now a focus point in the project and eagerly anticipated by all children and teachers. The first ceremonies took place in primary schools; but as the competition expanded, the ceremony was moved to the large indoor Tivoli Hall sport arena in the capital of Slovenia, Ljubljana, where it has been hosted as a major event for 20 years now. Every year in May or June, 17,000 children from the winning classes of more than 720 Slovenian schools (including special needs) gather to see how 9 regional winners and the top competitor receive their awards.

Awareness, Support and Success

To sustain awareness and enthusiasm, we developed journals that are published every few years. To date, we have published four journals (the first in 1998, the most recent one in 2013), showcasing our work and results.

The importance of the role of teachers in the project cannot be overemphasised, they are our right hands. Teachers whose class wins repeatedly receive awards that recognise their efforts and at the same time help to promote the project in their schools. One teacher's class in the Gorenjska region won as many as 16 times.
Consistent support has also come from the various presidents of the Slovenian Dental Association, the mayor of Ljubljana, and the head of the Ljubljana Community Health Centre, which has been vital to the project's success.

The success of this competition led to its nomination as one of the top 7 programmes competing for the Johnson-

3,000 schoolchildren gathered for the closing ceremony, Ljubljana, 2010 and 2013 (photo courtesy FUTURA PR, GSK and Matej Leskošek)

Johnson award in 1990. The Slovenian Dental Association won the Certificate of Recognition in 1997 and 2000, and the author received a national award in 2006. Also, and more importantly, the competition was integrated in the Slovenian paediatric dental health programme in 1986, improving dental hygiene of children and reducing caries significantly. Concrete statistics and results will be the subject of an article in a paediatric dental journal.

Easy Organisation, Visible Results

Tooth brushing is obviously not the only strategy to prevent caries and gingivitis, but it is undoubtedly a very effective component of dental health programmes. It may be considered the 'low-hanging fruit' in our College's attempts to raise awareness and dental hygiene standards worldwide. Our competition dramatically improved the dental health of Slovenian school children in a project that:

- is easy to organise
- can be implemented immediately
- requires only modest material costs, and
- delivers visible and measurable results ■

Suggested reading available on the ICD European Section website: http://www.icd-europe.com

Dr. Tatjana Leskošek Denišlič and Dr. Matej Leskošek are members of the Slovene Medical Society Dental Section in Ljubljana, Slovenia

From the Minutes of the Board of Regents Meeting, London, United Kingdom, 29 November 2014

Austria

The Vice-Regent of Austria Barbara Thornton, reported that the Austrian District had their local Meeting on 21 November 2014, which was attended by 15 Fellows. They will present 2 Inductees in Dublin. The District has 39 Active Members, 2 Life Members and 1 Master. They asked the Board of Regents of the European Section to grant Gerhard Ratzenberger Life Membership. He was inducted in 1999 in Amsterdam and through the years has been a strong supporter of the ICD, helping to organise the Vienna Meeting in 2011. He served the Austrian Dental Association by helping younger colleagues to establish private offices. He is now retired because of serious illness and is unable to continue his dental work. She concluded her report saying the District is in good order. President Feeney thanked Thornton for her report and asked the Board to vote on that proposal. The Board Members agreed and Ratzenberger is now a Life Member of the European Section.

Benelux

Benelux Regent Walter van Driel reported that District 2 had their Regional Meeting on 14 November 2014. Twenty-three Fellows attended, and they started with a tour of one of the Fellow's new dental clinic. Frans Kroon spoke on growth and development, and they discussed the problems they currently have in attracting new young members. The formation of a membership committee is being considered. They have two candidates for Dublin. The District of Benelux is in good order with all dues paid. They had asked attendees how they felt about receiving the ICDigest in electronic format only; 22 had no problem with it, so that is a pointer to what we should do in the future. The Benelux District now has 36 Active Members, 5 Life Members and 1 Master.

