

**BSDH Winter Scientific Meeting
SOAS, London
December 2003**

Karen Gordon, Honorary President held a very successful Winter Scientific meeting in London on December 5th, 2003. To celebrate and recognise the European Year of People with Disabilities, the meeting was opened by Dr Tom Shakespeare, Director of Outreach at the Policy Ethics and Life Science Research Institute at the University of Newcastle.

**Dr Tom Shakespeare
Director of Outreach at the Policy Ethics and Life Science Research Institute at the
University of Newcastle**

2003 is an interesting year because it is the European Year of Disabled People. That is something for disabled people to celebrate because it is recognising that disabled people speaking for themselves, allying with others and putting their issues on the agenda, have achieved major changes in Europe over the last 10 or 20 years since 1981 which was the International Year of Disabled People. The idea encapsulated in the slogan 'Unlocking barriers to care' is that disabled people are saying that their problems are not so much impairments of body or brain, rather the failures of environments, professionals, systems and policies to enable and include them – that people are disabled by societies and not by their bodies. I still think we have some way to go. For example, one of the trade stands which I'm sure is a highly professional and good organisation has a slogan that states 'Having trouble with wheelchair users?' which is perhaps the sort of language that we need to change. It may be more appropriate to say 'Do wheelchair users have trouble with dentists?' – using the barriers approach.

It's also the 50th anniversary of the discovery of the structure of DNA by Francis Crick, James Watson and Rosalind Franklin and so there's been a huge amount of excitement about science and about genetic science in particular. That's an area that I am particularly interested in and it seems to me that we are in danger of over exaggerating the potential impact of genetics and losing sight of some much more practical, social, environmental, and even medical and dental issues. That is to say that if you think that DNA is the happening thing and the solution to all our problems, you have a great deal of hyperbole. And if you think that DNA is the road to eugenics, Frankenstein foods and designer babies, you have a hysterical reaction to it but you also exaggerate the impact. It seems to me that DNA will not change the world, not in our careers; it will be increasingly important. But that the danger of focussing on the science of medicine or indeed the science of dentistry, you may risk losing sight of the fact that these professions and that these practices are also arts. And I'm really pleased that on the agenda that you have today, you have papers which are from an ethical perspective, a social science perspective as well as from a scientific perspective. I think we need to retain that balance between the science and the art in what we do, and I just want to plug the Journal of Disability and Oral Health which you all have as a constant companion and which I'm proud to say that I'm on the Editorial Board. It does have a range of articles, personal experiences, social science, ethics, and the dental sciences. We really want to make this the premier journal and I hope that you will contribute to it, commit to it and make even better than it has been over the last three years.

It seems to me that if we are to improve the art of dentistry or medicine, particularly as it pertains to disabled people, then the priorities are improving our communication, our interaction and our abilities to meet the needs of the diversity of the public and the patients whom we serve. And I just want to make three points about that before I hand over to my colleagues.

The first is that we are all schooled in this idea of special needs. You have been trained in the idea of special needs, and there are courses in special care dentistry, and that's brilliant because we need to have the skills to provide care appropriately. But I want to challenge it slightly because disabled people basically have the same needs as everyone else, the same needs as the people in this room for health, housing, transport, education, leisure facilities and indeed dentistry. The problem is that

these ordinary needs that disabled people have are not ordinarily met. So I would like to challenge us to see how we can have broad and diverse provision to meet the ordinary needs and not to exclude disabled people.

The second point I want to make is that generally the best experts on disability are disabled people themselves. They are people who daily experience it or who care for or live with people who daily experience disability. There's a very interesting first hand account in the October issue of the Journal of a guy with cerebral palsy, communicating in a very direct and friendly tone some of the issues that he has with the dental services that he has received. If we are to improve, we need to go forward together and in order to do that, we must listen to what disabled people themselves are saying. One of the things he mentions is that when he goes to the dentist with his wife, it is often his wife who is asked about his needs and issues. So listening to patients whenever possible and to families and others when the patients aren't able to speak for themselves is really important, to recognise that you have scientific professional skills and knowledge but that lay people have skills and knowledge too and that it's in partnership that we can go forward. There's an issue in your programme today about autonomy and choice, how we can preserve that, how we can act in the best interests of the patient and get their consent in an appropriate manner. These are some of the major equitable and problematic issues of any medical or dental profession as we go forward.

