CANADIAN JOURNAL OF DENTAL HYGIENE · JOURNAL CANADIEN DE L'HYGIÈNE DENTAIRE

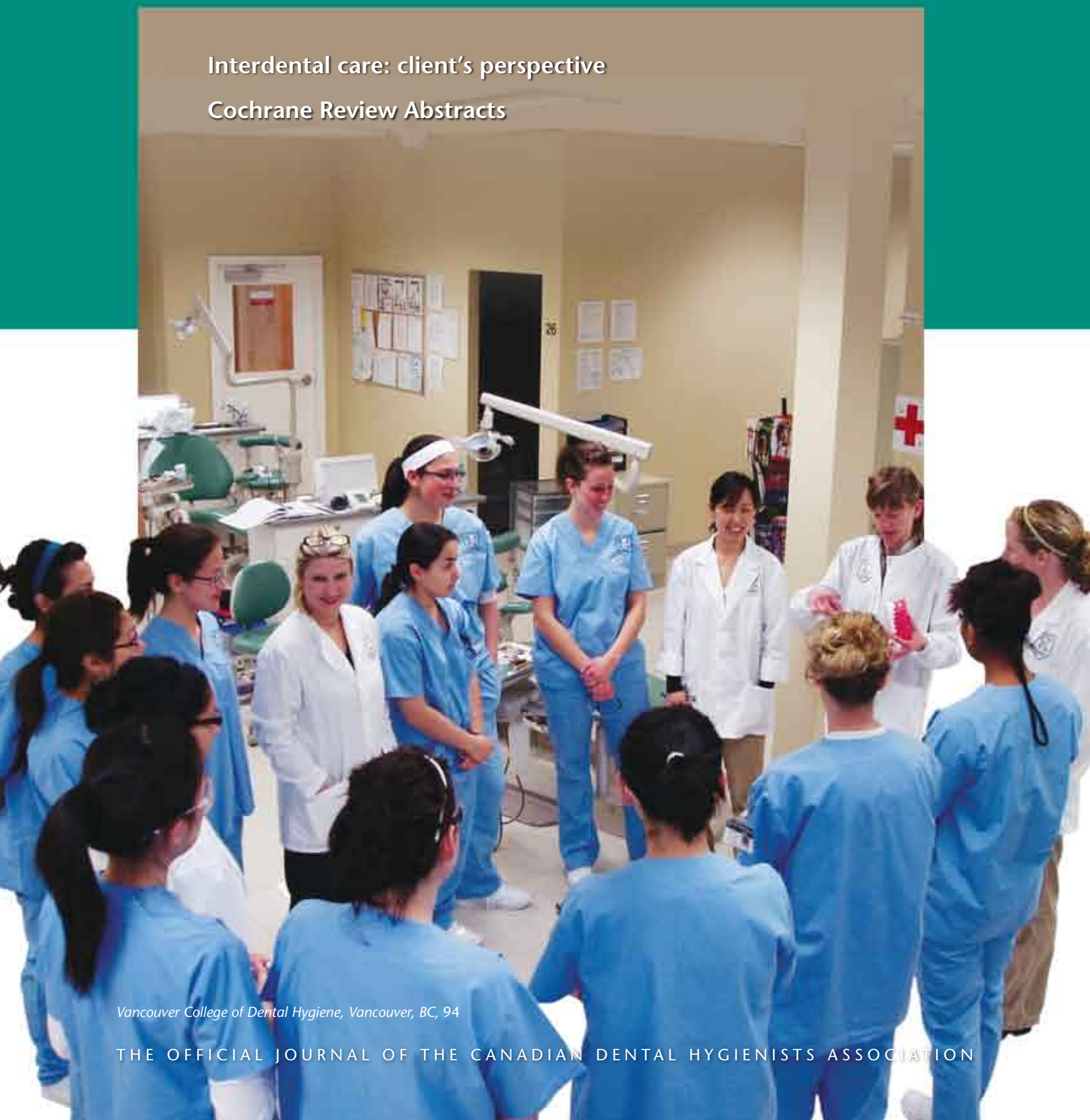
CJDH JCHD

CDHA ACHD

MARCH–APRIL 2010, VOL. 44, NO. 2

Interdental care: client's perspective

Cochrane Review Abstracts



Vancouver College of Dental Hygiene, Vancouver, BC, 94

THE OFFICIAL JOURNAL OF THE CANADIAN DENTAL HYGIENISTS ASSOCIATION

It starts with you

Jacki Blatz,
RDH

In 2010, the dental hygiene graduating classes of 1985 across Canada will celebrate 25 years of dental hygiene in practice. I note this with pride because I will have been a practising dental hygienist for a quarter of a century.

When I think of the significance in years of that number, I reflect on the substantial changes in dental hygiene, the role of dental hygienists, and how the changes in our profession have impacted my own personal experiences.

Our scope of practice has increased in most provinces, and a greater number of dental hygienists have the ability to access dental hygiene bachelor degree programs and master degree programs.

For myself, while I have not taken a degree completion program, like many dental hygienists of my era, I have been active in the pursuit of continuing dental hygiene education, and have taken the necessary courses for regulation of providing local anesthetic. I start a new chapter of continuing education this February with the Pharmacy Course for Prescribers in Alberta.

So while dental hygienists have had significant advances in the opportunities for education and career options, the majority of dental hygienists in Canada are employed in traditional dental office settings.

Recently, I received a letter, through the President's e-mail, from a dental hygienist who has been employed in the private practice setting for over thirty years. This dental hygienist is close to retiring from the dental hygiene profession, and presents the issue to me that she will retire without any employer pension benefits. This is something that every dental hygienist employed in a private practice has faced. In the private practice setting, there are no employer pension benefits or really any benefits to speak of that many other health professionals are recipients of.

This, of course, is nothing new. We all realize that most dental offices are really small businesses. I would like to propose that every dental hygienist is her or his own best advocate of ensuring that individual financial needs and working conditions are met. This task can seem enormous and daunting. An important member benefit of CDHA is an extensive member benefit package that I encourage all members to take advantage of.

Savings and retirement programs, RRSPs, investment planning, TFSAs, liability insurance, disability insurance, mortgage services are some of the many membership affiliations that CDHA offers. You, as a CDHA member, receive a professional membership discount. The time to think of your future is now.

…continued on page 70

CDHA welcomes your feedback: president@cdha.ca

Ça commence avec vous

En 2010, les diplômées canadiennes de 1985 en hygiène dentaire célébreront leur 25e anniversaire d'exercice de la profession. Je le souligne avec fierté parce que j'aurai alors exercé l'hygiène dentaire depuis un quart de siècle.

Quand je pense à l'importance de ce nombre en terme d'années, je ressasse les changements substantiels qui ont marqué l'hygiène dentaire et le rôle de l'hygiéniste dentaire ainsi que l'impact que ces changements professionnels ont eu sur mon expérience personnelle.

L'étendue de notre pratique s'est accrue dans la plupart des provinces et un plus grand nombre d'hygiénistes dentaires ont pu accéder aux programmes de baccalauréat et de maîtrise en hygiène dentaire.

Quant à moi, si je n'ai pas suivi de programme vers un grade supérieur, comme plusieurs hygiénistes dentaires de mon secteur, j'ai suivi activement des programmes de perfectionnement continu en hygiène dentaire et les cours réglementaires nécessaires en anesthésie locale. J'entreprends en ce mois de février une nouvelle étape de formation continue dans un cours de prescription en pharmacie, en Alberta.

Ainsi, alors que les possibilités de perfectionnement et les options de carrière les font progresser considérablement, la majorité des hygiénistes dentaires du Canada travaille dans le cadre traditionnel du cabinet dentaire.

J'ai reçu récemment, par un courriel adressé à la présidente, une lettre d'une hygiéniste dentaire qui travaille dans un cabinet privé depuis plus de trente ans. La correspondante se dit à la veille de la retraite de la profession d'hygiéniste dentaire et m'informe de son problème : elle ne touchera aucune prestation de retraite de la part de son employeur. C'est là une situation que toute hygiéniste dentaire employée doit affronter. Dans le cadre de la pratique privée, il n'y a pas de prestation de retraite de la part de l'employeur ni aucun avantage véritable pour ainsi dire dont plusieurs autres professionnels de la santé bénéficient.

Évidemment, cela n'est pas nouveau. Nous savons toutes que la plupart des cabinets dentaires sont à vrai dire de petites entreprises. Je souhaite proposer que chaque hygiéniste dentaire fasse valoir de son propre chef la satisfaction des besoins financiers personnels et des conditions de travail. Cette tâche peut paraitre énorme et intimidante. Un important avantage de l'ACHD à ses membres comporte un vaste ensemble d'avantages dont j'incite tous les membres à bénéficier.

Les programmes d'épargne et de retraite, les REER, la planification des investissements, les CELI, les services d'assurance responsabilité, d'assurance invalidité et d'hypothèque sont quelques-unes des nombreuses affiliations que l'ACHD offre à ses membres. Puis, à titre de membre de l'ACHD, vous bénéficierez du rabais d'adhésion en tant que professionnelle. Vous devez penser à votre avenir dès maintenant.

Je crois aussi que chacune d'entre nous peut influer sur le changement dans notre environnement de travail. En tant qu'hygiéniste dentaire, vous n'êtes pas seulement une employée

…suite page 70

L'ACHD accueille vos commentaires : president@cdha.ca

MASTHEAD

Scientific Editor: Susanne Sunell, EdD, RDH

Managing Editor: Chitra Arcot, MA (Pub.), MA (Eng.)

Acquisitions Editor: Linda Roth, RDH, DipDH

Graphic design and production: Mike Donnelly

Published six times per year: January, March, May, July, September and November. Canada Post Publications Mail #40063062.

CANADIAN POSTMASTER
Notice of change of address and undeliverables to:
Canadian Dental Hygienists Association
96 Centrepointe Drive, Ottawa, ON K2G 6B1

SUBSCRIPTIONS
Annual subscriptions are $90 plus GST for libraries and educational institutions in Canada; $135 plus GST otherwise in Canada; C$140 US only; C$145 elsewhere. One dollar per issue is allocated from membership fees for journal production.

CDHA 2010
6176 CN ISSN 1712-171X *(Print)*
ISSN 1712-1728 *(Online)*
GST Registration No. R106845233

All CDHA members are invited to call the CDHA Member/Library Line toll-free, with questions/inquiries from Monday to Friday, 8:30 a.m. – 5:00 p.m. ET. **Toll free: 1-800-267-5235, Fax: 613-224-7283, E-mail: info@cdha.ca, Web site: http://www.cdha.ca**

The *Canadian Journal of Dental Hygiene (CJDH)* is the official publication of the Canadian Dental Hygienists Association. The CDHA invites submissions of original research, discussion papers and statements of opinion of interest to the dental hygiene profession. All manuscripts are refereed anonymously.

Editorial contributions to the *CJDH* do not necessarily represent the views of the CDHA, its staff or its board of directors, nor can the CDHA guarantee the authenticity of the reported research. As well, advertisement in or with the journal does not imply endorsement or guarantee by the CDHA of the product, service, manufacturer or provider.

CDHA acknowledges the financial support of the Government of Canada through the Canada Magazine Fund toward editorial costs.

Canada

FSC Mixed Sources
Product group from well-managed forests, controlled sources and recycled wood or fiber
www.fsc.org Cert no. SW-COC-001506
© 1996 Forest Stewardship Council

CONTENTS

THE CANADIAN DENTAL HYGIENISTS ASSOCIATION
L'ASSOCIATION CANADIENNE DES HYGIÉNISTES DENTAIRES

EVIDENCE FOR PRACTICE

DEPARTMENTS

INFORMATION

Rock stars

Dr. Susan A. Ziebarth

*Leaders of the future need an essential set of attributes for being leaders of character that have a passion for **doing** – getting things done with a conscious intention to deliver positive results.*

– Debbe Kennedy in Organization of the Future 2, *Leadership by Perpetual Practice*

In early January 2010, CDHA's Research Advisory Committee (or the RAC) met at the University of British Columbia in Vancouver. The RAC exists to advise CDHA in creating a vision for research within the profession so that our professional association can be involved in creating, supporting, disseminating, and translating dental hygiene research and knowledge uptake as well as in building research capacity. Such a meeting allows thoughtful discussion and debate about what dental hygiene research is, and how we can involve each and every one of our members in benefiting from research. The News section in this issue features the names of this outstanding committee. The vision of the committee is that "dental hygiene research makes a positive contribution to the body of knowledge on how best to promote health and wellness, prevent disease, address social inequity and related determinants of health, through better oral health care policies, models of care, and systems of delivery."

Underlying this vision is the RAC members' passion for doing research and a conscious intention to deliver positive contributions. They, as Debbe Kennedy has so nicely stated in the quote above, are leaders of the future. Janice Murray of Hope BC, a leader in her own right, is the recent recipient of the 2009 CDHA *Visionary* prize in participation with TD Insurance Meloche Monnex. Prior to presenting her research area on learning outcomes in the master's level dental hygiene education, Janice shared a story with us that emphasizes the inspirational role which leaders of character have within a culture.

The morning Janice was leaving for the meeting, her four children were gathered for breakfast at the kitchen table. Her 11-year old son, Kyle, expressed his concern that his mother was going to be gone for two whole nights. She told him that she had to go because it was important for mommy to meet these really important people from her profession and to talk about really important stuff for dental hygienists. Kyle wasn't convinced, and felt the phone was a good alternative. Through the discussion Jan tried to convince her son of the importance to her telling him that she really, really wanted to meet these important people as she had read many articles that they had written, and because they were really special individuals.

He did not understand. It was at this point that Tyler, her 15-year old, looking rather annoyed over his bowl of cereal, turned down his iPod and translated for her with 4-year old Oliver and 2-year old Taia looking on. In his

…continued on page 63

CDHA welcomes your feedback: info@cdha.ca

Les rock stars

*Les leaders de l'avenir ont besoin d'un ensemble essentiel d'attributs qui en feront des personnes de caractère passionnées d'**action** – avec une efficacité résultant d'une intention bien arrêtée de livrer un résultat positif.*

– Debbe Kennedy dans « Organization of the Future 2, *Leadership by Perpetual Practice* »

Au début de 2010, le Comité consultatif de la recherche (CCR) de l'ACHD se réunissait à l'Université de la Colombie-Britannique à Vancouver. Le CCR a pour mission de développer une nouvelle conception de la recherche au sein de la profession de façon à ce que notre association puisse participer à la création, au soutien, à la diffusion et à l'expression de la recherche et du savoir, et développer ainsi une nouvelle capacité de recherche. Une telle rencontre permet une discussion et un débat attentifs sur la nature de la recherche en hygiène dentaire et les façons de faire participer à leur avantage chacune de nos membres. La section Informations du présent numéro présente les noms des personnes qui forment ce remarquable comité. Celui-ci entrevoit que « la recherche en hygiène dentaire contribue de façon positive à l'ensemble des connaissances sur la meilleure façon de promouvoir la santé et le bien-être, prévenir la maladie, aborder l'iniquité sociale et les déterminants de la santé par le biais de politiques, de modèles de soin et de régimes de prestation pour améliorer la santé buccale. »

Sous-jacent à cette perspective se trouve la passion des membres du CCR pour la recherche et leur intention arrêtée d'y apporter des contributions positives. Comme l'a si bien décrit Debbe Kennedy dans la citation ci-dessus, ce sont des leaders de l'avenir. Janice Murray, de Hope (C.-B.), leader par son seul talent, a reçu récemment le prix Visionnaire *de l'ACHD avec la participation de TD Insurance Meloche Monnex. Avant de présenter son secteur de recherche sur les résultats de l'étude au niveau de la maîtrise en hygiène dentaire, Janice a partagé avec nous une histoire qui soulignait l'inspiration que les leaders de caractère apportent à une culture.*

Ce matin-là, avant que Janice quitte la maison pour la réunion, ses quatre enfants prenaient le petit déjeuner dans la cuisine. Son fils de 11 ans, Kyle, s'inquiétait de voir partir sa mère pour deux nuits entières. Elle lui dit qu'elle devait le faire parce que c'était important que maman rencontre ces personnes vraiment importantes de sa profession et de traiter de sujets importants pour les hygiénistes dentaires. Kyle, qui n'en était pas convaincu, pensa que le téléphone offrirait une alternative. Dans la discussion, Jan tenta de convaincre son fils que c'était important pour elle de lui dire qu'elle voulait vraiment, vraiment rencontrer ces personnes importantes parce qu'elle avait lu plusieurs articles qu'elles avaient rédigées et parce qu'elles étaient des personnes vraiment spéciales. Il n'a pas compris.