Scandinavia

Past President of the Section and Regent of the Scandinavian District Henrik Harmsen reported that there are 41 Active Fellows in the Scandinavian District, 4 Life Members, and they will have 4 Inductees for Dublin. The above membership includes Iceland, which is not formally part of the District; Harmsen suggested including Iceland in the District. A regional Meeting is planned for April 2015. Dues are paid and the District is in good order.

England Scotland and Wales

Section Vice-President and Regent of the District Shelagh Farrell reported that they have 62 Active Fellows, 4 Life Members, 2 of whom are also Masters. They had a dinner meeting with a lecture on 25 October 2014 with slightly lower attendance versus the previous year. The quality of the lecture was such that she is considering to propose having this lecturer introduce the Scientific Meeting in 2017. The District is in good order.

France

The Regent of France Jean-Louis Portugal reported that the District has 48 Active Members, 6 Life Members and 1 Master who is also a Life Member. The District had two Meetings in 2014, the first on 7 October, the local Meeting with dinner and a conference at a restaurant in Paris, where he took the opportunity to reinforce the aim of the ICD and inform the Fellows of accomplishments in Ljubljana. The second meeting was on 28 November, which was the first ICD joint French-Swiss Meeting at the Procope restaurant in Paris, where 24 Fellows attended. They were able to take advantage of a French language Dental Congress in Paris, and they had the pleasure of hosting a Fellow from the US, Ben Johnson, who is an endodontist. The District is in good order.

Germany

The Regent of Germany Matthias Bimler reported that they now have 49 Active Fellows, 3 Life Members and 1 Master, and 3 inductees for Dublin. Joerg Schroeder was appointed Vice-Regent. He noted that in relation to the total number of registered dentists in countries, smaller Districts have the highest percentage of Fellows whereas the larger Districts have the lowest percentage. District memberships average 30-60 Fellows, there are no guidelines on how many Fellows each District should have. He suggested that having one Fellow for every 1,000 registered dentists and one Inductee for every 10,000 registered dentists seems feasible; e.g. if Germany has 90,000 registered dentists, membership should average 90 Fellows and the District should introduce 9 new Inductees each year. Even though this would not generate all the growth we need, it would be a good start. Otherwise the District is in good order.

Greece and Cyprus

Regent Heraklis Goussias expected to have 3 or 4 Inductees for Dublin. Dues have been paid and the District is in good order. They have 34 Active Fellows, 7 Life Members and 1 Master. He will propose an active ICD Fellow for Life Membership and suggests granting this honour to younger Fellows so as to maintain the Life Membership ratio in the District.

Ireland

The President and Regent of Ireland Tom Feeney reported that the Irish District is in good health, and all the focus now is on the preparations for the Dublin Meeting in October 2015. The numbers are 43 Active Members, 2 Masters, 2 Life Members and 1 Honorary Fellow, totalling 48 Fellows in the Irish District. Their annual social Meeting is on 10 January 2015; last year it was very well attended with 44 people present.

Israel, Malta and Baltic States

Dov Sydney, Regent of Israel, Malta and the Baltic States, reported they have 17 Active Members and 4 Life Members. They are continuing their student award programme, which is a good way to promote the College, and the graduating student scholarship grant, which gives senior graduating students the opportunity to present their research projects at the IADR. They use this as a way to promote the ICD through academic institutions. The District is in good order.

Italy

President-Elect of the Section and Regent for Italy Corrado Paganelli reported that they have 50 Active Fellows and 5 Life Members. They had their Regional Meeting on 20 September 2014; an excellent achievement was getting the Deutsche Bank as a funding agent and the Dental Tribune and an Italian Journal as a means to diffuse the spirit of the ICD. He pointed out this is a very good way to promote the Meeting in 2016, which will be focusing on comprehensive oral care in a culturally based holistic approach. The Italian District is in good order.