The third point I want to make is an issue of action or words. I went to a presentation on Wednesday evening to celebrate the International Day of Disabled People. We have years of disabled people, days of disabled people and sometimes even hours of disabled people! I was sitting at a table with some very nice people from Barclays Bank who were promoting corporate social responsibility, diversity and all issues that are the jargon of modern business that we approve of and welcome. They had sponsored the conference and they were great and I was very impressed. Then on the way home, I needed some cash. I passed a Barclays Bank and the cash point was half way up the wall. So I rang my wife, and she reminded me that there are two branches of Barclays in Newcastle city centre and neither of the branches are accessible to wheelchair users. That struck me. What you say is important, but it is what you do that counts. I think that's a good time to stop and declare the meeting open.

Disability and Oral Care – experiences from Mun-H-Center

Dr Jan Andersson-Norinder

Senior Consultant in Hospital Dentistry

Director of the Mun-H-Center, Sweden

Dr Andersson started to work as a dentist at the largest institution in Sweden for people with mental retardation in 1975. He met wonderful patients there who became his friends forever and learnt a great deal from them. During this period, these patients had no priority for dentistry in Sweden and most had severe untreated periodontitis and even carious disease. His knowledge of these patients was very limited and at that time he could identify only one diagnosis and that was Down's syndrome. Over time, the knowledge of genetics has developed. Through working at a Centre for Rare Disorders, Dr Andersson's knowledge of syndromes that cause mental retardation has greatly increased as has the importance of oro-facial aspects in making a diagnosis. Knowledge of the diagnosis is important for planning treatment. Down's syndrome (DS) is a good example of this and it has led to an international medical health programme or check-list. In Sweden, oral aspects and oral care are included in the programme. This health programme has really improved the medical care of people with DS and all diagnoses should have such a medical programme in the future.

He described how following the development of the lives of these people over the years as being a most fantastic experience. Their life in Sweden is completely different today; institutions for people with learning disabilities are no longer legal in Sweden. However it took a long time for the Swedish government to understand that all children have a right to grow up with their own parents. But to fulfil this right, a law was necessary and was passed as late as 1986. Parents' attitudes have also changed; many modern parents are fighting for their children's rights and needs, demanding that their children should have the best, and that includes high quality dental care.

For adults with mental retardation, the law supports independent community living in their own homes or in small group accommodation with personal assistance and if necessary for twenty-four hour care. Community living for adults is funded by the taxation system. To realise this programme, legislation is necessary. There is also a Swedish Dental Act concerning oral health for people with disabilities which stresses good oral health for all people on equal terms with the rest of the population with a focus on reducing oral diseases, and with special attention to be given to people with disabilities to achieve good oral health. The Swedish parliament decided in 1988 that the Swedish counties were responsible for fulfilling the requirements of the Swedish Dental Act by offering auxiliary oral health visits to all people with severe disabilities, including the elderly. This was to be annual, voluntary and free of charge and a dental hygienist would carry out the oral examination at home. Nursing personnel should be present at the examination in order to be advised of information that focussed on oral health care. The dental hygienist visiting the patient should also offer necessary dental care by a dentist in order to improve nutritional intake, reduce pain and discomfort. This is determined by the patient's general health, dental health and the benefit of treatment. Dental care may be offered as part of medical treatment of the illness or disease by referral from a medical practitioner. The cost of dental treatment for each disabled person is only 10 euros per visit. The cost limit for dental treatment as part of medical care is 90 euros per year. The total cost for the inclusive domiciliary oral health service for adults is 100 million euros per year.