À ce moment-là Tyler, son fils de 15 ans, qui avait l'air plutôt ennuyé au-dessus de son bol de céréales, ferma son iPod

…suite page 63

L'ACHD accueille vos commentaires : info@cdha.ca

Encouraging client compliance for interdental care with the interdental brush: The client's perspective

Pauline H Imai, CDA, DipDH, BDSc(DH), MSc(DS) and Penny C Hatzimanolakis, DipDH, BDSc(DH), MSc(DS)

ABSTRACT

Background: Toothbrushing for daily oral biofilm disruption is well accepted by clients, but dental flossing is not, due to poor dexterity or lack of motivation or both. The interdental brush is considered an easy to use alternative, which may influence daily self care compliance; however it has only been studied in subjects with open embrasures. **Purpose:** To determine whether interdental brush's ease of use influences willingness for daily compliance in subjects with intact interdental papillae. **Methods:** This paper focuses on the secondary outcome of a randomized controlled trial comparing interdental brush to dental floss in 32 adults with intact but bleeding interdental papillae. Subjects received non surgical debridement two weeks prior to intervention phase, and instructions to use toothbrush, dental floss, and interdental brush at baseline (week 0) and week 6. Subject compliance was measured with self reported journals and amount of products used. Exit survey collected information about subjects' perceptions and preferences for interdental brush and dental floss. **Results:** Subjects were more than twice as likely to "strongly agree" that interdental brush was easy to use compared to flossing, with 40% having neutral opinions about dental floss's ease of use. They were also willing to use the interdental brush daily (43.3% strongly agreed and 50% agreed). The subjects' opinions regarding daily dental flossing ranged from "disagree" to "strongly agree" (6.7% to 30.0% respectively). **Discussion:** Study results were similar to other studies that demonstrated client compliance with interproximal oral self care is associated with clients' perceptions of ease of use and motivation. **Conclusion:** Interdental brush is easy to use and well accepted by study subjects, which may positively influence daily interproximal self care compliance.

RESUME

Contexte : La clientèle accepte bien le brossage des dents pour le nettoyage quotidien du biofilm, mais il n'en est pas ainsi de l'usage de la soie dentaire à cause du manque de dextérité ou de motivation, ou des deux. Considérée plus facile à utiliser, la brosse interdentaire peut influencer la pratique des soins personnels quotidiens; toutefois, cela n'a pas fait l'objet d'études chez les sujets ayant des embrasures ouvertes. **Objet :** Établir si la facilité d'utilisation de la brosse interdentaire influence la propension au brossage quotidien chez les sujets dont les papilles interdentaires sont intactes. **Méthode :** Cet article se concentre sur les effets secondaires d'un essai contrôlé et randomisé, comparant le brossage interdentaire à l'utilisation de la soie dentaire chez 32 adultes ayant des papilles interdentaires intactes, mais saignantes. Les sujets ont reçu un débridement non chirurgical deux semaines avant la phase d'intervention et des instructions sur la façon d'utiliser la brosse à dents, la soie dentaire et la brosse interdentaire au départ (semaine 0) et à la 6e semaine. La propension des sujets a été mesurée à partir de comptes-rendus quotidiens et de la quantité de produits utilisés. Le dernier questionnaire a permis de recueillir de l'information sur la perception et les préférences des sujets concernant la brosse et la soie dentaire. **Résultats :** Les sujets étaient au moins deux fois plus enclins à être « vivement d'accord » sur la facilité d'utilisation de la brosse interdentaire comparativement à la soie dentaire, et 40% se sont dit neutres sur la facilité d'utilisation de la soie dentaire. On était aussi d'accord à utiliser la brosse interdentaire quotidiennement (43,3 % étaient très d'accord et 50 %, d'accord). L'avis des sujets concernant l'usage quotidien de la soie dentaire variait entre « d'accord » et « ytès d'accord » (6,7 % à 30,0 %, respectivement). **Discussion :** Les résultats de l'étude ressemblent à ceux des autres études qui ont démontré que la propension des clients aux soins buccaux interproximaux personnels s'associe à la perception de facilité d'usage et à la motivation des clients. **Conclusion :** La brosse interdentaire est facile à utiliser et bien acceptée par les sujets de l'étude, ce qui peut influencer positivement la propension aux soins interproximaux personnels et quotidiens.

Key words: dental home care devices, client compliance, oral hygiene, interdental cleansing/aids

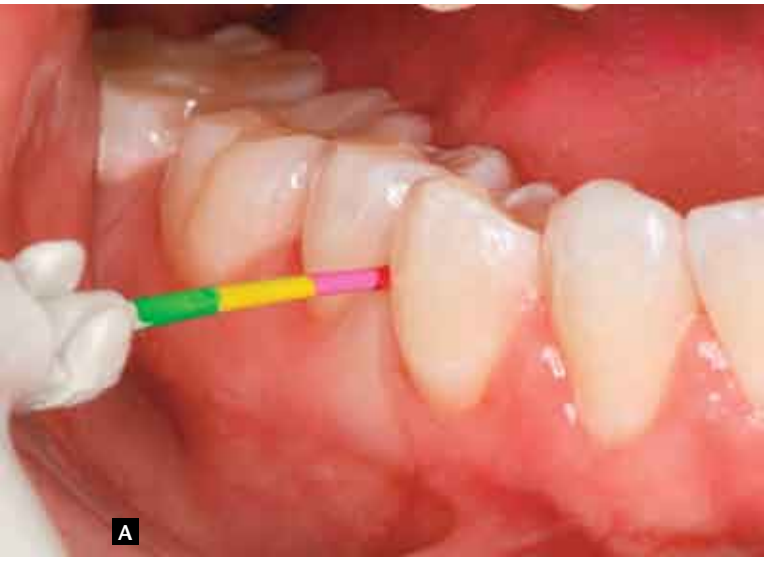
INTRODUCTION

Oral biofilm, known as dental plaque, is a complex bacterial community that naturally develops on a tooth surface, and contributes to the host's defences by preventing the colonization of exogenous species.[1] However if left undisturbed, there is a gradual shift in the bacterial flora to Gram-negative anaerobes that have been associated with periodontitis.[2–4] Plaque induced gingivitis is the early, reversible stage of periodontal disease.[2] Although not all sites with gingivitis will progress to periodontitis, oral health professionals are unable to predict the level or rate of progression,[2–4] which necessitates the prevention and treatment of gingivitis.[2]

Daily mechanical disruption of the oral biofilm remains the primary self care method for achieving and maintaining oral health because studies have demonstrated that bacteria are protected in the biofilm from orally delivered antimicrobial agents.[5,6] Although toothbrushing is well accepted, interdental self care is not.[7] The toothbrush is unable to penetrate intact interdental areas to disrupt the biofilm where periodontal disease is prevalent.[7,8] Dental hygienists commonly recommend dental floss for their client's interproximal oral biofilm disruption, but clients' compliance for daily flossing is usually low, ranging from 10% to 30%, due to lack of dexterity and motivation.[7] Studies have demonstrated that individuals who experience difficulties with dental floss are less motivated to floss daily.[7]

Other interdental aids have been developed to facilitate easier oral self care and thus, attempt to address the compliance issue.[9,10] The interdental brush is a small cylindrical or cone shaped brush that is inserted interproximally. Usually the interdental brush is studied in subjects with clinical attachment loss who present with

Submitted 7 Dec. 2009; Revised 22 Jan. 2010; Accepted 26 Jan. 2010
This is a peer reviewed article.
Faculty of Dentistry, University of British Columbia.
Correspondence to: Pauline H Imai; imai@interchange.ubc.ca
2199 Wesbrook Mall, University of BC, Vancouver, BC V6T 1Z3



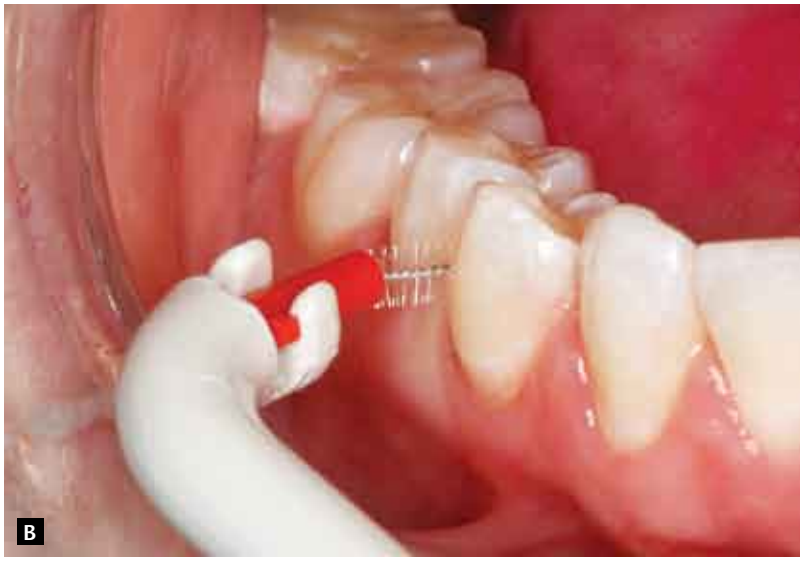


Figure 1: Coloured probe and corresponding interdental brush inserted interproximally. **A.** The coloured probe is inserted horizontally into the interproximal site until snug. **B.** The visible colour on the buccal aspect corresponds to the best fitting interdental brush for the site.

larger interdental embrasure spaces.[8] In subjects with large embrasure spaces, the interdental brush reduced probing depths, bleeding scores, and had superior plaque reducing abilities compared to dental floss.[8] However there is no published literature on the efficacy of interdental brush for clients with intact interdental papillae. Since it is desirable to treat gingivitis with the aim to prevent possible progression to periodontitis and clinical attachment loss, oral health professionals need alternative, evidence based interdental oral self care aids to recommend to their clients who are adverse to or cannot floss.

This paper focuses on the subjects' perceived ease of use with the interdental brush and dental floss, as well as how this perception may influence their willingness for daily self care compliance. A separate paper will be published later reporting the clinical findings surrounding the relative effectiveness of interdental brush to dental floss in individuals with intact interdental papillae.

MATERIALS AND METHODS

Study design

The study was an examiner blinded, split mouth, three month, randomized controlled trial comparing interdental brush to dental floss on premolars, first and second molars in thirty-two healthy adults with intact, but bleeding interdental papillae. Clinical outcomes and subjects perceptions were measured. This paper will focus on the subjects' perceptions in the exit survey. The study protocol was reviewed and approved by the University of British Columbia's Clinical Research Ethics Board. The study is registered with www.clinicaltrials.gov (Identifier NCT00743548).

Study recruitment and enrolment

Subjects were recruited via a newspaper ad in the local paper, Vancouver Craig's List, flyers posted on the University of British Columbia's (UBC) campus, and orally through the Vancouver Westside dental community. Participation was not limited by race or gender. Study subjects were not dental or dental hygiene students, but were recruited from the general population. All study visits were held at the Nobel Biocare Oral Health Centre, which is the dental clinic located on UBC's Point Grey campus in Vancouver, Canada.

All potential subjects were screened to inform them of the nature of the study and to determine whether they met the inclusion/exclusion criteria. Inclusion criteria consisted of:

1. a minimum of four interproximal areas per side that could accommodate a minimum 0.6 mm interdental brush width as determined with the Curaprox probe™ (Curaden Swiss, Amlehnstrasse, Switzerland),
2. a minimum of eight interproximal bleeding sites upon stimulation with a Stimu-Dent™ (Johnson & Johnson Inc., NB, Canada) inserted horizontally four times,
3. dexterity to use waxed dental floss without any additional aids, and
4. ability to attend five study visits.

Subjects were only required to present with interdental papillae filling the interdental spaces of adjacent teeth that are in contact. Interdental brush width was determined by horizontally inserting the Curaprox coloured probe™ from the buccal aspect until snug, and by observing the colour left visible as shown in Figure 1. Each colour on the probe corresponds to a brush diameter. The diameters range from 0.6 mm (dark green on the probe) to 2.0 mm (light green).

Subjects were excluded from the study if they:

1. required premedication with antibiotics prior to dental therapy,
2. used chlorhexidine or over the counter mouthwash during the study,
3. used tobacco products, and/or
4. had full orthodontia.

Subjects who met the study's inclusion/exclusion criteria were invited to participate in the study, and they signed informed consent.

Maintaining client anonymity and randomization

The subjects were assigned an individual identification number upon study enrolment. Only the medical health history form contained the subjects' personal information. All data collection forms, compliance forms, and surveys were coded and separated from the medical history form to maintain the subjects' confidentiality and anonymity.

The non blinded examiner randomized subjects upon initial subject contact, before screening information was collected. The non blinded examiner randomized the subjects without knowledge of any subject information such as dominant hand, number of bleeding sites, and size of interdental spaces. The left side of the subjects' mouths was randomly assigned by flip of coin to interdental brush or dental floss with the right side receiving the remaining oral self care aid. There was no attempt to balance the distribution of interdental brush or dental floss to left side of the subjects' mouths, but the resulting distribution was fairly equal.

Study schedule

Upon enrolment and prior to the intervention phase of the study, all subjects received non surgical periodontal debridement using a combination of ultrasonic and hand instrumentation with no time limit, by an experienced dental hygienist two to three weeks before baseline data collection.

Subjects were given verbal and hands on oral hygiene instructions by the non blinded examiner at baseline and Week 6. Modified Bass tooth brushing method using Curaprox CS 5460 Prime ultra-soft compact toothbrush™ (Curaden Swiss, Amlehnstrasse, Switzerland), spool flossing with waxed dental floss and no flossing aids (Johnson & Johnson Inc., NB, Canada), and Curaprox Prime IDB™ (Curaden Swiss, Amlehnstrasse, Switzerland). Instructions were provided until the subject was comfortable with the techniques and had no unanswered questions. During the oral hygiene instructions the subjects' dominant hand was noted as the one the subjects used to brush, floss, and interdentally brush. Subjects were instructed to brush their teeth twice a day, morning and before bed; floss once a day on the assigned side preferably at night, and use the appropriate colored interdental brush inserted once in and out on the assigned side, once a day, again preferably at night. All subjects were instructed to use only these products and the toothpaste provided, Colgate Cavity Protection Regular toothpaste, (Colgate-Palmolive Canada Inc.) and to refrain from using professional dental hygiene services and over the counter and prescription mouthwashes during the study period. Subjects were given a compliance folder to note their daily progress with the interdental brush or dental floss. The compliance folder included a diagram of the teeth and indications as to where to use the dental floss and specific interdental brush, which included a maximum of three colours representing differing diameters. Subjects were encouraged to place this diagram in their bathroom as a reference and reminder. Subject compliance was evaluated through the self reported journal, and product wear and usage at Weeks 6 and 12.

The exit survey was distributed and collected by the non blinded examiner at the end of the Week 12 visit. A 5-point Likert scale, ranging from "Strongly agree" to "Strongly disagree", was used for the exit survey to capture the study subjects' opinions regarding the interdental brush or dental floss. The survey consisted of four closed item statements and one open ended question to provide subjects with an opportunity to add their own comments.

Exit survey statements:

1. The interdental brush was easy to use.
2. The dental floss was easy to use.
3. I would use dental floss every day.
4. I would use the interdental brush every day.
5. Please add additional comments, concerns, or suggestions regarding the interdental brush and/or dental floss used in this study.

Statistical analyses

Descriptive statistics and chi-square tests were used to analyze the exit survey data and the major theme was extracted from the subjects' comments.

RESULTS

There were no reported or observed side effects during the study, suggesting that the interdental brush, dental floss, and toothbrush were well tolerated by the subjects. Thirty adults completed the three-month study. Two adults were unable to be contacted upon completion of the debridement, and did not enter the intervention phase of the study.

The exit survey results indicated 50% of the study subjects strongly agreed and 46.7% agreed that the interdental brush was easy to use (Figure 2). In the survey, subjects stated that the "interdental brush was easier to use even with a busy schedule and was faster than dental floss." Other subjects commented, "I like the interdental brush over flossing because of the ease of use; I can reach parts [with the interdental brush] that I find difficult to clean with dental floss." Subjects had no prior experience with the Curprox™ IDB system because this product is unavailable in western Canada.

Fewer subjects agreed that dental floss was easy to use (Figure 2). Although there was no statistically significant difference between interdental brush and dental floss for ease of use, $X^2(1, n=30)=0.9, p<0.05$, forty per cent of subjects were neutral about dental floss's ease of use. Study subjects comments included, "the dental floss is slippery and difficult to grasp, which made it less convenient than the interdental brush. I found dental floss irritating to use, especially trying to maneuver it in the back teeth." The majority of subjects (97%) entered the study with no history of daily flossing, but by the end of the study, 30% of the subjects strongly agreed and 36.7% agreed that they were willing to use dental floss every day (Figure 2). These subjects attributed their willingness to floss daily to learning the proper flossing technique and the structure created within the study. The other 26.7% held neutral opinions on daily flossing, and 6.7% were not willing to floss daily beyond the study because they found it difficult to use and time consuming (Figure 2). Subjects "strongly agreed" (43.3%) and "agreed" (50.0%) that they were willing to brush interdentally daily (Figure 2). In particular, the majority of the subjects' open comments indicated they would more likely use the interdental brush daily although

there was no statistically significant difference between interdental brush and dental floss for daily use preference in the closed items, $X^2(1, n=30)=0.87, p<0.05$. Ease of use was a major theme, and this may have influenced the subjects' willingness to continue and use the interdental brush daily. Subjects commented, "I really prefer the interdental brush; I can still clean my teeth before bed, even in a busy daily schedule, with the interdental brush, but this is not the case with dental floss." Two subjects, who were neutral about using the interdental brush daily, commented they had difficulty accessing the interproximal site between the last two molars and did not like changing the brush tips for the various sites.