Portugal

The Regent of Portugal Gil Alcoforado reported they have 40 Active Fellows and 5 Life Members. On 30 May 2014, the Portuguese District organised a dinner which 22 Fellows attended. They had the opportunity to give the Fellows the news of the College and also had a Professor of Endocrinology present a conference about the evolution of Clinical Medicine in the last 50 years, which was very interesting. The District is in good order.

Spain

The Regent of District 12 Spain, Santiago Jane reported that the Spanish District now has 26 Active Fellows and 2 Life Members. They plan to have the Regional Meeting in Barcelona at the same time as the Mediterranean Dental Forum in March. Otherwise the District is in good order.

Switzerland

The Regent of Switzerland Christian Robin reported that the Swiss District is in good order. They have 16 Active Fellows, 6 Life Members, and 4 new Inductees for Dublin. He confirmed the success of the joint Meeting with the French District, which gave the Swiss Fellows the opportunity to meet with their French colleagues. He congratulated Past President Ljubo Marion for the excellent Meeting in Ljubljana in June 2014.

Eastern and Central Europe

The Past President and Regent of District 14 Eastern and Central Europe, Ljubo Marion reported that District 14 has 41 active Fellows in 13 countries. He has tried to expand in other countries like Kosovo, Bosnia-Herzegovina, Macedonia and Albania, but unsuccessfully because of the high cost. He wants to go to Slovakia in 2015 where there is no one, Czech Republic where there is only 1, Poland where there are only 2, and just 1 in Montenegro. He had the chance of meeting with other Fellows from the District in other meetings like the Balkan Stomatological Society, where there are 6 Fellows, or the European Academy of Esthetic Dentistry, where there are a few more. Such opportunities are few, but this is how he can meet other Fellows from his District because financial reasons do not allow them to come to this Meeting too. He expects to have more Inductees than last year.

European Section Officers and Regents

June 2014 at the Annual Congress of ICD-Section V, Europe (from left to right)

Phillip Dowell, Vice-President, College at Large
Michael Pavão, Vice-Regent, Portugal
Paul Gerlozchy, Vice-Regent, Hungary
Christian Robin, Regent, Switzerland
Shelagh Farrell, Vice-President, European Section and Regent, United Kingdom
Matthias Bimler, Regent, Germany
Joe Kenneally, President-Elect, College at Large
Aris Petros Tripodakis, Past President, European Section and Master of Ceremonies
Ljubo Marion, Acting President for Ljubljana Meeting and Regent, Eastern & Central Europe
Walter van Driel, Regent Benelux and Editor, European Section
Tom Feeney, Incoming President, European Section and Regent, Ireland
Corrado Paganelli, President-Elect, European Section and Regent, Italy
Argirios Pissiotis, Registrar and International Councilor, European Section
Hendrik Donker, Treasurer, European Section
Werner Lill, Regent, Austria
Jean-Louis Portugal, Regent, France
Jané Santiago, Regent, Spain
Henrik Harmsen, Regent, Denmark, Finland, Iceland, Norway, Sweden
Dove Sydney, Regent, Israel, Malta and Baltic States and International ICD Editor

Current Officers and Regents of the European Section on www.icd-europe.com

College at Large President-Elect Joseph Kenneally addresses the 2014 Inductees

Fellows and guests of the International College of Dentists' European Section, I bring you the greetings of President Woong Yang, who could not be here in Slovenia with us today.

'η αρχή είναι το ήμισυ του παντός'. That quote is from the Greek philosopher Aristotle, and it means "Well begun is half done."

Today, New Fellows, your ICD journey is well begun. You have been chosen to enter the oldest and largest honorary society for dentists in the world. Our members come from 122 countries, and although we have 12,000 Fellows, they have been selected from a worldwide population of 1.7 million dentists. It is indeed a rare and singular honour to be invited into Fellowship.

You are joining the ranks of the leaders in our profession, the outstanding teachers and researchers, and the providers of humanitarian care to the less fortunate. You will be presented to the audience, your accomplishments will be celebrated, and you will receive your Keys and your Scrolls. You will have begun your journey well, but you will only be half done. This honour comes with rights and responsibilities.