The law also made it possible to establish national centres for people with rare disorders. The Mun Centre is one of two such centres in Sweden. The Mun Centre is a national oro-facial resource centre for rare disorders and also a national resource centre for oro-facial aids and appliances for persons with disabilities. The Centre's task is to collect, develop and spread oro-facial knowledge about rare disorders and oro-facial aids and appliances. To achieve this the Centre carries out educational activities, consultation, treatment, research and development. The team consists of Paedodontists, Hospital dentists, Orthodontists, Prosthodontists, Dental Hygienists, Dental Nurses and Speech Pathologist in association with medical specialists thus providing a multi-professional team. The Centre is located in the Faculty of Odontology in Gothenburg and at the Agrenka Academy. The latter is a national family centre for rare disorders situated in the archipelago of Gothenburg. The Agrenka Centre organises family weeks where up to ten families with a child with the same specific diagnosis can stay for a week. Parents have the opportunity to obtain specific information about their child's diagnoses from medical and other specialists in the field, and form networks for future mutual support. A very successful new programme has begun for adults who attend without their parents. Over the years, the Mun Centre had become an important collaborator during the family weeks and Agrenka is an extremely important meeting place where the users are the main focus, and professionals have the opportunity to learn from users. It also provides a fantastic opportunity to learn about oro-facial aspects in rare disorders and opportunities to meet other medical professionals and teach them about oro-facial aspects of rare disorders. This has led to multi-professional cooperation.

It is recognised that the mouth is the most important part of the human body. It is not hard to understand the importance of oro-facial functions in breathing, eating and drinking, communication by speech or facial expression, and even perception. All these functions are dependent upon oral health. For the individual born with a neurological impairment or malformation, or following disease or trauma, there is a high risk of oro-facial dysfunction and with the additional problems of bruxism and drooling. These problems influence the lives of the individuals and their families. During the residential week at Agrenka, children are examined by a dentist and speech pathologist, and information obtained from questionnaires to parents and observation charts is entered in the database. From the data collected, it is evident that oro-facial dysfunction is common. This information can be accessed on the Mun-H Centre website. 40% of children attending the Agrenka centre have eating difficulties, 52% have speech difficulties and 28% have drooling problems. Even though preventive dental care for children with disabilities in Sweden has been very successful, 7% of children have poor oral health.

The Centre's vision is to promote good oral health and good oral function. To fulfil this, a number of important missions have been identified. The first issue is to know more about the patient. Early

identification is essential but there is a risk that children with disabilities meet dental professionals even later than non-disabled children. Medical professionals and especially rehabilitation centres should cooperate with a special dental team, but even in Sweden, that is rather rare. Focussing on early preventive oral care is essential to maintain the child's oral health. In dentistry today, preventive methods exist. It is also important that when dental treatment is needed, the patient has access to dentists who are experienced in special care. Parents often complain about difficulties in obtaining orthodontic treatment. For adults it has been difficult to obtain prosthodontic treatment and implants. However the Mun-Centre team includes a prosthodontist who provides implants for disabled patients.

Oro-motor therapy is another objective which is being achieved by working with the Speech Pathologist and other medical professionals. Active and passive oro-facial stimulation pioneered by Russell, a Danish dentist, was introduced in Sweden in the mid seventies. Castillo Morales, a rehabilitation doctor and physiotherapist from Argentina introduced the concept of facial oro-regulation therapy. This includes physiotherapy, oro-facial manual therapy and intra-oral appliances. This mode of therapy was introduced in Sweden some 15 years ago. Among other things, these concepts reinforce the importance of early interventions and preventive care. The Centre gives advice to parents and pre-school teachers on what they can do to stimulate the child's oro-motor development. Even new born babies and infants who are tube fed need oro-motor stimulation. Dr Andersson illustrated a number of aids to stimulate sucking and chewing actions. Exercise programmes for the jaws, lips and tongue are basic in an oro-motor programme. The problem is that both the patient and parents need strong motivation to continue with this programme which can be rather boring. Castillo Morales introduced palatal plates for oro-motor training and stimulation; different types of stimuli based on individual assessment are attached to the plates depending on the aims of the therapy. The aim might be to improve the rest position of the tongue and lips, or to train oro-motor skills like tongue tip elevation, tongue lateralisation or sound production. Palatal plate therapy is frequently used in Sweden in children with Down's syndrome and hypertonic oro-facial muscles. A positive effect on oro-motor development has been demonstrated and the evidence published.