DISCUSSION

Many dental hygienists focus on instructing their clients in the use of dental floss for oral health maintenance and treatment of gingival diseases because they have been taught flossing in their dental hygiene education, and are familiar with the product.[7] However client compliance with dental floss is historically low[7] in spite of dental hygienists providing oral health education and flossing instructions. Clients frequently choose not to floss because of lack of motivation and ability.[7]

Motivation to change behaviour may be imposed externally, which may then develop into an internally valued belief that is sustained.[11] In this study, subjects became keenly aware of the sites that were bleeding, and became interested in monitoring these sites while using the interdental brush and dental floss. The presence of bleeding, which is an objective sign of gingival inflammation, became an effective external motivator for the subjects.[12] Subjects commented that they were motivated to brush interdentally and floss to attain non bleeding status, and began to equate non bleeding sites with gingival health. In this study, several subjects stated they now understood the importance of self care for oral health. The internalization of health beliefs, such that external motivators no longer play a role in compliance, needs further investigation.[13]

Simply being in the study may have also motivated the study subjects to comply with interdental brush and dental floss. The Hawthorne Effect occurs when subjects are immersed in an environment that supports positive behaviours.[14] In this study, subjects were required to report their daily use of interdental brush and dental floss in a journal. The journal had to be submitted to the non blinded examiner along with the subjects' dental products at Weeks 6 and 12 to be inspected for usage, and thus, subjects may have been motivated to please the examiners.

Study subjects were also motivated by the frequent, intensive oral hygiene instructions that encouraged them to continue to improve their oral self care techniques as well as their daily use of interdental brush and dental floss. According to Stewart and Wolfe,[15] subjects who received two 30-minute sessions of oral hygiene instruction were able to maintain their newly acquired self care skills a year later, but other studies have shown that educational attempts at modifying client behaviour for daily flossing is unsuccessful.[7] Since the present study had no long term follow up, it is unknown if these study subjects would continue their daily interdental self care routine. A long term study is needed to observe whether intensive, continuous oral hygiene instructions in self care skill acquisition and oral health knowledge would assist clients in achieving long term interdental self care compliance.

According to Asadoorian, motivation to self care interdentally is closely linked to the individual's ability to use the aid.[7] Although there was no statistically significant difference for subjects' product preference in the present study, the overall theme collected from the subjects' comments was that "ease of use" played a significant role in their willingness to continue the daily use of the interdental brush. In this study, almost all subjects agreed that the interdental brush was easy to use. The interdental brush could be used with one hand and subsequently, without the use of a mirror. The study findings were similar to those reported by Slot et al.,[8] in which patients considered the interdental brush to be simpler to use, in spite of the brush's tendency to bend and distort.

While subjects were familiar with dental floss, and had received flossing instructions previously from their oral health professionals, the majority of the subjects did not floss daily prior to enrolling in this study because they did not like dental floss, found it difficult to use, and/or were not motivated to use it. Dental floss takes a certain amount of dexterity and instruction to achieve optimal interproximal oral biofilm disruption[7] and this was apparent in this study. Subjects received intensive one-on-one flossing technique instructions at baseline and week 6, and even with repeated instructions, two subjects were unable to master the skill as evidenced by their stable interproximal plaque scores. For some subjects, the repeated flossing instructions not only assisted them with achieving the correct technique, they became more accustomed to dental floss, and thus indicated that they were more willing to continue with daily flossing on the exit survey. These findings support Asadoorian's comment that ability and motivation are closely linked.[7]

There are numerous health behavioural theories, such as the Health Belief Model, Trans Theoretical Model, Stages of Change, Self Efficacy, and Locus of Control Model that have explored oral health behaviour modification.[16,17] These models focus on individuals assuming responsibility for their own health.[16,17] A complete review of oral health behaviour models can be found elsewhere.[16,17] Having a clear understanding of these models and the clients' stage of behaviour are critical for identifying, modifying or changing behaviours that contribute to optimal oral and overall health.

This study demonstrates the importance of assessing the client's abilities and source of motivation prior to making an oral self care recommendation for optimal compliance. Frequent client centred oral hygiene instruction and support is necessary to nurture the new behaviour until the client becomes accustomed to the technique and routine. Dental hygienists must consider their own biases and preferences in addition to the scientific evidence when recommending oral self care products to their clients.

CONCLUSION

The interdental brush is an easy to use alternative, interdental self care aid for clients with gingivitis and intact

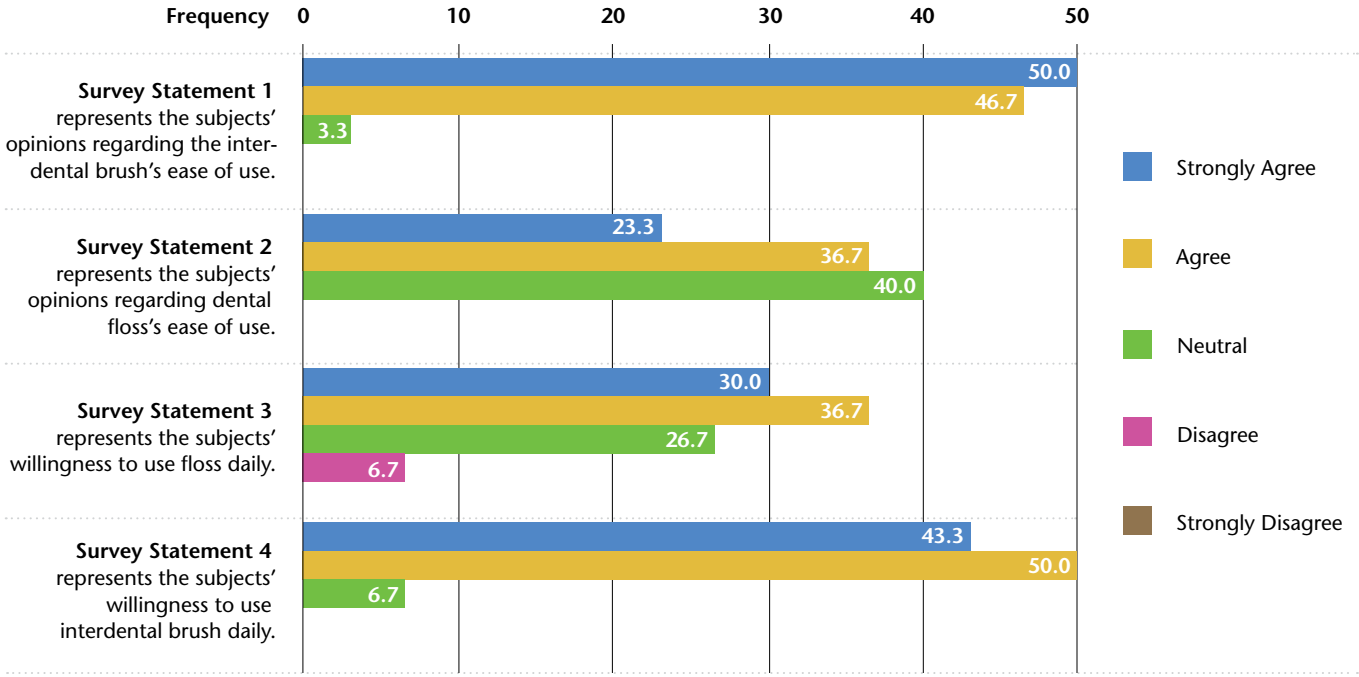


Figure 2: Frequency of subjects' responses to exit survey. The coloured bars represent the five point Likert scale ranging from "Strongly Agree" to "Strongly Disagree" that subjects used. The length of the bars represents the frequency of the subjects' responses for each statement.

interdental papilla in the posterior sites, who cannot or choose not to use dental floss as part of their oral self care preventive routine. Study subjects were more willing to use the interdental brush than dental floss for their daily interdental self care due to its ease of use, which may enhance oral self care compliance.

Acknowledgements:

"Thank you" to Kaitlin Hong Tai and Eugene Chien for their assistance in the clinic, and to G. William Mercer, PhD, for his statistical assistance.

The study was conducted at the Nobel Biocare Oral Health Centre at the University of British Columbia, Vancouver, BC. "Thank you" to Dean Charles Shuler, DMD, PhD, for use of the clinic facilities for the study.

Conflict of interest and source of funding statement:

The authors declare that they have no conflict of interest. The authors received no financial compensation from Curaprox Swiss or Entreprise Dentalink Inc.

This study was funded by the Canadian Foundation for Dental Hygiene Research and Education, and the British Columbia Dental Hygienists Association. Entreprise Dentalink Inc. generously provided the interdental brushes and toothbrushes for the study.

REFERENCES

1. Marsh PD. Plaque as a biofilm: pharmacological principles of drug delivery and action in the sub- and supragingival environment. *Oral Dis*. 2003;9(Suppl.1):16–22.
2. Rosen PS. American Academy of Periodontology. Research, science, and therapy committee. Treatment of plaque-induced gingivitis, chronic periodontitis, and clinical conditions. *Pediatr Dent*. 2008–2009;30(7 Suppl):253–62.
3. Loesche WJ, Grossman NS. Periodontal disease as a specific albeit chronic infection: diagnosis and treatment. *Clin Microbiol Rev*. 2001;14(4):727–52.
4. Haffajee AD, Socransky SS. Introduction to microbial aspects of periodontal biofilm communities, development, and treatment. *Periodontol 2000*. 2006;42:7–12.
5. Schaudinn C, Gorur A, Keller D, Sedghizadeh PP, Costerton JW. Periodontitis: an archetypical biofilm disease. *J Am Dent Assoc*. 2009;140:978–86.
6. Kuramitsu HK, He X, Lux R, Anderson MH, Shi W. Interspecies interactions within oral microbial communities. *Microbiol Mol Biol Rev*. 2007 Dec;71(4):653–70.
7. Asadoorian J. Dental flossing: Canadian Dental Hygienists Association position paper. *Can J Dent Hygiene*. 2006;40:112–25.
8. Slot DE, Dőrfer CE, Van der Weijden GA. The efficacy of interdental brushes on plaque and parameters of periodontal inflammation: a systematic review. *Int J Dent Hyg*. 2008;6:253–64.
9. Yost KG, Mallatt ME, Liebman J. Interproximal gingivitis and plaque reduction by four interdental products. *J Clin Dent*. 2006;17:79–83.
10. Gjermo P, Flőtra L. The effect of different methods of interdental cleaning. *J Periodontal Res*. 1970;5:230–36.
11. Sim MG, Wain T, Khong E. Influencing behaviour change in general practice. Part I: brief intervention and motivational interviewing. *Aust Fam Physician*. 2009;38(11):885–88.
12. de Souza PH, de Toledo BE, Rapp GE, Zuza EP, Neto CB, Mendes AJ. Reliability of bleeding and non-bleeding on probing to gingival histological features. *J Int Acad Periodontol*. 2003;5(3):71–76.
13. Lőe H. Oral hygiene in the prevention of caries and periodontal disease. *Int Dent J*. 2000;50(3):129–39.
14. Mayo E. *The human problems of an industrial civilization*. Volume 3. 2nd ed. New York: MacMillan; 1993. 53–73.
15. Stewart JE, Wolfe GR. The retention of newly-acquired brushing and flossing skills. *J Clin Periodontol*. 1989;16(5):331–32.
16. Hollister MC, Anema MG. Health behaviour models and oral health: a review. *J Dent Hyg*. 2004;78(3):6.
17. Tilliss T, Stach D, Cross-Poline G, Annan S, Astroth D, Wolfe P. The transtheoretical model application to an oral self care behavioral change: Development and testing of the instruments for stages of change and decisional balance. *J Dent Hyg*. 2003;77(1):1–10.

Instructions aux auteures

THE CANADIAN DENTAL HYGIENISTS ASSOCIATION
L'ASSOCIATION CANADIENNE DES HYGIÉNISTES DENTAIRES

Le *Journal canadien de l'hygiène dentaire (JCHD)* est un outil de diffusion de la recherche en hygiène dentaire ayant pour but d'enrichir l'ensemble des connaissances au sein de la profession. Mieux encore, il vise à sensibiliser et à intéresser davantage la communauté des hygiénistes dentaires à la recherche.

Le *JCHD* est une publication évaluée par les pairs. Les manuscrits peuvent être présentés en anglais ou en français. Les textes acceptés peuvent faire l'objet de révisions sur le plan de la cohérence, du style, de la grammaire, de la redondance, de la verbosité, ainsi que pour faciliter l'organisation du manuscrit dans son ensemble.

Critères de présentation : Un manuscrit soumis à l'examen du *JCHD* doit être une œuvre originale des auteures, ne pas avoir été présenté ou publié ailleurs sous forme écrite ou électronique ni être en cours d'examen par aucune autre organisation. Cela ne comprend pas les résumés rédigés et présentés lors d'une rencontre scientifique, publiés par la suite.

Demandes de renseignements préalables : Linda Roth, RDH, Directrice des acquisitions, *JCHD*, 96 Centrepointe Drive, Ottawa ON K2G 6B1; Tél. : 613-224-5515, poste 136; Télécopie : 613-224-7283; Courriel : acquisitions@cdha.ca ou lroth@cdha.ca; sans frais : 1-800-267-5235, poste 136

Le *JCHD* accueille vos manuscrits sur les sujets que voici :

1. **Le professionnalisme :** textes traitant d'éthique, responsabilité sociale, problèmes juridiques, entrepreneuriat, gestion, maintien de la compétence, assurance de la qualité et autres sujets dans le cadre général de la pratique professionnelle.
2. **La promotion de la santé :** textes traitant des politiques et des divers éléments essentiels au développement des capacités des personnes, des groupes et de la société en général. À partir des éléments clés de la charte fédérale, cela peut comprendre les politiques en matière de santé, la création de milieux de soutien de l'apprentissage, les capacités de développement, le renforcement de l'action communautaire et la réorientation des services de santé buccale.
3. **L'éducation :** textes portant sur l'enseignement et l'apprentissage aux niveaux des personnes, des groupes et de la société. Cela comprend l'éducation des clients, des autres professionnels ainsi que les programmes d'intégration dans la pratique.
4. **La pratique clinique :** textes traitant des procédures des soins interceptifs, thérapeutiques, préventifs et habituels pour soutenir la santé buccale.
5. **La pratique communautaire :** textes traitant des programmes de santé buccale, y compris l'estimation, la planification, l'application et l'évaluation.
6. **Les sciences de la santé buccale :** textes sur les connaissances scientifiques soutenant la pratique de l'hygiène dentaire.
7. **La théorie :** textes traitant des notions et des processus d'hygiène dentaire.

Types de manuscrits acceptés pour soumission :

1. Comptes-rendu d'études et de recherches – au plus 6 000 mots avec un maximum de 150 références. Résumé d'au plus 300 mots.
2. Revue de la littérature – au plus 4 000 mots et avec toutes les références nécessaires. Résumé d'au plus 250 mots.
3. Exposé de principe – d'au plus 4 000 mots avec un maximum de 100 références. Résumé d'au plus 250 mots.
4. Observation – entre 1 000 et 1 200 mots et un maximum de 25 références et 3 auteures. Résumé de 100 mots.
5. Article de fond – sur invitation seulement, possibilité de 1 000 à 1 500 mots, avec toutes les références nécessaires. Résumé non nécessaire.
6. Tribune libre – limite de 500 mots avec un maximum de 5 références et 3 auteures. Résumé non nécessaire.

Évaluation par les pairs : La rédactrice scientifique fait un premier choix des articles quant à leur pertinence. Les articles retenus sont alors soumis à un comité d'évaluation par les pairs formé d'au moins deux personnes. On peut aussi solliciter au besoin un avis de spécialiste, de la statistique par exemple.
Révision : Lorsqu'un manuscrit est renvoyé aux auteures correspondantes pour révision, la version révisée doit être présentée dans un délai de 6 semaines après réception de l'avis des lectrices spécialisées. Les auteures indiquent ensuite par courrier si elles acceptent ou réfutent les révisions. Le retour d'un manuscrit révisé est alors considéré comme étant une nouvelle soumission. La directrice de l'édition peut, à sa discrétion, allouer sur demande plus de temps pour la révision.
Un **appel** de réévaluation peut être adressé par courriel à la rédactrice scientifique (journal@cdha) qui le fera suivre au Comité consultatif de la recherche de l'ACHD. Les membres du comité peuvent acquiescer à la demande ou la rejeter, mais les auteures ne pourront pas demander un deuxième appel.