The European Section of the ICD has been a vibrant and vital body since its founding by Philip Dear nearly 60 years ago, in 1955. In my years of service to the College Council, I have witnessed the many contributions of Section V's councillors, Phillip Dowell, Joseph Lemasney, Frans Kroon, Argirios Pissiotis, and Peter Kotschy. This group has been instrumental in our growth and development, and Dr Dowell has been particularly instrumental in promoting our financial stability with his hard work on both our Diamond Sponsor Program and his stewardship of our new international charitable foundation, the Global Visionary Fund.

Our outstanding publication The Globe, our electronic newsletter The College Today, our website, www.icd.org, and its Media Center are all the work of Section V Fellow Dov Sydney, who was presented with Section I's Silver Scroll Award for journalism this year, for The Globe. The European Section makes many important contributions to the College internationally.

I would be remiss if I did not mention the leadership and activities of the Section itself. Your President, Professor Ljubo Marion and his committee have presented an original and memorable Annual Meeting in this 59th year of the Section, here in Ljubljana. I have attended Convocations and Induction Ceremonies all over the world, and I have never had a better time, nor have I seen a more impressive meeting. Section V is famous throughout the ICD world for its meetings, I consider myself fortunate to be able to join you this year as President-Elect, and next year in Dublin, Ireland, as President. European Section President-Elect Tom Feeney has planned a wonderful event for the 60th Annual Meeting. Tom was kind enough to lend me the shirt off his back when my luggage was temporarily lost.

I am pleased to note the participation of New Fellows from last year in this year's Annual Meeting, not the least of which included not only the scientific presentations of Dr Maja Osvenik and Dr Ksenija Rener Sitar of Slovenia, but also the performance of Ireland's Dr Declan Corcoran, who borrowed a fiddle at the Welcome Party and displayed his impressive musical skills. I am also pleased to note the humanitarian presentation of Portugal's Dr Miguel Pavão, who is young for a Fellow, never mind a Regent. All of these members have become active in the Section very early in their time as Fellows.

The European Section 2014 Inductees

Franz Hastermann

Ulrike Pinl

Tushar Patel

Ray Rattan

Nigel Taylor

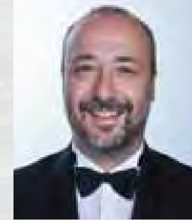
Henri-Pierre Naveau

Ives Vernet

Bettina Seeher

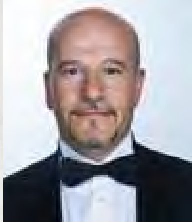
Andreas Parashis

Eleonora Bakiri


Panos Zoidis

Paula McHenry

Adut Meir


Giuseppe Galvagna

Jose Fausto Carracho

Alexandre Cavalheiro

J. Sampaio-Fernandes

Tomislav Jukič

Rok Jurič

Igor Kopač

Martina Zore Albreht

So you see, "well begun is half done". Enjoy your evening tonight, and celebrate your achievements, because no one is honoured for what they received, but only for what they gave. But after you receive your Scroll and your Key, remember to participate in your Section to the extent of your talents and abilities. I hope to see each of you next October in Dublin, when the European Section will also be hosting the Annual Meeting of the International Council, bringing in leaders from all over the world. And please consider sponsoring a deserving colleague that you know to be performing outstanding service into the College. To paraphrase Scottish philosopher Thomas Carlyle, "Show me the person you honour, and I will know what kind of person you are."

I congratulate all New Fellows and their Sponsors. This is a milestone in your career, and a bright beginning to your Fellowship.

Future Annual Meetings of the European Section
International College of Dentists

2015 Dublin, Ireland • 7-11 October
also hosting the International Council

2016 Milan, Italy • 30 June - 2 July

2017 London, England • 14-18 June