Other intra-oral appliances include the MVS which stimulate activity in the orbicularis oris muscles. As with most intra-oral training appliances, this acts passively without any conscious effort by the patient. The oral screen is an effective tool to strengthen the buccinator muscles. It is used frequently in patients with impaired lips and drooling. In Dr Andersson's experience, the individually constructed oral screen is more effective than a pre-fabricated oral screen.

According to Castillo-Morales, oro-facial massage normalises oro-facial muscle tone and helps to facilitate facial expression. Different techniques are utilised depending upon whether the musculature is tense or flaccid. These techniques are normally carried out by Speech Therapists and Physiotherapists but can also be taught to carers working with the individual disabled person. Intra-oral massage stimulates the sucking reflex in new born babies and to avoid or treat oral hypersensitivity or deprivation in children who are tube fed and resist oral feeding. This can be carried with a finger tooth brush or with the fingers. Sensory-motor stimulation is often recommended with an electric toothbrush on lips and tongue when the patient has an oro-motor impairment. The tactile stimulation can sometimes facilitate the development of tongue mobility and the patient becomes more aware of their mouth.

Multi-professional cooperation is very important to help children and adults with oro-motor dysfunction. However the mouth and its function do not have a high profile in general health care. Oro-facial treatment is not well developed even in Sweden. It is an area that is inadequately covered in both medical and dental education, an issue that is being addressed by the Mun-Centre.

Dr Andersson ended with a video demonstration of the Toy Kit, a computerised game developed as a result of multi-professional collaboration. The game is played using an intra-oral device where chewing activity simulates the action of a mouse click. It helps to overcome the boredom of oro-motor programmes. Several prototypes have been developed. Research into the effectiveness of this prototype is necessary and funding is being sought to this end.

He concluded by stressing the importance of finding effective ways of reducing oro-motor impairments and that the lack of clinical trials and studies of oro-motor therapy is a problem. There is a need for objective instruments to evaluate oro-motor skills and muscle strength, an instrument that is adapted to children and adults with disabilities. Multi-centre studies are necessary to obtain larger samples. Colleagues were invited to visit the Mun-Centre website and encouraged to collaborate in research in this field.

Dr Andersson ended his excellent and stimulating presentation by describing the Swedish initiative to focus on dentistry in the European Year of People with Disabilities. A poster was circulated to all dental clinics in Sweden illustrating a photograph from the opening ceremony from the National Congress of the Swedish Dental Association. At the opening ceremony, the Swedish Family Minister opened the congress by focussing on the issue of disability and oral health and Dr Andersson spoke on improving dental services for disabled people. As entertainment, a music group of 14 girls with severe learning disabilities were singing and dancing. When they ended with a song entitled with Love me for the one I am, there was not a dry eye in the house. Dr Andersson suggested that this probably had a greater effect on promoting dental services for disabled people than all the seminars on disability and oral health that were included in the programme.

His final words were in support of IADH, the IADH textbook 'Disability and Oral Care' edited by Professor June Nunn and her dedication to the IADH Committee to which she has returned to take up the roles of IADH Secretary and Treasurer. The collaboration with FDI that took place over the textbook has resulted in 6 statements that relate to oral care and disability that all national dental associations signed up to in Sydney in 2003. Fulfilment of these statements in relation to oral care and disability will achieve great improvements in oral health care for disabled people.