	Vérification	Éléments à appliquer
1		Caractères standard comme Arial, New Times Roman, Verdana en 10–12 points.
2		Texte en double espace dans le corps du manuscrit.
3		Marge standard de 1 pouce (2,5 cm) : haut, bas, gauche, droite.
4		Numérotation consécutive des pages, à partir de la page de titre.
5		Lettre de présentation précisant l'originalité du texte, tout conflit d'intérêt et les données pour vous contacter.
6		Placement des figures, tableaux, graphiques, photos à la fin du manuscrit.
7		Autorisation signée pour tout texte ou toute photo du patient ou client.
8		Crédits pertinents pour toutes illustrations déjà publiée. Vérification dans Internet des restrictions et conditions d'utilisation des éditeurs ?
9		Coordonnées de communication des auteurs en page de titre.
10		Titres universitaires des auteurs et organismes auxquels ceux-ci sont attachés.
11		Lettre de présentation contenant les noms et coordonnées de 2 réviseurs possibles et consentants pour votre manuscrit.
12		Mots clés qu'on trouve dans la base de données de MeSH de Search "MeSH" : http://www.ncbi.nlm.nih.gov/sites/entrez
13		Utilisation uniquement du style de référence Vancouver dans le manuscrit : http://www.nlm.nih.gov/bsd/uniform_requirements.html
14		Utilisation des titres abrégés des journaux de la base de données PubMed, sous recherche "Journals" : http://www.ncbi.nlm.nih.gov/sites/entrez

Les composantes du manuscrit :

1. **Page de titre :** Le titre doit désigner clairement le contenu de la soumission en 12 mots. Il devrait être suivi du nom de chacune des auteurs (prénom, initiale et nom de famille) ainsi que leurs titres universitaires et leurs institutions. Nom de l'auteure correspondante, adresse postale et courriel. Toutes les auteures doivent avoir participé suffisamment à l'ouvrage pour en assumer le contenu.
2. **Résumé :** Il ne doit contenir ni références ni titres de section. En voici les formats typiques :
   a. **Compte-rendu d'étude et de recherche :** Contexte (question à l'étude, problème traité et raisons); Méthodes (comment l'étude a été effectuée); Résultats (principales données statistiques); Examen et conclusion (ce que les auteures ont tiré des résultats).
   b. **Revue de la littérature :** Contexte (sujet ou procédure examinés); Méthodes (stratégie suivie, avec données de base); Résultats et discussion (constatations et analyse de la documentation); Conclusion (ce que les auteures ont tiré de l'analyse).
   c. **Exposé de principe :** (même structure que la précédente)
   d. **Observation :** Introduction (nature générale de la condition ou du programme); Description du cas (avec données); Discussion (du cas fondée sur la documentation), Conclusion.
3. **Mots clés :** Fournir une liste de 6 mots clés tout au plus ou de courtes phrases extraites du texte aux fins d'indexation. On utilisera de préférence les termes de la liste *Index Medicus* du *Medical Subject Headings* (MeSH).
4. Corps du **texte :** Structuration logique de l'information. Tout fait prétendument réel doit l'être au moment de la rédaction.
5. **Remerciements :** Reconnaissance de l'aide ou du soutien apporté par les personnes, organisations, institutions ou entreprises. Les personnes ou organismes mentionnés doivent avoir consenti, document à l'appui, à la publication de leurs noms, vu que cela peut laisser entendre qu'elles adhèrent au contenu, aux données ou aux conclusions de l'article.
6. **Maquette :** Elle comprend les illustrations, figures, photos, graphiques et toute autre expression graphique qui soutiennent ou rehaussent le texte dans le format de leurs fichiers originaux (fichiers sources).
   - Sont acceptables les formats de fichier .eps, .pdf, .tif, .jpg, .ai, .cdr haute résolution, prêts à imprimer :
     i. minimum de 300 dpi pour les gammes de gris et les demi-teintes couleurs,
     ii. 600 dpi pour les dessins au trait,
     iii. 1 000 dpi au minimum pour les maquettes pixélisées.
   - Les illustrations en couleur doivent toutes être en mode couleur CMYK (et non en RGB).
   - Elles devraient être numérotées à la suite les unes des autres et indiquées dans le texte.
   - Les auteurs doivent indiquer dans la légende la source des illustrations publiées antérieurement.
   - La rédaction se réserve le droit de reporter la publication d'un manuscrit accepté s'il survient des retard dans l'obtention des documents d'impression dont elle doute de la qualité.
7. **Données et tableaux :** Présentation en format Excel ou Word. Ces tableaux et données peuvent aussi être inclus à la fin du document Word.
8. **Abréviations et unités :** Elles doivent être conformes au Système international d'unités (SI). On peut utiliser les symboles SI et les symboles des éléments chimiques sans les définir dans le corps de l'article. Les abréviations doivent être indiquées entre parenthèses après la première mention de l'expression concernée dans le texte; ne pas dresser de liste d'abréviations.
9. **Information supplémentaire :** Toute information supplémentaire doit être fournie dans son format définitif, car elle ne sera pas corrigée et paraîtra en ligne exactement comme elle aura été présentée. Veuillez vous renseigner auprès de la Rédaction avant d'envoyer des fichiers de plus de 1 Mbit.
10. **Style des références et citations :** La présentation des références s'inspire du style Vancouver au http://www.nlm.nih.gov/bsd/uniform_requirements.html Les références devraient être numérotées dans l'ordre où elles sont citées dans le texte. Une référence citée plus d'une fois dans un même texte conservera toujours son numéro et l'auteur en fera rappel en utilisant des adverbes ou abréviations telles que *op cit*, *ibidem* ou *ibid*. On utilisera des chiffres arabes en exposant pour identifier les références dans le texte (e.g. [1,2] ou [3–6]). La liste de la section Références suivra l'ordre numérique paraissant dans le texte.

(Version condensée, janvier 2010)

CEO's message, *Rock stars* …continued from 55

rather uninterested teenager monotone voice he said, "Kyle, these people are like ROCK STARS to mom. You know, like ACDC, you dummy! She wants to meet them. Mom is like a groupie."

At that point Kyle understood. How could he stop Jan from going to see her own ACDC? Or, as in Jan's case, RAC? So, as Jan drove to Vancouver she thought about what her wise teenager had said to calm what could have been a rather difficult transition for Kyle. She told me "He was right. All these people I was about to meet were the ROCK STARS of the profession. The icons who have worked hard to make this profession better, stronger for each and every dental hygienist in Canada. And I was going to meet them!!! AND I forgot my camera... "

So, on that note I salute the RAC members as well as all of the other ROCK STARS of the profession who lead passionately with conscious intention towards positive contributions. You may recognize a few of your own "rock stars" gracing the front covers of this journal, or featured on our website's homepage through the year. And in the spirit of an embracing community, join me in this salute.

Message de la CD, *Les rock stars* …suite 55

et traduisit pour elle sous le regard d'Oliver, 4 ans, et Taia, 2 ans. Dans une voix plutôt monotone d'adolescent désintéressé, il dit : « Kyle, ces gens-là sont comme des ROCK STARS pour maman. Tu sais, comme ACDC, imbécile! Elle veut les rencontrer. Mom est comme une groupie. »

Kyle a compris sur-le-champ. Comment pouvait-il empêcher Jan d'aller voir ses propres ACDC? Ou, pour Jan, CCR? Ainsi, en roulant vers Vancouver, Jan a pensé à ce que son habile adolescent avait dit pour atténuer ce qui aurait pu être un moment difficile pour Kyle. Elle m'a dit : « Il avait raison. Tous ces gens que j'allais rencontrer étaient les ROCK STARS de la profession. Des idoles qui ont travaillé fort pour améliorer la profession, la rendre plus forte pour chacune des hygiénistes dentaires du Canada! Et j'allais les rencontrer!!! PUIS, j'avais oublié ma caméra… »

Alors, sur cette note, je salue les membres du CCR de même que toutes les autres ROCK STARS de la profession qui ont pris les devants avec une intention bien arrêtée vers des contributions positives. Vous reconnaîtrez peut-être certaines de vos propres « rock stars » qui ornent la couverture de ce journal ou figurent sur la page titre de notre site Web au cours de l'année. Puis, au diapason d'une communauté vivante, joignez-vous à moi dans cet hommage.

April 15th–17th, 2010 Vancouver, BC Canada

Pacific Dental Conference

Make Vancouver your spring destination for CE learning and holiday experience!

Earn up to 15 hours of CE credits during three days of lectures and hands-on courses. Enjoy the largest two day dental tradeshow in Canada featuring all the newest equipment and products. Lunch and exhibit hall reception are included in the registration fee.

Shopping, hotels, restaurants and breath-taking Stanley Park are all within blocks of the new spacious Vancouver Convention Centre. Experience the Pacific Dental Conference in the springtime. Online hotel reservations are now available.

Easy online registration and program information at...

Pacific Dental Conference

April 15–17 2010

www.pdconf.com

Celebrate National Dental Hygienists Week™ with your colleagues from across the country.

Recognizing excellence in 2009

CDHA is once again proud to announce the recipients of the *Recognition Prize Program* for 2009. This program annually acknowledges dental hygienists and dental hygiene students from across Canada who promote oral health and overall wellness, and who advance the dental hygiene profession. Congratulations to all participants and winners of the 2009 Dental Hygiene Recognition Prize program.

CDHA *Global Health* prize 2009 in participation with Sunstar G•U•M

This honour, with a $3,000 prize, is presented to **Andrea Slater of Vancouver, BC**, a dental hygienist who has made a commitment to volunteering as part of an initiative to provide oral health related services to a disadvantaged community or country.

In 2008, when Andrea was nearing graduation she contacted the charity, Kindness in Action (KIA) Service Society of Alberta, and set in motion events that would help realize her commitment to provide oral care services to a disadvantaged community. In 2009, Andrea travelled with a group of twenty-four volunteers to Cambodia to the Peaceful Children's Home orphanages in Chamnaon village, and then to a prison near Battambang to provide oral health care. She was able to collect donations of sufficient oral hygiene aids to provide for all the children and inmates, and through interpreters taught self care techniques, and provided debridement services. Andrea has made a firm promise to continue volunteering with KIA and hopes to inspire other dental hygienists to investigate volunteer activities.

CDHA *Leadership* prize 2009 in participation with Dentsply

This honour, with a $2500 prize, is presented to **Emilie Laforge of North Bay, ON**, currently enrolled in a dental hygiene program, who has contributed significantly to her local, academic or professional community through involvement and leadership.

Right from her first days as a dental hygiene student, Emilie recognized an opportunity to support her classmates as partners in health care and to be the "best she could be." Her prior educational and life experiences not only enriched her learning but will continue to enhance her professional career. Emilie's ability to remain unbiased when addressing issues, and her approachability have enabled her to become an effective voice and advocate for her fellow students as class representative.

The team of dental hygiene students that Emilie led was awarded the first place in the 2009 North Bay Santa Claus parade. Dressed in colourful purple shirts representing Canada's Olympic hockey team, they distributed tubes of dentifrice and a message promoting the use of mouth guards. As Emily reflects on her academic achievements and professional contributions to date, she is confident that she will continue to take a leadership role throughout her dental hygiene career.

CDHA *Achievement* prize 2009 in participation with Sunstar G•U•M

This honour, with a $2,000 prize, is presented to **Kera McClement of Riverview, NB**, a student who has overcome a major personal challenge during her dental hygiene education.

Kera was completing her college chemistry prerequisites when her son was born in May 2008. He was extremely ill; and was hospitalized for three months. His doctors gave a very guarded prognosis. Devastated by this news, Kera nevertheless brought her textbooks to the hospital and studied by his side in order to complete her course.

Her son proved to be a fighter, and was released after many tests and surgeries just as Kera began first year dental hygiene studies. That year was very challenging as financial hardships, as well as caring for an infant who had repeated hospital admissions meant physical and mental exhaustion. In addition, Kera's own father was deployed to Afghanistan at this time.

During her second year of studies, Kera's son required additional surgery, and dealing with his further health complications required the administration of medications every three hours around the clock. Inspired by her child's struggle, Kera has persevered through these challenges and has realized that through overcoming these obstacles she has developed the skills essential to grow and contribute as a health professional herself.

CDHA *Visionary* prize 2009 in participation with TD Insurance Meloche Monnex

This honour, with a $2,000 prize, is presented to **Janice Murray of Hope, BC**, currently enrolled in the Master of Science in Oral Health (MSOH) program through Ohio State University.

While attending a humanitarian event in Vancouver, aimed at Canadian youth, Janice was privileged to hear the Dalai Lama, and activist Mia Farrow speak about the global consciousness and commitment for change possessed by this generation. Subsequently, observing her own dental hygiene students' involvement with the issues of those populations lacking the benefits of oral health care, Janice realized that this future cohort of dental hygienists embodies all that previous visionaries have struggled to accomplish.

However, with the increased educational and professional opportunities such as private dental hygiene practice, also comes greater responsibility. It is more important than ever to contribute, though research, to the body of knowledge that is uniquely dental hygiene. Janice's vision for her profession includes the availability of higher level learning in Canada through a Master of Science degree in Dental Hygiene, a development that she believes will act as a catalyst in propelling the profession forward.

CDHA *Oral Health Promotion* prize 2009 in participation with Crest Oral-B

These prizes are presented for creative promotion of dental hygiene including education, community impact, and innovative partnerships. The three categories are:

1. a dental hygiene school,
2. a clinic team, and
3. an individual.

The prize money is shared equally by the winner and the winner's local dental hygiene society.

1. *Dental Hygiene School* prize of $2,000 to University of the Fraser Valley Dental Hygiene Program, Chilliwack, BC

Learning from research that many children do not protect the teeth and mouth while playing sports, the senior dental hygiene class recognized an opportunity to reach the community and promote oral health and the dental hygiene profession.

Targeting parents or guardians of young athletes, the class decided to create an infomercial to be displayed on the jumbotron at the local arena during a Chilliwack Bruins home hockey game. This venue provided an audience of approximately 5,000 spectators. The short video, starring the Bruins mascot "Bruiser" demonstrated the process of having a custom sportsguard fabricated and fitted.

The class members also constructed an attractive booth featuring information on mouthguards, sports nutrition, oral self care instructions, and interactive oral health games for children. The booth became a drop off facility for the local food bank, and contributions from local dental offices provided over 1,000 toothbrushes to distribute in return for non perishable food items.

This initiative has made further educational opportunities possible as the students have made the infomercial available for other community events.

2. *Clinic Team* prize of $2,000 to Harbour City Dental Hygiene, Nanaimo, BC

"Smiles for Life" is a compassionate prenatal oral care program offered by Heather Cooper and the Harbour City team. Each month, expectant mothers who do not have access to dental insurance or benefits receive free dental hygiene care for the duration of their pregnancy. This program is aimed at helping mothers deliver healthier babies by minimizing any effect that uncontrolled periodontal disease may have on pregnancy. It also provides access to mothers in order to provide education about the importance oral health.

In March 2009, *Harbour City Dental Hygiene* launched a residential care program for seniors' care facilities and for homebound clients. The team is currently partnering with such non profit organizations as Samaritans Purse and Healing Hands Foundations to utilize its mobile dental equipment for international missions.

Harbour City Dental Hygiene also contributes to dental hygiene education and volunteers its time and facilities to mentor students as an introduction to private dental hygiene practice. The clinic also played an integral role in the development of the local dental hygiene study club.

3. *Individual* prize of $1,000 to Monica Maletz of Chilliwack, BC

In the late 1990s, Monica received her British Columbia residential care qualification, purchased mobile dental equipment, and began to seek out residential care contracts. It took several years of committee meetings before Monica signed the first Health Authority dental hygiene contract in BC to provide services to the five extended care facilities in the Fraser valley. Other privately managed facilities followed and in 2009, Monica provided services for over 1,000 patient beds in nine health facilities.

Monica has presented regional in-services for nursing and health care aids and serves on the Dental Hygiene Advisory Board at University of the Fraser Valley. In November 2009, Monica coordinated an oral health booth at the Fraser Valley Health and Wellness Show in Chilliwack. The booth was supported by the British Columbia Dental Hygiene Association, and Monica scheduled local dental hygienists and students to volunteer at the booth over the three-day event. She arranged for donation of a powered toothbrush to be given away in a draw for attendees.

As a visiting instructor to the dental hygiene program at the University of the Fraser Valley, Monica lectures on residential care and takes each graduating class to her facility. She hopes in this way to encourage the next generation of dental hygienists to seek out career opportunities in this community health specialty area.

CDHA *Dental Hygiene Baccalaureate Student* prize 2009 in participation with Crest Oral-B

This honour, with a $1,500 prize is presented to **Alison C. MacDougall of Charlottetown, PE**, (University of Alberta distance education degree completion program) for contributing to the advancement of dental hygiene.

Five years after receiving her diploma in dental hygiene from Dalhousie University, Alison decided to further her education, first at a local university and now as a distance education dental hygiene degree student at the University of Alberta. Alison is actively involved in the Prince Edward Island Dental Hygienists Association (PEIDHA) where she has served as president and representative to the CDHA Board and is currently chair of the PEIDHA Visionary Committee.

Over the past year Alison has been involved in three important projects that were created to raise awareness about dental hygiene within the local professional community. The PEIDHA Visionary Committee is mandated to increase access to dental hygiene care through modernizing practice regula-

tions, and has been able to influence some early changes.

During oral health month in April, Alison created an oral health awareness display at a local pharmacy, and was available to answer customers' questions about oral care products. She has organized a dental hygiene study club to encourage local dental hygienists to access CDHA online professional development opportunities.

The flexibility of the University of Alberta's distance education degree program has allowed Alison to continue practising, remain at home with her family, and to stay active in her local dental hygiene association.

CDHA *Dental Hygiene Diploma Student* prize 2009 in participation with Crest Oral-B

This honour, with a $1,000 prize, is presented to **Nicole Moore of North Vancouver, BC**, for contributing to the advancement of dental hygiene.

When Nicole first entered the dental hygiene program at Vancouver Community College, she anticipated a profession involving slightly more responsibility than her previous dental assisting career. Now, halfway through her final year of studies she finds that she is constantly challenged by the need for accountability and responsibility. Recently, Nicole and some classmates prepared and presented community table clinics on "Alcohol and Oral health." While dental hygienists have become more comfortable with discussing tobacco use with clients, Nicole believes that alcohol use still seems to be a "Don't ask, Don't tell" topic. The table clinic will be presented again at the Mid-Winter Clinic in Vancouver in hopes of having other dental professionals recognize this gap in their practices.

Nicole has also developed a series of three presentations for secondary school ESL students. This information includes dental terminology, oral self care techniques, and how to locate and access dental professionals. Nicole has been challenged in many ways by the dental hygiene profession, and plans to continue to seek out ways to share all that she has learned.

CDHA *Student Leadership* prize 2009 in participation with P&G

This honour, with a $2,000 prize, is presented to **Tanis Maxwell of Victoria, BC**, currently enrolled in a dental hygiene program, who has contributed significantly to her local, academic or professional community through involvement and leadership.

Tanis took her role and responsibility as class president at Camosun College as her initial steps to dental hygiene leadership. She coordinated a fundraiser endeavour to benefit Cool-Aid Community Dental Clinic that provides oral care for people who do not have medical coverage, many of whom suffer from mental health and addiction illnesses. On a fundraiser mode, Tanis took the lead to initiate and compile donated recipes in *Cookbook Fundraiser*. Tanis understands the importance of representing the dental hygiene profession within her community. She has delivered Early Childhood Caries presentations to a prenatal group at the Victoria Native Friendship Centre as well as to a class of Grade 6 students at a local elementary school.

Tanis finds interdisciplinary collaboration appealing with the nursing students at their already established "Feet First" program. Tanis is excited to be able to participate in the 2010 Mexico Field Externship, giving her the opportunity to provide dental hygiene services and education in another culture. She believes her strong organizational skills and positive attitude are the necessary attributes to succeed in her diverse enterprises.

CDHA received many excellent submissions for these prizes and wishes to thank all participants for the effort and creativity displayed in their submissions. We also express our appreciation to the program sponsors for their support in collaborating with CDHA to increase awareness across Canada of our profession, and oral health.

Celebrate National Dental Hygienists Week™ - 11 to 17 April

National Dental Hygienists Week™ is an annual event dedicated to heighten awareness about preventive oral health care, and to helping Canadians understand the role and importance of the dental hygiene profession.

Dental hygienists in every province and territory will be marking National Dental Hygienists Week™ from 11 to 17 April in diverse and creative ways. Activities are most often community outreach events, and may include contests, classroom presentations, mall displays, tours of dental offices, just to name a few.

International Women's Day 2010

International Women's Day, celebrated annually on 8 March, is a global day celebrating the economic, political and social achievements of women past, present and future. In some places like China, Russia, Vietnam and Bulgaria, International Women's Day is a national holiday. Visit www.internationalwomensday.com to learn more.

Nutrition Month 2010

March is *Nutrition Month* across Canada. In celebration of healthy eating, dietitians across Canada unite to organize events and communications to reinforce the importance of nutrition in achieving health and wellbeing. *Nutrition Month* celebrated its 25th anniversary in 2006. Since the early 1980s, the campaign has grown to be one of the most recognized social marketing campaigns in Canada. *Nutrition Month* stimulates nutrition activities in communities across Canada, and shows you where to find dietitians, your best source of reliable nutrition information. For more information, visit www.dietitians.ca

Research Advisory Committee (RAC)

Its mission is to create a vision for research within the dental hygiene profession. The committee will also assist CDHA to operationalize CDHA's vision for research and guide CDHA's involvement in creating, supporting, disseminating, and translating dental hygiene research.

Chairperson	**Shafik Dharamsi**, PhD	Faculty Lead, Community Liaison for Integrating Study & Service, Department of Family Practice, Faculty of Medicine & Associate Director, Centre for International Health, College of Health Disciplines	University of British Columbia, Vancouver
Member	**Susanne Sunell**, BA, DipDH, MA, EdD	Oral Biological & Medical Sciences Online Instructor, Dental Hygiene Degree Program	University of British Columbia, Vancouver
Member	**Marilyn Goulding**, BSc, MOS	Faculty member, Health Science	Niagara College, Welland
Member	**Brenda Currie**, DipDH, RDH, BDSc (DH), MSc	Online Instructor Oral Microbiology / Immunology, Dental Hygiene Program	University of British Columbia, Vancouver
Member	**Cindy Isaak-Ploegman**, RDH, BA, MEd	Graduate Student Education	University of Manitoba, Winnipeg
Member	**Judy Lux**, BA, MSW	Health Policy Communications Specialist	Canadian Dental Hygienists Association, Ottawa
Member	**Susan Ziebarth**, DM	CEO	Canadian Dental Hygienists Association, Ottawa

President's message, *It starts with you* …continued from 51

I also believe that each of us has the ability to influence change within our working environment. You, as a dental hygienist, are not just an employee but an integral part of a collaborative team. In fact, you have unique skills and knowledge that no other professional in your office has, and you are essential to each client's professional care program. The challenge is to have open communication with your employer and discuss your needs and your goals. It really does start with you.

To quote Gandhi, "Be the change you wish to see in the world".

Message de la présidente, *Ça commence avec vous* …suite 51

mais vous faites partie intégrante d'une équipe de travail en collaboration. De fait, vous avez des capacités et des connaissances uniques que n'ont pas les autres professionnels du cabinet, et vous occupez une part essentielle des soins professionnels dont chaque client a besoin. Le défi est donc de communiquer ouvertement avec votre employeur et de discuter de vos besoins et de vos buts. Ça commence vraiment avec vous.

Pour citer Gandhi : « Soyez le changement que vous souhaitez voir dans le monde. »

WEBINAR WATCH

Learn by accessing CDHA's live interactive online sessions

Webinars
virtual sessions...
real professional development

NEW CDHA WEBINAR

Professional development coming to you.

7 April 2010

SRP+ARESTIN®: Working together for your clients

Find out why dental hygienists use ARESTIN® (minocycline hydrochloride) as an adjunct to scaling and root planing (SRP). Join us for this one hour webinar from Johnson & Johnson, in partnership with CDHA.

WEBINAR WATCH

All you need is a computer and Internet connection

Visit www.cdha.ca for weekly programming updates and registration

CDHA ACHD
THE CANADIAN DENTAL HYGIENISTS ASSOCIATION
L'ASSOCIATION CANADIENNE DES HYGIÉNISTES DENTAIRES

ACHD Appel à l'action

Chère communauté des hygiénistes dentaires francophones, Le *Journal canadien d'hygiène dentaire* a besoin de votre participation, à titre d'auteures, pour accroître son contenu original de langue française. Nous aimerions vous publier. Aidez-nous à le faire.

Ce contenu doit venir de vous, car c'est à vous qu'il incombe de veiller au nombre d'articles publiés en français dans le journal. Soyez, avec enthousiasme, le fer de lance pour susciter plus d'articles en français dans le *JCHD*. Partagez vos expériences d'apprentissage, vos vues ou votre formation en hygiène dentaire dans des *Lettres à l'éditeur* en français. Pour mener le mouvement en ce sens, il suffit de rédiger un message d'environ 500 mots. Puis, vous pouvez ajouter à votre lettre une photo pertinente.

Vous êtes bienvenues. Contactez la rédaction à journal@cdha.ca

8th International Dental Ethics and Law Congress

This event will take place **18–20 August 2010** in Helsinki, Finland. This year's theme is *Dentistry and Information Technology: Ethical and Legal Considerations*. Details are available at www.ideals.ac/congress/?event=4

CDHA's Silver Partner

For better dentistry
DENTSPLY CANADA

CDHA is pleased to announce Dentsply's induction to its Partners' Circle. A Silver member of the Partner's Circle, Dentsply is dedicated to engaging dental hygienists in conversations to help support the oral health of Canadians. Dentsply is offering a complimentary webinar and discussion forum, as well as a student leadership prize, exclusively to CDHA members. We thank Dentsply for their commitment and their support of the profession and CDHA. For more information on Dentsply's partnership initiatives with CDHA, visit www.cdha.ca

CDHA ACHD
THE CANADIAN DENTAL HYGIENISTS ASSOCIATION
L'ASSOCIATION CANADIENNE DES HYGIÉNISTES DENTAIRES

Vision to Venture

– CDHA Leadership Event
13–14 August 2010, Montreal, Quebec

CDHA is proud to host "Vision to Venture – CDHA Leadership Event" a unique day and a half event, fulfilling CDHA's commitment to the CDHA community members' professional growth.

Your message is your business

Business Development Manager, Ann E. Wright

How many times have you called a business and been greeted by a disinterested receptionist? Have you had to endure listening to a long winded recorded telephone message that completely taps your patience? Cute personal messages our friends have on their home phones, family jingles, babies cooing, music playing, and attempts at humour, much of which misses the mark, are inappropriate in a business setting. We tolerate, and are amused by these messages because more often than not, we know the family. However, the telephone is a powerful asset in your dental hygiene business. Your message and the manner you answer the telephone is often the first point of contact with a new client. The last thing you want to do is irritate or frustrate your caller.

There are several commercial message options for your voicemail. With such features as "on hold", you have the capability to offer a running advertisement for your practice. These features provide your business with a professional image, but may not capture the personal connection many dental hygienists hope to create with clients. Generally, most dental hygienists starting out in business rely on a personal greeting or voice message to connect with their callers. Let's look at some message pointers.

ANSWERING IN PERSON

1. Number of rings before pick up: All calls should be answered before the third ring.

2. Courtesy and enthusiasm: This is what establishes the impression of your company and the tone for the conversation. If you answer the phone in a brusque manner, your caller will become brusque as well. If you answer the phone pleasantly, your caller will respond in kind. We may have experienced the situation when we called a business with a complaint to have our anger diffused by a helpful, gracious representative at the other end.

Practise sitting up straight, taking a deep breath, and smiling as you answer the phone. You will notice that your voice becomes calmer and friendlier. Avoid negative statements. If you don't know the answer to a specific question, rather than saying "I don't know", try "Let me find out about that for you, and I will get back to you this afternoon".

3. Be specific: No one should ever have to ask if they have reached the right business.

Welcome callers and identify yourself and your business. For instance, "Good morning, Smiles for Life, Dental Hygiene office, this is Susan speaking. How may I help you?" Speak clearly and enunciate. Practise speaking much more slowly than you normally would, so your caller can understand you and you will not have to repeat the message. Refrain from using slang and phrases like "No problem", "Can do", "Got it" etc. It may seem old fashioned, but callers respond much more positively to a professional approach, especially if you can solve their problem. Use words such as "Certainly", "Yes, I understand", "I can take care of that right now for you".

4. Always ask if you can put a caller "on hold" saying that you are getting them the information or person they have called about. If your callers anticipate a tedious wait without any justification provided, they are likely to hang up the receiver. This is not what you want potential clients to do.

5. Speaker phone: Speaker phones are intended for calls that involve multiple people in the room. If you need your hands free to use the computer to schedule an appointment, then it may be wise to invest in a headset. If you must put your clients on speaker phone, tell them that you are doing so in order to access their data.

RECORDED MESSAGES

1. Number of rings before recorded message picks up: The same advice as for answering the phone live applies. Ensure that calls are answered before the third ring.

2. Record a professional and concise message: "Thank you for calling Smiles for Life, dental hygiene office. We are dedicated to providing you with excellent oral healthcare services, so that you keep your smile for life. All of our lines are currently busy, so please leave your name, phone number, and time of your call, and we will return your call as soon as possible."

3. Try to resist giving out too much information: I called a dental hygiene office and received a voicemail that ran along these lines. "Hello, you have reached Susan at Smiles for life, dental hygiene office. Our office is located at 300 Smiley Place, just behind the Tim Horton's, across from Canadian Tire and adjacent to the city library. Our office hours are Monday, 6–9 p.m., Tuesday 8–2, Wednesday 9–6, Friday 5–8 and Saturdays, by request from 9–4." As you can imagine, the caller is completely lost after the details about the office location, and confusion further compounded by the lengthy schedule of office hours. Even if you have decided on a limited number of business hours, resist the temptation to communicate this to your caller. The menu of office hours makes it seem more difficult to get an appointment.

4. Length of recorded message: Generally, the message should be no longer than 45 seconds. Allow time for the caller to leave you their call-back information.

5. Important announcements: Change your message for holidays, or to announce events.

Your voicemail greeting, in many cases, is your client's very first impression of you as a professional, and indicative of the treatment they are likely to receive when they visit. Are you able to provide service to your bilingual or multicultural community, if your business is so located? It could even help callers determine whether they will be doing business with you. What you say and how you say it, whether in person or on the phone, has a direct impact on your client's feelings, decisions, and actions.

Your message is your business.

CDHA welcomes your feedback: awright@cdha.ca

Your CDHA **Member Benefits**

Connect

- Connect with top opinion leaders on various evidence based issues within the CDHA community. **Free**
- Create your community profile; join discussion groups that fit your needs and interests. **Free**
- Create your own **free web page** to promote your story, post your résumé, and highlight your community involvement (some limitations may apply)
- Share your opinions and provide feedback on a variety of latest oral health topics on your **free personalized** blog space
- Exclusive *Members Only* access to the newest job and career opportunities with our Career Centre

Learn

- Online courses you can take when you want, 24/7, all year long
- Receive tax receipts for your CDHA professional development courses (some restrictions apply)
- Manage and track your professional development and portfolio with our free professional manager tool
- Oral health database to help you find the answers to the latest evidence based issues
- At your finger tips and just a click away. The latest cutting edge products, news, and information
- Webinars featuring the most innovative topics relevant to your practice

Contribute

- Let your voice be heard with our online polls and surveys, or submit a manuscript for CDHA's professional publication, the Canadian Journal of Dental Hygiene
- Over $23,000 of awards, bursaries and prizes to recognize your efforts in the community

Live

BMO CDHA MasterCard **rewards you** with one Air Miles® reward mile for $20 spent or 0.5% cashback® and no annual fees

Group Retirement Services

No annual fees for RRSP, savings and retirement programs designed exclusively for CDHA members

GoodLife CORPORATE WELLNESS

Keeping you fit with up to **50% off GoodLife Fitness** regular individual memberships

Access up to **30% on special discounts and savings on HMI hotel properties** across Canada

National nationalcar.com

Free National Car Rentals' EMERALD CLUB membership (a $75 value!) and enjoy our special CDHA preferred corporate daily rates (some conditions apply)

ROGERS

Coming soon…

Free cellphones through our exclusive partnership with Rogers™ Wireless Express

CDHA saves you money

- Receive a 25% discount off all registration fees for webinars, online CE courses, and live onsite events.
- Shop at CDHA e-store for your educational resources.

Expert advice

- Independent Practice Expert dedicated to answering your independent practice questions.

Coming soon

- Electronic claim processing.
  - Planned launch mid 2010 — process electronic insurance claims through the internet with CDHA-ACHD.net™ — CDHA's exclusive proprietary electronic insurance claims security processor.
- Complimentary Unique Identifier Numbers for CDHA members.

WIN!

Exclusive CDHA member contests to win fabulous prizes including cash, vacations of a lifetime, oral health products, gym memberships and so much more!

Our insurance partners

TD Insurance Meloche Monnex — *Enjoy preferred group rates on home and auto insurance*

AON RISK SERVICES — *Protect yourself, your career, and you business with CDHA's best in class professional liability insurance at competitive pricing*

Sun Life Financial — *Long Term Disability, Life, Accidental Death and Dismemberment, Critical Illness and Extended Health Care Insurance*

Call our Membership Services Team at 1-800-267-5235.

Monday to Friday from 8:30 a.m. to 5:00 p.m. ET, or e-mail membership@cdha.ca. We will be happy to assist you.