Science and Clinical Practice in Chronic Facial Pain
Dr Alexander Crighton
Consultant Oral Medicine
Glasgow Dental Hospital and School

Dr Crighton aimed to review the current understanding of the mechanisms of chronic facial pain and discuss how it translates into the treatment options offered to patients. Current understanding of the mechanisms behind the development of chronic pain were reviewed from early ideas such as the stimulus-response model to neural plasticity in the generation and maintenance of pain. The mechanisms of pain perception, neural transmission, pain modification and pain interpretation were discussed in generating chronic pain. Improvements in the understanding of ion channel involvement in nerve conduction have led to the discovery of an enhanced disposition to patients in pain where gene coding for a particular variant is found. This is important not only in somatic nerves, but also in autonomic nerves. Current and promising new the drugs for chronic pain relief were described and alternative approaches such as Clinical Psychology, Transcutaneous Electrical Nerve Stimulation (TENS) and Acupuncture. Dr Crichton concluded this very informative paper with a summary of future developments in drug therapy and gene therapy for the management of chronic pain.

(Powerpoint presentation available to download on BSDH website)

Principles of Intervention for people unable to comply with routine oral care – BSDH Policy
Dr Sue Greening
Chair BSDH Working Group

The BSDH executive committee and particularly the members of the working group have been discussing this policy for some time. The working group consisted of Professor June Nunn, Janet Griffiths, Kathy Wilson, Barbara Hylton, Karen Gordon and Sue Greening as chair. The policy is currently in draft form. Sue discussed the progress of the report which is in its final draft and has

been issued for consultation to the British Institute for Learning Disabilities (BILD) from the service user's perspective. Before publishing the final draft, it will be reviewed from a legal perspective by the dental protection societies to ensure that the complexity of the law has been correctly interpreted. The final document will not be in tablets of stone, rather a 'living' document that will need to be reviewed in line with changes in legislation and case law.

The need for a policy arose primarily due to the interest and concerns of BSDH membership. Clinicians recognise the difficulty of managing care for people who cannot cope with routine dental care and the issues it raises for patients, parents and carers. There is currently a high emphasis on the European Human Rights Act, and the Disability Discrimination Act, with increasing awareness of the occasional apparent conflict between the clinician's duty of care to the patient and the legal principles. Greater awareness of the need for risk management and the fact that any form of dental intervention can pose a risk to the patient, however small. One of the main drivers at present is that other relevant organisations are publishing guidelines in this area. This topic has a very high priority within the field of learning disabilities, disability circles, autistic spectrum disorders etc. BILD published a policy framework for physical intervention, a very useful document which provided the working group with a sound basis for developing this BSDH policy. Similarly, the Department of Education and Skills produced guidance for restrictive physical interventions. Publication of these documents provided the background for setting up the BSDH working group. Internationally, the issue of physical intervention is very high on the agenda; a fairly hostile debate ensued at the International Association for Disability and Oral Health in Athens in 2002 because of legal and cultural approaches to physical intervention in other countries.

Guidelines for physical intervention would be difficult to produce as guidelines tend to be prescriptive. Although there are legal principles under which clinician's operate, there are no rules for interventions to facilitate care. Each individual is different and therefore every treatment will be different and based on individual assessment. Sue continued discussing the issues that need to be considered in the process of planning intervention, the process rather than the procedure. The policy must be viewed as a starting point for discussion within the profession and other interested parties.

Guiding principles are crucial in providing a baseline and that those providing care would share common values that individuals have a right to equal standards of oral care, and that good oral health has positive benefits. It is important that the policy is relevant to people inside and outside of dentistry. One of the basic reasons for developing the policy was to enable provision of care for those individuals who need further support, and mainly of relevance to people who were unable give informed consent for their own care.

It was also essential to consider the legal framework within which clinician's and carers are required to operate, legal and ethical principles appropriate to any kind of intervention. The first premise was that the dental team needs to work within the law and must be aware of the protection of the laws and infringement of the law. This is an issue that all members of the dental team must understand if they are to avoid allegations which lead to the possibility of charges of assault and battery. Conversely, withholding care may lead to an accusation of negligence if treatment is not provided.