Considering client satisfaction

CDHA staff

Measuring client satisfaction is essential for all health care providers. This importance is reflected by an emphasis on client approval, motivated in part by the interests of the client as consumer, and as an independent health care end result. Evaluation of client satisfaction using a variety of data collection, self assessment, and communication techniques, is included in dental hygiene practice standards as a significant oral care outcome.[1]

The delivery of high quality preventive oral care has always been the goal of the dental hygiene profession.[2] Implementing formal quality assurance programs is one way that the profession has encouraged this value. Self assessment is a key component of quality assurance and can be applied to the delivery of dental hygiene care in private, community, and educational settings. Quality assessment criteria relative to private practice are of particular concern to the profession because most dental hygienists are employed in somewhat isolated settings and practice without the benefit of peer review.

Self assessment can be simply described as the process of gathering and evaluating data on one's own actions. The four major uses of self assessment are: evaluate performance, identify learning needs, improve performance, and reinforce cognitive abilities and skills. As primary oral health care providers and professionals, dental hygienists are accountable for regular review of their knowledge, skills, and judgment. Studies indicate that the acquisition of self assessment skills can promote mature, productive, and collaborative environments.[2]

REFLECTIVE PRACTICE

How can dental hygienists develop these self assessment skills? Certainly, dental hygienists do informally compare their own clinical actions to professional standards each day, but may lack the specific outcome measurements they use when evaluating therapy results. Reflection has been defined as an internal process that individuals use to help refine their understanding of situations, and that may lead to changes in their perspectives.[3] Reflection is particularly important for health care providers where evidence based practice and client centred care require the practitioner to analyze scientific evidence while also considering the values, beliefs, and goals of each client. Being reflective practitioners will assist dental hygienists maintain the attitude necessary to their professional role.

SILENCE VERSUS SATISFACTION

Consumers of oral health care have traditionally been unable to evaluate objectively the quality of care they receive.[2] Although their feedback is valued, the fact is that most clients hesitate to make negative remarks. Health care is composed of two primary elements—the technical adequacy of therapy, and the art or manner of care. Depending on their perspective, clients tend to perceive "good" practitioners as either kind or technically capable. Client satisfaction or dissatisfaction is a complex issue linked to expectations, health status, and personal characteristics. What is perceived as merely acceptable care by one person may be an exceptional experience to another while unacceptable to a third.[4] Clients commonly object to mechanical or impersonal care, so rather than limiting evaluations to technical skills, dental hygienists do need to address the broader aspects of quality assurance.[5] For example, clients with low self esteem or perceived lesser status may hesitate to offer comments. At the same time such behavioural indicators as high no-show rates could indicate less satisfaction with the care they have received.

It is important that the voices of clients are heard. One of the simplest quantitative evaluation techniques for client feedback is the use of comment cards. While this method does not yield statistically valid data, it can produce an understanding of clients' overall experience. For example, if the card responses indicate a recurring problem, attention can be directed to correcting this situation. On the other hand, positive remarks can reinforce many exceptional aspects of the care provided. Brief personal interviews, using a standardized script, can also be conducted to determine clients' perceptions of their care. This informal dialogue could be accomplished onsite by the practitioner or office manager at little or no cost. Finally, by working together as a unit, the members of the dental care team can convey both confidence and competence to their clients.[6] Clients are more satisfied when they are cared for by professionals who are part of a cohesive team that shares values, ideas and a clear sense of mission.

REFERENCES

1. Canadian Dental Hygienists Association. *Dental Hygiene: Definition, Scope, and Practice Standards*. Ottawa. 2002;8.
2. DeVore L et al. Dental Hygiene Self-Assessment: A key to Quality Care. *J Dent Hyg*. 2000;74(4):27;1–9.
3. Boyd E, Fales A. Reflective Learning: Key to Learning from Experience. *J Hum Psychol*. 1983;23:99–117.
4. Ford R et al. Methods of Measuring Patient Satisfaction in Health Care Organizations. *Health care management review*. 1997;22(2):74–89.
5. Crall JJ. Evaluation of Effectiveness of Quality of Care. *J Dent Educ*. 1989;63:673–76.
6. Brown SW et al. *Patient Satisfaction Pays: Quality Service for Practice Success*. Gaithersberg, MD: Aspen Publishers. 1993.

CDHA welcomes your comments: bleggett@cdha.ca

Position for commercial advertisement

2010 *Dental Hygiene Programs Recognition* Award

Prix de reconnaissance 2010 *pour les programmes en hygiène dentaire*

The Canadian Dental Hygienists Association is proud to announce the recipients of the *Dental Hygiene Programs Recognition Award*. This award officially recognizes dental hygiene programs whose faculty achieves 100% membership in CDHA. CDHA congratulates these educators for demonstrating outstanding commitment to the dental hygiene profession by supporting and promoting their national professional association, and for being exceptional role models to their students.

APLUS Institute, Toronto, ON
Camosun College, Victoria, BC
College of New Caledonia, Prince George, BC
University of Alberta, Edmonton, AB
University of the Fraser Valley, Chilliwack, BC
Vancouver Community College, Vancouver, BC
Vancouver Island University, Nanaimo, BC

L'Association canadienne des hygiénistes dentaires est heureuse de présenter les récipiendaires du *Prix de reconnaissance pour les programmes en hygiène dentaire*. Ce prix récompense officiellement les programmes en hygiène dentaire dont 100 % des membres du corps professoral à temps plein et à temps partiel font partie de l'ACHD. L'ACHD félicite ces corps professoraux de montrer de façon exemplaire, par leur appui à leur association professionnelle nationale et la promotion qu'ils en font, que la profession d'hygiéniste dentaire leur tient à coeur. Elle les félicite aussi de servir de modèles exceptionnels auprès de leurs étudiants et étudiantes.

CDHA ACHD
THE CANADIAN DENTAL HYGIENISTS ASSOCIATION
L'ASSOCIATION CANADIENNE DES HYGIÉNISTES DENTAIRES

Position for commercial advertisement

CDHA became an affiliate member of the Canadian Cochrane Network and Centre in March 2008. CDHA is pleased to publish selected Cochrane Review abstracts related to oral health without any modifications in this issue of the journal. These intervention review abstracts are the copyright of Cochrane Collaboration, and are reproduced with permission.

Based on the best available information about health care interventions, Cochrane reviews explore the evidence for and against the effectiveness and appropriateness of treatments in specific circumstances.

Dental fillings for the treatment of caries in the primary dentition

Veerasamy Yengopal[1], Soraya Yasin Harnekar[2], Naren Patel[3], Nandi Siegfried[4]

[1]Department of Community Dentistry, School of Public Health, Division of Public Oral Health, Wits University, Wits, South Africa. [2]Department of Paediatric Dentistry, Faculty of Dentistry, University of the Western Cape, Cape Town, South Africa. [3]Division of Restorative Dentistry, School of Oral Sciences, Tygerberg, South Africa. [4]South African Cochrane Centre, South African Medical Research Council, Tygerberg, South Africa

Cochrane Database of Systematic Reviews 2009, Issue 2. Art. No.: CD004483. DOI: 10.1002/14651858.CD004483.pub2.

Abstract

Background

Childhood caries (tooth decay) consists of a form of tooth decay that affects the milk teeth (also known as baby or primary teeth) of children. This may range from tooth decay in a single tooth to rampant caries affecting all the teeth in the mouth. Primary teeth in young children are vital to their development and every effort should be made to retain these teeth for as long as is possible. Dental fillings or restorations have been used as an intervention to repair these damaged teeth. Oral health professionals need to make astute decisions about the type of restorative (filling) material they choose to best manage their patients with childhood caries. This decision is by no means an easy one as remarkable advances in dental restorative materials over the last 10 years has seen the introduction of a multitude of different filling materials claiming to provide the best performance in terms of durability, aesthetics, symptom relief, etc when placed in the mouth. This review sought to compare the different types of dental materials against each other for the same outcomes.

Objectives

The objective of this review was to compare the outcomes (including pain relief, survival and aesthetics) for restorative materials used to treat caries in the primary dentition in children. Additionally, the restoration of teeth was compared with extraction and no treatment.

Search strategy

Electronic searches of the following databases were undertaken: the Cochrane Oral Health Group's Trials Register (up to January 2009); CENTRAL (*The Cochrane Library* 2009, Issue1); MEDLINE (1966 to January 2009); EMBASE (1996 to January 2009); SIGLE (1976 to 2004); and conference proceedings on early childhood caries, restorative materials for paediatric dentistry, and material sciences conferences for dental materials used for children's dentistry (1990 to 2008). The searches attempted to identify all relevant studies irrespective of language.

Additionally, the reference lists from articles of eligible papers were searched, handsearching of key journals was undertaken, and personal communication with authors and manufacturers of dental materials was initiated to increase the pool of suitable trials (both published and unpublished) for inclusion into this review.

Selection criteria

Randomised controlled trials (RCTs) or quasi-randomised controlled trials with a minimum period of 6 months follow up were included. Both parallel group and split-mouth study designs were considered. The unit of randomisation could be the individual, group (school, school class, etc), tooth or tooth pair. Included studies had a drop-out rate of less than 30%. The eligible trials consisted of young children (children less than 12 years) with tooth decay involving at least one tooth in the primary dentition which was symptomatic or symptom free at the start of the study.

Data collection and analysis

Data were independently extracted, in duplicate, by two review authors. Disagreements were resolved by consultation with a third review author. Authors were contacted for missing or unclear information regarding randomisation, allocation sequence, presentation of data, etc. A quality assessment of included trials was undertaken. The Cochrane Collaboration statistical guidelines were followed for data analysis.

Main results

Only three studies were included in this review. The Fuks 1999 study assessed the clinical performance of aesthetic crowns versus conventional stainless steel crowns in 11 children who had at least two mandibular primary molars that required a crown restoration. The outcomes assessed at 6 months included gingival health (odds ratio (OR) 0.3; 95% confidence interval (CI) 0.01 to 8.32), restoration failure (OR 3.29; 95% CI 0.12 to 89.81), occlusion, proximal contact and marginal integrity. The odds ratios for

occlusion, proximal contact and marginal integrity could not be estimated as no events were recorded at the 6-month evaluation. The Donly 1999 split-mouth study compared a resin-modified glass ionomer (Vitremer) with amalgam over a 36-month period. Forty pairs of Class II restorations were placed in 40 patients (21 males; 19 females; mean age 8 years +/- 1.17; age range 6 to 9 years). Although the study period was 3 years (36 months), only the 6- and 12-month results are reported due to the loss to follow up of patients being greater than 30% for the 24- and 36-month data. Marks 1999a recruited 30 patients (age range 4 to 9 years; mean age 6.7 years, standard deviation 2.3) with one pair of primary molars that required a Class II restoration. The materials tested were Dyract (compomer) and Tytin (amalgam). Loss to follow up at 24 and 36 months was 20% and 43% respectively. This meant that only the 24-month data were useable. For all of the outcomes compared in all three studies, there were no significant differences in clinical performance between the materials tested.

No studies were found that compared restorations versus extractions or no treatment as an intervention in children with childhood caries.

Authors' conclusions

It was disappointing that only three trials that compared three different types of materials were suitable for inclusion into this review. There were no significant differences found in all three trials for all of the outcomes assessed. Well designed, randomised controlled trials comparing the different types of filling materials for similar outcomes are urgently needed in dentistry. There was insufficient evidence from the three included trials to make any recommendations about which filling material to use.

Extraction of primary (baby) teeth for unerupted palatally displaced permanent canine teeth in children

Nicola Parkin[1], Philip E Benson[1], Anwar Shah[2], Bikram Thind[3], Zoe Marshman[1], Gillian Glenroy[4], Fiona Dyer[5]

[1]Department of Oral Health and Development, School of Clinical Dentistry, Sheffield, UK. [2]Falchion Orthodontics, Darlington, UK. [3]Department of Orthodontics, Argyll House, Aberdeen, UK. [4]Foxbar Clinic, Paisley, UK. [5]Department of Orthodontics, Charles Clifford Dental Hospital, Sheffield, UK

Cochrane Database of Systematic Reviews 2009, Issue 2. Art. No.: CD004621. DOI: 10.1002/14651858.CD004621.pub2.

Abstract

Background

The permanent canine tooth in the upper (maxillary) jaw sometimes does not erupt into the mouth correctly. In about 1% to 3% of the population these teeth will be diverted into the roof of the mouth (palatally). It has been suggested that if the deciduous canine is removed at the right time this palatal eruption might be avoided.

Objectives

To evaluate the effect of extracting the primary maxillary canine on the eruption of the palatally ectopic maxillary permanent canine.

Search strategy

We searched the Cochrane Oral Health Group's Trials Register (to April 2008); CENTRAL (*The Cochrane Library* 2008, Issue 3); MEDLINE (1966 to April 2008); EMBASE (1980 to April 2008). There were no language restrictions. Authors of trials were contacted for further data.

Selection criteria

Trials were selected if they met the following criteria: a randomised or quasi-randomised controlled trial, involving the extraction of the primary maxillary canine and assessing eruption/non-eruption of the palatally displaced maxillary permanent canine.

Data collection and analysis

Seven review authors independently, in duplicate, examined the studies found in the search. The primary outcome was the reported prevalence of eruption or non-eruption of the ectopic permanent canine into the mouth following observation or intervention. Results were to be expressed as risk ratios for dichotomous outcomes with 95% confidence intervals and mean differences for continuous outcomes. Heterogeneity was to be investigated, including both clinical and methodological factors.

Main results

The search identified 324 publications of which 295 were excluded after reviewing the abstract. Full articles were obtained for the remaining 31, of which 19 were non-English and required translation. Three reports of two randomised controlled trials were identified for possible inclusion in the review; however, the data in the publications were not presented in a form that could be usable and the authors have been contacted for further details.

Authors' conclusions

There is currently no evidence to support the extraction of the deciduous maxillary canine to facilitate the eruption of the palatally ectopic maxillary permanent canine. Two randomised controlled trials were identified but unfortunately, due to deficiencies in reporting, they cannot be included in the review at the present time.

Orthodontic treatment for deep bite and retroclined upper front teeth in children

Declan T Millett[1], Susan Cunningham[2], Kevin D O'Brien[3], Philip E Benson[4], Alison Williams[5], Cesar M de Oliveira[6]

[1]Department of Oral Health and Development, University Dental School and Hospital, Wilton, Cork, Ireland. [2]Department of Orthodontics, Eastman Dental Institute, UCL, London, UK. [3]Orthodontics, School of Dentistry, The University of Manchester, Manchester, UK. [4]Department of Oral Health and Development, School of Clinical Dentistry, University of Sheffield, Sheffield, UK. [5]Oral Health Services Research and Dental Public Health, GKT Dental Institute, London, UK. [6]School of Dentistry, The University of Manchester, Manchester, UK

Cochrane Database of Systematic Reviews 2006, Issue 4. Art. No.: CD005972. DOI: 10.1002/14651858.CD005972.pub2.

Abstract

Background

Correction of the type of dental problem where the bite is deep and the upper front teeth are retroclined (Class II division 2 malocclusion) may be carried out using different types of orthodontic treatment. However, in severe cases, surgery to the jaws in combination with orthodontics may be required. In growing children, treatment may sometimes be carried out using special upper and lower dental braces (functional appliances) that can be removed from the mouth. In many cases this treatment does not involve taking out any permanent teeth. Often, however, further treatment is needed with fixed braces to get the best result. In other cases, treatment aims to move the upper first permanent molars backwards to provide space for the correction of the front teeth. This may be carried out by applying a force to the teeth and jaws from the back of the head using a head brace (headgear) and transmitting this force to a part of a fixed or removable dental brace. This treatment may or may not involve the removal of permanent teeth. In some cases, neither functional appliances nor headgear are required and treatment may be carried out without extraction of any permanent teeth. Instead of using a headgear, in certain cases, the back teeth are held back in other ways such as with an arch across or in contact with the front of the roof of the mouth which links two bands glued to the back teeth. Often in these cases, two permanent teeth are taken out from the middle of the upper arch (one on each side) to provide room to correct the upper front teeth. It is important for orthodontists to find out whether orthodontic treatment only, carried out without the removal of permanent teeth, in children with a Class II division 2 malocclusion produces a result which is any different from no orthodontic treatment or orthodontic treatment only involving extraction of permanent teeth.

Objectives

To establish whether orthodontic treatment, carried out without the removal of permanent teeth, in children with a Class II division 2 malocclusion, produces a result which is any different from no orthodontic treatment or orthodontic treatment involving removal of permanent teeth.

Search strategy

The Cochrane Oral Health Group's Trials Register, the Cochrane Central Register of Controlled Trials (CENTRAL), MEDLINE and EMBASE were searched (to June 2008). There were no restrictions with regard to publication status or language of publication. International researchers, likely to be involved in Class II division 2 clinical trials, were contacted to identify any unpublished or ongoing trials.

Selection criteria

Trials were selected if they met the following criteria: randomised controlled trials (RCTs) and controlled clinical trials (CCTs) of orthodontic treatments to correct deep bite and retroclined upper front teeth in children.