Clinicians' have a duty to operate in the best interests of the patient. They have a responsibility for ensuring that patients are not put at risk either by providing or withholding treatment. These principles were also fundamental in the BILD document. The act of omission is interesting from an oral health perspective. Clinicians are very aware that failure to treat an acutely abscessed tooth when the patient is in pain can be viewed as an act of omission. An issue that needs to be reinforced to carers is that inadequate standards of oral hygiene may also be considered as acts of omission, as failure to carry the duty of care. This is an important issue for the dental profession when faced with the challenges of inadequate oral hygiene for dependent persons. These issues are addressed within the policy.

A further ethical principle is that the care provided must be in the best interests of the patient. This is inextricably linked with the capacity of the patient to give consent and agree to treatment. The law on consent indicates that a clinical decision is made, discussed, and agreed with the patient. Physical

intervention may be requested by a patient who can give informed consent to ensure that treatment can be provided safely and comfortably. Interventions of this type should be recorded and are acceptable. Similarly anxious patients may agree to sedation for treatment as an adjunct to manage their care. In many cases, a general anaesthetic is the ultimate intervention.

For individuals who do not have capacity for informed consent, the clinician must make decisions on the basis of clinical need. Sometimes, physical intervention may be in the best interests of the patient. This applies equally to treatment under sedation or general anaesthesia. Decision making for individuals who lack capacity must involve the individual as much as possible, and people within their support network. This is the basic premise underlying the legal principle. If wide consultation occurs, then the clinician's responsibilities under duty of care can be discharged in the best interests of the patient. In the decision making process on any aspect of care, best interests includes not just the patient's oral status, but also medical, social and cultural factors, effectiveness of treatment, the likelihood of improvement, and the views of people close to them.

An essential requirement for best interests is the completion of a thorough risk assessment. It requires that all issues that are pertinent to the interventions are considered. The assessment within the policy has been adapted from the BILD document. Information about the management of other aspects of personal care will contribute to an informed risk assessment, the potential risks to the patient and persons providing care, and the resources that are in place to minimise risk or deal with the potential consequences. The underlying principle is to identify the least restrictive intervention. Accurate written records are essential to indicate that the correct processes have been followed; this will help to justify the procedures in the event of a legal challenge.

Although the policy is primarily about physical intervention, sedation and general anaesthesia need to be considered. General anaesthesia is the ultimate form of physical intervention as it removes the patient's autonomy. Although it is an important treatment modality, the same process approach should be applied and documents. Oral pre-medication for physical intervention may be in the best interests of the patient in preference to general anaesthesia.

Having considered legal and ethical issues, and carried out a risk assessment, the type and degree of physical intervention should be considered. Shuman and Bebeau (1994) laid down the basic principles; they viewed physical intervention as being part of planned treatment, as being the minimum to be effective, to be clearly documented and beneficial to the individual. Physical intervention must not be seen as punishment, must not be for convenience and cause minimal psychological trauma eg a short intervention as a means of avoiding a general anaesthetic. Whenever possible, it must be agreed with the patient and their support network in an ethos of respect for the patient and an openness about decision making within the team. The dental team should receive training to understand local policies and the agreed procedures for physical intervention.

Restraint is described in the Department of Health document as an application of force with the intention of overpowering the individual. By definition, this is without consent. This is a very negative definition that is not appropriate to oral health care provided that the correct assessment procedures and consultations have been completed and documented. Restraint within a dental context should be about holding and containing the patient. Any patient for whom physical intervention is being considered must also be assessed for contra-indications. It is important that the clinician uses skill and judgement as to when an intervention should be stopped. This policy encourages the development of local policies and stresses the importance of staff training to ensure that the correct procedures are used.