Data collection and analysis

Screening of eligible studies, assessment of the methodological quality of the trials and data extraction were to be conducted in duplicate and independently by two review authors. Results were to be expressed as random-effects models using mean differences for continuous outcomes and risk ratios for dichotomous outcomes with 95% confidence intervals. Heterogeneity was to be investigated including both clinical and methodological factors.

Main results

No RCTs or CCTs were identified that assessed the treatment of Class II division 2 malocclusion in children.

Authors' conclusions

It is not possible to provide any evidence-based guidance to recommend or discourage any type of orthodontic treatment to correct Class II division 2 malocclusion in children.

Group behaviour therapy programmes for smoking cessation

Lindsay F Stead[1], Tim Lancaster[1]

[1]Department of Primary Health Care, University of Oxford, Oxford, UK

Cochrane Database of Systematic Reviews 2005, Issue 2. Art. No.: CD001007. DOI: 10.1002/14651858.CD001007.pub2.

Abstract

Background

Group therapy offers individuals the opportunity to learn behavioural techniques for smoking cessation, and to provide each other with mutual support.

Objectives

We aimed to determine the effects of smoking cessation programmes delivered in a group format compared to self-help materials, or to no intervention; to compare the effectiveness of group therapy and individual counselling; and to determine the effect of adding group therapy to advice from a health professional or to nicotine replacement. We also aimed to determine whether specific components increased the effectiveness of group therapy. We aimed to determine the rate at which offers of group therapy are taken up.

Search strategy

We searched the Cochrane Tobacco Addiction Group Trials Register, with additional searches of MEDLINE and PsycINFO, including the terms behavior therapy, cognitive therapy, psychotherapy or group therapy, in July 2008.

Selection criteria

We considered randomized trials that compared group therapy with self help, individual counselling, another intervention or no intervention (including usual care or a waiting list control). We also considered trials that compared more than one group programme. We included those trials with a minimum of two group meetings, and follow up of smoking status at least six months after the start of the programme. We excluded trials in which group therapy was provided to both active therapy and placebo arms of trials of pharmacotherapies, unless they had a factorial design.

Data collection and analysis

We extracted data in duplicate on the participants, the interventions provided to the groups and the controls, including programme length, intensity and main components, the outcome measures, method of randomization, and completeness of follow up.

The main outcome measure was abstinence from smoking after at least six months follow up in patients smoking at baseline. We used the most rigorous definition of abstinence in each trial, and biochemically validated rates where available. Subjects lost to follow up were analysed as continuing smokers. Effects were expressed as a relative risk for cessation. Where possible, we performed meta-analysis using a fixed-effect (Mantel-Haenszel) model.

Main results

A total of 53 trials met inclusion criteria for one or more of the comparisons in the review. Thirteen trials compared a group programme with a self-help programme; there was an increase in cessation with the use of a group programme (N = 4375, relative risk (RR) 1.98, 95% confidence interval (CI) 1.60 to 2.46). There was statistical heterogeneity between trials in the comparison of group programmes with no intervention controls so we did not estimate a pooled effect. We failed to detect evidence that group therapy was more effective than a similar intensity of individual counselling. There was limited evidence that the addition of group therapy to other forms of treatment, such as advice from a health professional or nicotine replacement, produced extra benefit. There was variation in the extent to which those offered group therapy accepted the treatment. Programmes which included components for increasing cognitive and behavioural skills were not shown to be more effective than same length or shorter programmes without these components.

Authors' conclusions

Group therapy is better for helping people stop smoking than self help, and other less intensive interventions. There is not enough evidence to evaluate whether groups are more effective, or cost-effective, than intensive individual counselling. There is not enough evidence to support the use of particular psychological components in a programme beyond the support and skills training normally included.

Relapse prevention interventions for smoking cessation

Peter Hajek[2], Lindsay F Stead[1], Robert West[3], Martin Jarvis[4], Tim Lancaster[1]

[1]Department of Primary Health Care, University of Oxford, Oxford, UK. [2]Wolfson Institute of Preventive Medicine, Queen Mary's School of Medicine and Dentistry, London, UK. [3]Dept of Epidemiology and Public Health, University College London, London, UK. [4]Health Behaviour Unit of Cancer Research UK, Department of Epidemiology and Public Health, London, UK

Cochrane Database of Systematic Reviews 2009, Issue 1. Art. No.: CD003999. DOI: 10.1002/14651858.CD003999.pub3.

Abstract

Background

A number of treatments can help smokers make a successful quit attempt, but many initially successful quitters relapse over time. Several interventions were proposed to help prevent relapse.

Objectives

To assess whether specific interventions for relapse prevention reduce the proportion of recent quitters who return to smoking.

Search strategy

We searched the Cochrane Tobacco Addiction Group trials register in August 2008 for studies mentioning relapse prevention or maintenance in title, abstracts or keywords.

Selection criteria

Randomized or quasi-randomized controlled trials of relapse prevention interventions with a minimum follow up of six months. We included smokers who quit on their own, or were undergoing enforced abstinence, or who were participating in treatment programmes. We included trials that compared relapse prevention interventions to a no intervention control, or that compared a cessation programme with additional relapse prevention components to a cessation programme alone.

Data collection and analysis

Studies were screened and data extracted by one author and checked by a second. Disagreements were resolved by discussion or referral to a third author.

Main results

Fifty-four studies met inclusion criteria, but were heterogeneous in terms of populations and interventions. We considered 36 studies that randomized abstainers separately from studies that randomized participants prior to their quit date.

Looking at studies of behavioural interventions which randomised abstainers, we detected no benefit of brief and 'skills-based' relapse prevention methods for women who had quit smoking due to pregnancy, or for smokers undergoing a period of enforced abstinence during hospitalisation or military training. We also failed to detect significant effects of behavioural interventions in trials in unselected groups of smokers who had quit on their own or with a formal programme. Amongst trials randomising smokers prior to their quit date and evaluating the effect of additional relapse prevention components we also found no evidence of benefit of behavioural interventions in any subgroup. Overall, providing training in skills thought to be needed for relapse avoidance did not reduce relapse, but most studies did not use experimental designs best suited to the task, and had limited power to detect expected small differences between interventions. For pharmacological interventions, extended treatment with varenicline significantly reduced relapse in one trial (risk ratio 1.18, 95% confidence interval 1.03 to 1.36). Pooling of five studies of extended treatment with bupropion failed to detect a significant effect (risk ratio 1.17; 95% confidence interval 0.99 to 1.39). Two small trials of oral nicotine replacement treatment (NRT) failed to detect an effect but treatment compliance was low and in two other trials of oral NRT randomizing short-term abstainers there was a significant effect of intervention.

Authors' conclusions

At the moment there is insufficient evidence to support the use of any specific behavioural intervention for helping smokers who have successfully quit for a short time to avoid relapse. The verdict is strongest for interventions focusing on identifying and resolving tempting situations, as most studies were concerned with these. There is little research available regarding other behavioural approaches.

Extended treatment with varenicline may prevent relapse. Extended treatment with bupropion is unlikely to have a clinically important effect. Studies of extended treatment with nicotine replacement are needed.

Interventions for preventing weight gain after smoking cessation

Amanda C Parsons[1], Mujahed Shraim[2], Jennie Inglis[3], Paul Aveyard[4], Peter Hajek[5]

[1]Department of Primary Care & General Practice, University of Birmingham, Birmingham, UK. [2]Public Health and Epidemiology, Birmingham and Midland Eye Centre, Birmingham, UK. [3]Dept of Public Health, University of Birmingham, Birmingham, UK. [4]Primary Care Clinical Sciences, University of Birmingham, Birmingham, UK. [5]Wolfson Institute of Preventive Medicine, Queen Mary's School of Medicine and Dentistry, London, UK

Cochrane Database of Systematic Reviews 2009, Issue 1. Art. No.: CD006219. DOI: 10.1002/14651858.CD006219.pub2.

Abstract

Background

Most people who stop smoking gain weight, on average about 7kg in the long term. There are some interventions that have been specifically designed to tackle smoking cessation whilst also limiting weight gain. Many smoking cessation pharmacotherapies and other interventions may also limit weight gain.

Objectives

This review is divided into two parts.

(1) Interventions designed specifically to aid smoking cessation and limit post-cessation weight gain

(2) Interventions designed to aid smoking cessation that may also plausibly have an effect on weight

Search strategy

Part 1: We searched the Cochrane Tobacco Addiction Group's Specialized Register which includes trials indexed in MEDLINE, EMBASE, SciSearch and PsycINFO, and other reviews and conference abstracts.

Part 2: We searched the included studies of Cochrane smoking cessation reviews of nicotine replacement therapy, antidepressants, nicotine receptor partial agonists, cannabinoid type 1 receptor antagonists (rimonabant), and exercise interventions, published in Issue 4, 2008 of The Cochrane Library.

Selection criteria

Part 1: We included trials of interventions designed specifically to address both smoking cessation and post-cessation weight gain that had measured weight at any follow-up point and/or smoking six months or more after quitting.

Part 2: We included trials from the selected Cochrane reviews that could plausibly modify post-cessation weight gain if they had reported weight gain by trial arm at end of treatment or later.

Data collection and analysis

We extracted data in duplicate on smoking and weight for part 1 trials, and on weight only for part 2. Abstinence from smoking is expressed as a risk ratio (RR), using the most rigorous definition of abstinence available in each trial, and biochemically validated rates if available. The outcome is expressed as the difference in weight change between trial arms from baseline. Where appropriate, we performed meta-analysis using the Mantel-Haenszel method for smoking and inverse variance for weight using a fixed-effect model.

Main results

We found evidence that pharmacological interventions aimed at reducing post-cessation weight gain resulted in a significant reduction in weight gain at the end of treatment (dexfenfluramine (-2.50kg [-2.98kg to -2.02kg], fluoxetine (-0.80kg [-1.27kg to -0.33kg], phenylpropanolamine (PPA) (-0.50kg [-0.80kg to -0.20kg], naltrexone (-0.76kg [-1.51kg to -0.01kg])). No evidence of maintenance of the treatment effect was found at six or 12 months.

Among the behavioural interventions, only weight control advice was associated with no reduction in weight gain and with a possible reduction in abstinence. Individualized programmes were associated with reduced weight gain at end of treatment and at 12 months (-2.58kg [-5.11kg to -0.05kg]), and with no effect on abstinence (RR 0.74 [0.39 to 1.43]). Very low calorie diets (-1.30kg (-3.49kg to 0.89kg] at 12 months) and cognitive behavioural therapy (CBT) (-5.20kg (-9.28kg to -1.12kg] at 12 months) were both associated with improved abstinence and reduced weight gain at end of treatment and at long-term follow up.

Both bupropion (300mg/day) and fluoxetine (30mg and 60mg/day combined) were found to limit post-cessation weight gain at the end of treatment (-0.76kg [-1.17kg to -0.35kg] I^2=48%) and -1.30kg [-1.91kg to -0.69kg]) respectively. There was no evidence that the weight reducing effect of bupropion was dose-dependent. The effect of bupropion at one year was smaller and confidence intervals included no effect (-0.38kg [-2.001kg to 1.24kg]).

We found no evidence that exercise interventions significantly reduced post-cessation weight gain at end of treatment but evidence for an effect at 12 months (-2.07kg [-3.78kg, -0.36kg]).

Treatment with NRT resulted in attenuation of post-cessation weight gain (-0.45kg [-0.70kg, -0.20kg]) at the end of treatment, with no evidence that the effect differed for different forms of NRT. The estimated weight gain reduction was similar at 12 months (-0.42kg [-0.92kg, 0.08kg]) but the confidence intervals included no effect.

There were no relevant data on the effect of rimonabant on weight gain.

We found no evidence that varenicline significantly reduced post-cessation weight gain at end of treatment and no follow-up data are currently available. One study randomizing successful quitters to 12 more weeks of active treatment showed weight to be reduced by 0.71kg (-1.04kg to -0.38kg). In three studies, participants taking bupropion gained significantly less weight at the end of treatment than those on varenicline (-0.51kg [-0.93kg to -0.09kg]).

Authors' conclusions

Behavioual interventions of general advice only are not effective and may reduce abstinence.

Individualized interventions, very low calorie diets, and CBT may be effective and not reduce abstinence.

Exercise interventions are not associated with reduced weight gain at end of treatment, but may be associated with worthwhile reductions in weight gain in the long term.

Bupropion, fluoxetine, nicotine replacement therapy, and probably varenicline all reduced weight gain while being used. Although this effect was not maintained one year after quitting for bupropion, fluoxetine, and nicotine replacement, the evidence is insufficient to exclude a modest long-term effect.

The data are not sufficient to make strong clinical recommendations for effective programmes.

Root coverage procedures for the treatment of localised recession-type defects

Leandro Chambrone[1], Flávia Sukekava[1], Maurício G Araújo[2], Francisco E Pustiglioni[1], Luiz Armando Chambrone[3], Luiz A Lima[1]

[1]Department of Periodontology, University of São Paulo, São Paulo, Brazil. [2]Department of Periodontology, State University of Maringá, Maringá, Brazil. [3]Department of Periodontology, Methodist University of São Paulo, São Paulo, Brazil

Cochrane Database of Systematic Reviews 2009, Issue 2. Art. No.: CD007161. DOI: 10.1002/14651858.CD007161.pub2.

Abstract

Background

Gingival recession is defined as the oral exposure of the root surface due to a displacement of the gingival margin apical to the cemento-enamel junction and it is regularly linked to the deterioration of dental aesthetics. Successful treatment of recession-type defects is based on the use of predictable periodontal plastic surgery (PPS) procedures.

Objectives

To evaluate the effectiveness of different root coverage procedures in the treatment of recession-type defects.

Search strategy

The Cochrane Oral Health Group's Trials Register, CENTRAL, MEDLINE and EMBASE were searched up to October 2008. The main international periodontal journals were handsearched. There were no restrictions with regard to publication status or language of publication.

Selection criteria

Only randomised controlled clinical trials (RCTs) of at least 6 months' duration evaluating recession areas (Miller's Class I or II > 3 mm) and that were treated by means of PPS procedures were included.

Data collection and analysis

Screening of eligible studies, assessment of the methodological quality of the trials and data extraction were conducted independently and in duplicate. Authors were contacted for any missing information. Results were expressed as random-effects models using mean differences for continuous outcomes and risk ratios for dichotomous outcomes with 95% confidence intervals.

Main results

Twenty-four RCTs provided data. Only one trial was considered to be at low risk of bias. The remaining trials were considered to be at high risk of bias.

The results indicated a significant greater reduction in gingival recession and gain in keratinized tissue for subepithelial connective tissue grafts (SCTG) compared to guided tissue regeneration with resorbable membranes (GTR rm).

A significant greater gain in the keratinized tissue was found for enamel matrix protein when compared to coronally advanced flap (0.40 mm) and for SCTG when compared to GTR rm plus bone substitutes.

Limited data exist on aesthetic condition change related to patients' opinion and patients' preference for a specific procedure.

Authors' conclusions

Subepithelial connective tissue grafts, coronally advanced flap alone or associated with other biomaterial and guided tissue regeneration may be used as root coverage procedures for the treatment of localised recession-type defects. In cases where both root coverage and gain in the keratinized tissue are expected, the use of subepithelial connective tissue grafts seems to be more adequate.

Randomised controlled clinical trials are necessary to identify possible factors associated with the prognosis of each PPS procedure.

The potential impact of bias on these outcomes is unclear.

Vos avantages en tant que membre de l'ACHD

Communiquer

- Entrer en contact au sein de la communauté de l'ACHD avec des leaders d'opinion de tout premier plan, au sujet de diverses questions factuelles **— Gratuit**
- Créer votre profil; vous joindre à des groupes de discussion qui correspondent à vos besoins et à vos intérêts **— Gratuit**
- Créer votre propre **page web gratuite** pour vous mettre en valeur, afficher votre curriculum vitæ et souligner votre engagement social (*moyennant certaines restrictions*)
- Faire part de votre point de vue et de vos réactions sur diverses questions d'actualité en hygiène dentaire sur votre **blog personnalisé gratuit.**
- Avoir accès aux plus récentes offres d'emploi et perspectives de carrière à notre Centre des carrières, un *accès réservé aux membres*

Apprendre

- Des cours de formation continue que vous pouvez suivre quand vous voulez, à n'importe quelle heure du jour, à longueur d'année
- Des reçus aux fins de l'impôt pour les cours de formation continue de l'ACHD (*moyennant certaines restrictions*)
- La gestion et le suivi de votre perfectionnement professionnel et de votre portfolio grâce à notre outil gratuit de gestion professionnelle de la formation continue
- L'accès à une base de données en hygiène dentaire qui vous aidera à trouver les réponses à des questions factuelles d'actualité
- Des produits dernier cri, des nouvelles et de l'information à jour, le tout en un clic
- Des webinaires sur les sujets les plus novateurs qui se rapportent à votre pratique

Contribuer

- Faire entendre votre voix par l'intermédiaire de nos sondages et de nos enquêtes en ligne, ou soumettre un article au *Journal canadien de l'hygiène dentaire*, la publication professionnelle de l'ACHD
- Courir la chance d'obtenir des prix et des bourses d'une valeur de plus de 23 000 $, en reconnaissance de votre action dans votre milieu

Vivre

Un mille de **récompense** Air Miles® par tranche de dépenses de 20 $ ou une remise en espèces de 0,5 %, et ce, sans frais annuels, grâce à la carte MasterCard BMO de l'ACHD

Group Retirement Services

Pas de frais annuels sur les RÉER, les régimes de retraite et les programmes d'épargne conçus spécialement à l'intention des membres de l'ACHD

GoodLife CORPORATE WELLNESS

Possibilité de garder la forme grâce à **GoodLife Fitness**, à un tarif pouvant atteindre **50 % de moins** que le prix de l'abonnement individuel régulier

Accès **à des rabais et à des économies pouvant atteindre 30 %** dans les propriétés hôtelières de HMI, aux quatre coins du Canada

National nationalcar.com

Adhésion **gratuite** au EMERALD CLUB de Location d'autos National (d'une valeur de 75 $), pour profiter de nos tarifs préférentiels de groupe quotidiens (*à certaines conditions*)

ROGERS

Et prochainement…

Des téléphones cellulaires **gratuits** grâce à notre association exclusive avec Rogers™ Wireless Express

Économiser grâce à l'ACHD

- Rabais de 25 % sur les droits d'inscription à tous les webinaires, les cours de formation continue en ligne et les activités sur place
- Magasinage à la boutique en ligne de l'ACHD pour y trouver du matériel didactique

Obtenir les conseils d'une spécialiste

- Une conseillère en pratique autonome sur place, chargée de répondre à vos questions à ce sujet

À venir prochainement

- Le traitement électronique des demandes de règlement
  - Lancement prévu au milieu de 2010 – Traitement électronique des demandes de règlement au moyen de CDHA-ACHD.net[MC], le processeur de sécurité exclusif à l'ACHD servant à cette fin
- Un numéro d'identification unique offert gratuitement aux membres de l'ACHD

Gagner!

Des concours réservés aux membres de l'ACHD où l'on gagne des prix fabuleux : argent comptant, vacances de rêve, produits d'hygiène dentaire, abonnements au gym, et plus!

Nos partenaires en matière d'assurances

TD Assurance Meloche Monnex — *Des tarifs préférentiels de groupe sur l'assurance maison et l'assurance auto*

AON — *Une assurance responsabilité professionnelle de premier ordre, à prix compétitif, pour votre protection et celle de votre carrière*

Sun Life Financial — *Assurance-invalidité de longue durée, assurance-vie, assurance en cas de décès ou de mutilation par accident, assurance contre les maladies graves et assurance-maladie complémentaire*

Appelez notre Équipe de services aux membres au 1-800-267-5235.

Du lundi au vendredi, de 8 h 30 à 17 h (HE). Courriel : membership@cdha.ca. Nous sommes à votre service!

CANADIAN JOURNAL OF DENTAL HYGIENE · JOURNAL CANADIEN DE L'HYGIÈNE DENTAIRE

CJDH JCHD

Tarifs 2010 PLACARD PUBLICITAIRE

EN VIGUEUR LE 1er Janvier 2010

	1 fois		6 fois		12 fois		18 fois		24 fois	
	4 couleurs	N/B	4 couleurs	N/B	4 couleurs	N/B	4 couleurs	N/B	4 couleurs	N/B
1 page	2965 $	1195 $	2870 $	1100 $	2790 $	1020 $	2685 $	915 $	2615 $	845 $
2/3 page	2795	1025	2730	960	2645	875	2580	810	2510	740
1/2 page	2550	780	2480	710	2460	690	2410	640	2375	605
1/3 page	2420	650	2380	610	2330	560	2275	505	2230	460
1/4 page	2315	545	2265	495	2235	465	2210	440	2180	410
1/8 page	2235	465	2215	445	2185	415	2155	385	2130	360

COUVERTURE *(non résiliable; les tarifs comprennent le procédé 4 couleurs)*

Deuxième de couverture . . . . . 3 340 $
Troisième de couverture . . . . . 3 340 $
Quatrième de couverture . . . . . 3 790 $

INSERTIONS DANS UN SAC DE PLASTIQUE

Quantité requise : **14 000**. Devis accessible sur demande. Veuillez contacter Peter Greenhough chez Keith Communications Inc., 1-800-661-5004 ou 905-278-6700, poste 18, pour plus amples renseignements.

COMMISSION

Commission d'agence de 15 % aux agences de publicité reconnues (pas de rabais pour paiement anticipé).

BESOINS MATIÈRES

Envoyer les commandes d'insertion à : KEITH COMMUNICATIONS INC.1599 Hurontario Street, #104, Mississauga, Ontario L5G 4S1, Tél.: 905-278-6700 / 1-800-661-5004; Télec.: 905-278-4850
Courriel: pgreenhough@keithhealthcare.com
Site Web: www.keithhealthcare.com

FRÉQUENCE

Publication bimestrielle, à avoir : en janvier, mars, mai, juillet, septembre et novembre. Le nouveau volume commence avec l'édition de janvier-février.

DATES DE TOMBÉE

Ordres d'insertion : Le 1er jour, 8 semaines avant la date de publication, e.g. 1er novembre pour le numéro de janvier-février. **Matériel :** 1er jour du mois précédent, e.g. 1er décembre pour le numéro de janvier-février.

RÉGLEMENTATION DE LA COPIE ET DU CONTRAT

1. Toute copie doit être soumise à l'approbation de la DG.
2. Les annulations ne sont pas acceptées après la tombée.

DIFFUSION

13,331 (compte d'abonnements au 30 septembre 2009). Répartition approximative des membres de l'ACHD par province : TN=144; NÉ=599; IPÉ=50; NB=188; QC=166; ON=6495; MB=488; SK=438; AB=2180; CB=2491; NT/NU/YT=19; ÉU=56; Autres pays=17

FICHIERS DE DONNÉES

Il est préférable d'utiliser des fichiers conformes au format Adobe Acrobat PDF/X-1a. Les paramètres d'impression sont : couleur cmyk 300 dpi, polices enchâssées, repérage et offset avec marges perdues de 3/8". Les fichiers en formats d'autres programmes sont acceptés avec certaines limites. Pour se renseigner sur les autres formats, l'on contactera Peter Greenhough at 905-278-6700 or 1-800-661-5004. La publicité est imprimée en offset web. La reliure est en piqure à cheval. Les données numériques accompagnées d'une épreuve couleur sont requises pour les soumissions d'étalage publicitaire.

SPÉCIFICATIONS ICONOGRAPHIQUES

	Pouces		Picas	
	Width	Depth	Width	Depth
Taille du journal	8 3/8"	10 7/8"	50 1/4 p	65 1/4 p
Taille des pages de texte	7 1/16"	9 1/2"	42 1/2 p	57 p
Taille des annonces (mesure des traits de coupe)				
Page entière*	8 3/8"	10 7/8"	50 1/4 p	65 1/4 p
* ajouter une marge additionnelle de 1/2" aux quatre côtés				
2/3 page horizontal	7 1/16"	6 1/3"	42 1/2 p	38 p
1/2 page horizontal	7 1/16"	4 3/4"	42 1/2 p	28 p
1/2 page vertical	3 7/16"	9 1/2"	20 1/2 p	57 p
1/3 page horizontal	7 1/16"	3 3/16"	42 1/2 p	19 p
1/4 page	3 7/16"	4 3/4"	20 1/2 p	28 p

PRÉSENTATION DES FICHES DE DONNÉES

1. **FTP :** .pdf, .eps, .ai., sit ou .zip binaire. Pour télécharger votre fichier au client FTP, vous utilisez, par exemple, la barre d'adresse Windows Explorer, copie : ftp://ftp.cdha.ca/CJDH_adverts/ *Nom d'usager :* CJDH_journal *Mot de passe :* journal1! Confirmez par courriel à artwork@cdha.ca, indiquant le nom de votre archive de téléchargement pour que nous sachions qu'elle est là!
2. **Courriels :** fiches haute résolution : artwork@cdha.ca. (fichier joints : .pdf, .eps, .ai., sit ou .zip, maximum 5MB)
3. **Courriers :** fiches haute résolution (.pdf, .eps, .ai., sit ou .zip) sur CD à : Association canadienne des hygiénistes dentaires, 96 Centrepointe Drive, Ottawa, Ontario K2G 6B1

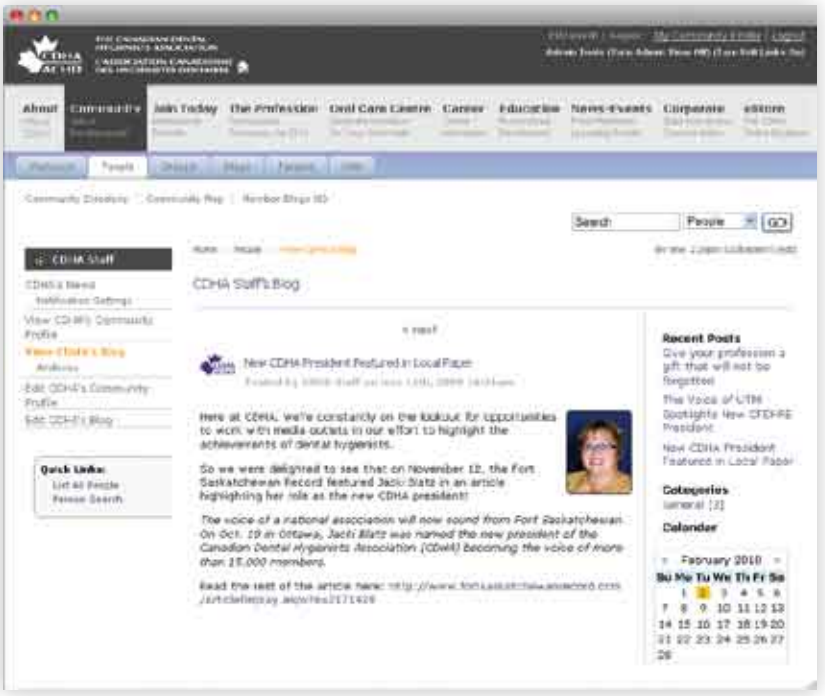
Education Advisory Committee (EAC)

Its mission is to support CDHA by providing the expertise and guidance that will cultivate the development of dental hygiene education and foster the profession's evolution.

Alberta/ Chairperson	**Sharon Compton**, DipDH, BSc, MA(Ed), PhD	Professor and Director of Dental Hygiene Program	University of Alberta, Edmonton
British Columbia	**Dianne Gallagher**, DipDH, BGS, MEd	Faculty Dental Hygiene, Dental Hygiene Program	Camosun College, Victoria
British Columbia	**Bonnie Craig**, DipDH, MEd, RDH	Director, Dental Hygiene Degree Program	University of British Columbia, Vancouver
East (Atlantic Canada)	**Nancy R. Neish**, BA, DipDH, MEd	Director, School of Dental Hygiene	Dalhousie University, Halifax
Manitoba	**Joanna Asadoorian**, AAS(DH), B.ScD(DH), MSc	Associate Professor, School of Dental Hygiene	University of Manitoba, Winnipeg
Ontario	**Linda Jamieson**, BA, MHS, RDH	Coordinator, Dental Hygiene Program	Georgian College, Orillia
Ontario	**Heather Blondin**, BSDH, RDH	Co-coordinator for Dental Health Programs	Cambrian College, Sudbury
Private School	**Larissa Voytek**, HBSc, BA, DipDH, RDH	Program Director	Ontario Dental Education Institute, Ancaster
Quebec	**Christine Fambely**, DH, Certified Health Ed, BA, MEd.	Clinical and Faculty Instructor, Department of Dental Hygiene	John Abbott College, St. Anne de Bellevue
Quebec	**Diane Lachapelle**, B.Sc(DH), RDH, MSc(diet)	Professeure titulaire, Faculté de Médecine dentaire	Université Laval, Québec
CDHA Board linkage	**Bonnie Blank**, AAS, RDH, BSc, MA	Instructor, School of Dental Hygiene	Camosun College, Victoria
CDHA Staff	**Judy Lux**, BA, MSW	Health Policy Communications Specialist	Canadian Dental Hygienists Association, Ottawa
CDHA Staff	**Susan Ziebarth**, DM	CEO	Canadian Dental Hygienists Association, Ottawa

Social networking

Ronald L. Shafer, PhD (Organizational leadership)
Elizabeth Cooper, BA (Hons.) English



This column on social networking is intended to help CDHA members understand the elements of social networking, and how these elements benefit dental hygienists.

BLOGS

The replacement of the newspaper has arrived, and it is called a blog. The name is derived from a contraction of the term 'Weblog' (Web Log). Blogs started out being individuals' journals, and then moved to more sophistication using graphics, videos, and commentaries. CDHA's sphere of blogs could be for each provincial association, and its outreach possibilities are vast. The dental hygienist community itself will determine what blogs are needed and how long these are to be maintained.

Many organizational newsletters have left the print media and electronic websites for what is called the blogosphere, or the community of all blogs. The uniqueness of the blog is that not only can a blogger provide a journal or coverage on an event or idea but also receive instant reader feedback. An example of an effective blogger was the then United States presidential candidate Barack Obama delivering his campaign messages to millions of readers, and getting almost instant feedback from those readers.

How can a blog benefit dental hygiene, and more importantly, dental hygienists? The Canadian Dental Hygienist Association's (CDHA) initial membership was 200 in 1964; today that membership number approaches 16,000. CDHA's membership spans the spectrum from student members to established leaders, to distinguished life members. Members come from so many different backgrounds such as regions of the country, ethnicities, experience, and type and scope of practice.

What an incredible pool of knowledge, experience, culture, and information! Within CDHA's social networking environment, individuals can provide to their colleagues, organizations, and provincial associations their experiences within the dental hygiene profession. A global discussion of practices and methodologies can enhance the very core of the profession. A dental hygienist in British Columbia can instantly share new treatments or procedures with someone in Nova Scotia. The experiences of setting up private practice or that of a graduating student transitioning to practice are valued topics in a blog on professional issues.

CONCLUSION

Dental hygiene practice is gaining traction in many dispersed areas, and instead of taking the road less trodden alone, dental hygienists can share their experiences informally through blogs. The wheel does not need to be reinvented every time. Participation is critical to a blog's success.

Please take the time to visit the CDHA website and click on the community tab. Browse the blog offering and the doors open to you to respond to a posted blog or to write one yourself. The more practical knowledge that is shared, the better client care and work place conditions can be. Enjoy the power of communication and the sharing of knowledge.

CDHA is striving to bring cohesion to the very dynamic and exciting professional community of dental hygienists. The more we share our knowledge and information in a timely and accurate basis, the better the profession and its individuals. It's a small step into the CDHA blogosphere—seize the opportunities, and join the conversation.

CDHA welcomes your feedback: info@cdha.ca

CDHA Community Calendar

Plan ahead. Participate in the events posted on this page. Or mark your calendar.

UPCOMING EVENTS/ ÉVÉNEMENTS À VENIR

Onsite Events

Programs may be subject to change.

15–17 April 2010	Vancouver, BC	Catch us at the Pacific Dental Conference	Pacific Dental Conference
17 April 2010	Vancouver, BC	Private Practice Workshop - BCDHA and CDHA	Practice Success
13–14 August 2010	Montreal, QC	Vision to Venture: CDHA Leadership Event	Vision to Venture
10–11 June 2011	Halifax, NS	*CDHA 2011* National Conference	CDHA ACHD

Online Events

Programs may be subject to change.

22 March 2010	Webinar	Oraqix®: Needle free anesthesia for non surgical periodontal therapy
7 April 2010	Webinar	SRP+ARESTIN®: Working together for your clients
24 June 2010	Virtual Q & A	Oraqix®: Needle free anesthesia for non surgical periodontal therapy

Annual Events

Every April is Oral Health Month.
Help spread the message.

CDHA ACHD National Dental Hygienists Week™ La semaine nationale des hygiénistes dentaires MD

11–17 April 2010 is National Dental Hygienists Week™

An annual event dedicated to heightened awareness about preventative oral health care, and to help Canadians understand the role and importance of the dental hygiene profession.

Advertisers' index

ABOUT THE COVER

The outer front covers in the six issues of Volume 44 in 2010 feature **dental hygiene educators in Canada**, honouring their service to the dental hygiene profession. This picture was one among the entries selected for the front cover competition first advertised mid-November 2009 in the journal. ©CDHA. Printed with permission.

The group huddle is held prior to the completion of clinical sessions at the Vancouver College of Dental Hygiene Inc. The students and instructors engage in this educational interaction of reflection. The huddle promotes cooperative learning while sharing experiences, triumphs, and challenges.

Clinical instructors from left to right:
Lois Sullivan, Heidi Kang, Christine Chore, and Kelly Mabey.
©CDHA. Printed with permission.