In summary, physical intervention may be used following a risk assessment where there is a policy in place to give staff guidance, where staff have been properly trained in the policies and procedures, as part of an individualised treatment plan and when other behaviour modification techniques have proved ineffective or impossible. Physical intervention must only be carried out with the agreement of the patient and/or carers, within legal, ethical and moral principles and when it is in the best interests of the patient.

Improving our communication with patients with pain

Dr Joanna Zakrzewska

Senior Lecturer / Honorary Consultant

Barts and the London, Queen Mary's School of Medicine and Dentistry, University of London

Dr Zakrzewska fulfilled her aim of changing our perception about how we communicate with patients. She reinforced the importance of understanding the need for establishing good communication with patients and of recognising different ways of effective communication. The importance of defining pain holistically and an awareness of the different measures to describe pain and their limitations were stressed. The value of art and narrative in communicating with patients in pain was vividly illustrated. Listening and observing are key communication skills for the clinician who also needs adopt a bio-psychosocial approach to patient management. A meaningful history relies on establishing the right environment, demonstrating empathy, respect, support, organisation and a non-judgemental attitude in forming an alliance and partnership with the patient. Alternative non-verbal communication methods to record pain were described together with conventional verbal and visual scales of pain measurement. Other scales which measure depression and quality of life are also important. Dr Zakrzewska ended by quoting Schweitzer 'We must all die. But that I can save (a person) from days of torture, that is what I feel as my great and ever new privilege. Pain is a more terrible lord of mankind than even death himself'.

(Powerpoint presentation available to download on BSDH website)

Dr John Meechan

Senior Lecturer and Honorary Consultant in Oral Maxillofacial Surgery

Newcastle Dental School, University of Newcastle

The central focus of Dr Meechan's paper was a description of the techniques of local anaesthesia (LA) which overcome pre and post-injection problems and the systemic effects of local anaesthesia and vasoconstrictors. Various techniques were discussed to overcome limited access. Adverse effects due to toxicity are caused by intravascular injection, the use of too large a dose or the body's inability to metabolise the LA. Use of aspirating syringes and maximum doses to avoid such problems were addressed. Dr Meechan covered the advantages and disadvantages of the different local anaesthetics, the systemic effects and potential interaction with other medication. Problems in the late post-injection period included self-inflicted trauma and LA techniques which limit the area of soft tissue anaesthesia. Successful intra-ligamental anaesthesia (ILA) is dependent upon vasoconstrictor concentration and is less successful on lower incisors. ILA is contraindicated in haemophiliacs and in patients with endocardial disease. Epinephrine produces systemic effects at dental doses, which are exaggerated in some medically compromised patients and which interact with other medication. In summary, Dr Meechan concluded that adapting LA techniques can overcome difficulties with access and limit soft tissue anaesthesia. LA doses must be controlled to limit the systemic effects of vasoconstrictors, which are further exaggerated in medically compromised patients.

(Powerpoint presentation available to download on BSDH website)

Dr Kathy Wilson

Senior Dental Officer & Honorary Staff Grade

South Tyneside PCT and Newcastle Dental School, University of Newcastle

Dr Wilson presented current evidence-based practice in the field of benzodiazepine sedation for anxious adolescent patients and results of an ongoing clinical study. It is the dental profession's responsibility to provide conscious sedation in line with current guidelines developed from evidence-based practice. Relative analgesia with nitrous oxide and oxygen is the mainstay of conscious sedation for adolescent dental patients in the UK. Benzodiazepine sedation is used extensively in the

UK for adult dental patients but has received little attention in the field of research for those under the age of 16 years. Dr Wilson summarised the current results of a study which aimed to investigate the safety, effectiveness and acceptance of Benziazepines for dental extractions in anxious adolescents. The trial based the Sedation Unit at Newcastle upon Tyne School of Dental Sciences is ongoing and it is hoped that Dr Wilson will present the results of the completed trial at a future meeting.

(Powerpoint presentation available to download on BSDH website)

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