The SDHA *Edge*

Spring Issue - #5
April 2013

Saskatchewan Dental Hygienists' Association

Striving for optimal oral and overall health for the people of Saskatchewan, and a dynamic dental hygiene profession.

this issue

The SDHA *Edge* is the newsletter publication for dental hygienists in SK. The newsletter is circulated in the fall, winter and spring seasons to inform members about issues that affect their dental hygiene practice. It has been designed to be a tool and resource for members to keep current on news, programs and services of the SDHA, new technologies and research, and a forum for discussion about current topics of interest.

Story ideas, articles and letters are always welcome. Please send your submission to sdha@sasktel.net.

2013 AGM and Professional Development Seminar

SATURDAY, MAY 4, 2013

The Willows, 382 Cartwright Street, Saskatoon, SK

1. SDHA AGM Agenda - 9:00 am to 10:30 am

1. Call to order
2. Appointment of Parliamentarian
3. Adoption of Agenda
4. Adoption of Minutes of AGM May 5, 2012
5. Council Report – Chris Gordon - President
6. Registrar-ED Report and Financial Report – Kellie Hildebrandt
7. Official Representative Reports
8. Awards and Recognitions
9. New Business
10. Elections – Council Members (2) and Committees
11. Adjournment.

2. SHIRP Presentation - 10:45 am to 11:15 am

The Saskatchewan Health Information Resources Partnership (SHIRP) provides access to a comprehensive suite of online health information resources for all health practitioners in Saskatchewan. The SHIRP digital library includes: 13 Medical and Interdisciplinary Health Databases, over 6,000 Full text Journals, 144 Full text Books, and 3 Clinical Decision Support Tools.

It is SHIRP's Mandate to provide province-wide access to an electronic library of health care resources to support the education, evidence-based practice, and research needs of Saskatchewan's health care practitioners, health sciences post-secondary students, and health-related provincial government departments.

3. Privacy in Oral Health - 11:15 am to 12:00 noon, *Gary Dickson, SK Privacy Commissioner*

Every SK resident has the right to have their personal information protected when they deal with public bodies. This is true whether the public body is a government department, a Crown Corporation, a school division, regional health authority, municipality, university, college, or a private health provider such as their doctor, dentist, pharmacist or therapist.

4. Trends and Treatment: Esthetics as a Gateway to Oral Health - 1 - 4pm *Mariana Leon*

Many Canadians believe a smile is an important social asset. Patients with beautiful, radiant smiles are your ambassadors for your practice. Learning to use esthetics as a gateway to oral health for your patient population will enhance your practice.

In this course, participants will discover new trends in dentistry that provide optimal care with lasting impressions. Trends highlighted include: spa dentistry, Botox for TMD and instant smile makeovers. Since most patients are "assessing their smiles" at home, developing a smile evaluation protocol with your dental team can promote discussions about needed and/or wanted dentistry.

Unlock the psychology of dentistry by recognizing patient avoidance behaviors and learn to recognize your own barriers with patients. Enhance your communication skills and learn how to effectively recommend esthetic treatment for successful clinical outcomes. Finally, reinvent your practice through social media, newsletters, websites and treatment completion gift ideas.

Please see more Oraqix Product Information on Page 8

Proud To Be A Dental Hygienist!
Proud To Be Your President! - Chris Gordon

What is a smile?

- It is the same in all languages
- It opens closed doors
- It reflects your soul
- It reveals your health status
- It is meant to last a lifetime

Did you know that across the world there are approximately 500,000 dental hygienists? We are in over 30 countries and are providing care for children and adults of all age groups. In Canada, there are about 24,000 dental hygienists.

When I sat down to write my final message as the SDHA president, I really had to think about what I want to say. I asked myself, "What does it really mean to be a member of SDHA?" "Why is this association important and what do the members get from the fees that they pay?" This is what I know.

Well, being a member of SDHA also means that you are a member of CDHA! This means that you are not only represented provincially but also nationally. CDHA is also our voice worldwide. This year CDHA is representing Canadian Dental Hygienists at the International Federation of Dental Hygienists Conference in Cape Town, South Africa. This conference only happens every three years and CDHA is very well respected as a contributor. So to sum it up, as a SDHA member you are represented provincially, nationally and internationally!

Being a member of SDHA and CDHA provides you with liability insurance, which is so convenient. No need to shop around or to have to count on our employers to provide this.

SDHA and CDHA are more than just members' services. The SDHA most importantly provides your dental hygiene license and all the information you need to practice in this province. Regulating the profession of dental hygiene and protecting the public is the SDHA's primary responsibility. The SDHA and CDHA provide resources such as professional development courses and position statements, and we act as advocates for our members and the profession.

In the past this is what SDHA has done:

- We have successfully advocated for dental hygienists having their own billing numbers; dental insurance companies recognizing and directly compensate them for the services provided. We have gone from a situation where direct payment from an insurance company to a dental hygienist was the exception to the rule, to a situation where it is now the norm.
- We collaborate on national competencies to ensure an educational standard across Canada.
- We represent our profession to other organizations and health professionals. We work hard to have dental hygienists become a well-recognized profession and our presence is now being requested at other health organizations. This is very important progress. Dental hygienists are now becoming recognized as an critical component to the dental team.
- We continue to lobby government for changes to allow dental hygienists to better serve the public by practicing in alternative settings.
- We continue with setting goals and developing a strategic plan on how to reach the goals.
- We continue to link with stakeholders like educators, students, and grassroots hygienists to get input that will guide our direction.
- We along with CDHA support research that lends credibility to dental hygiene as a profession.

There are so many reasons why it is great to be a member of SDHA/CDHA. It might mean that you have questions about starting an independent practice and you don't know where to start. It may mean that you have a unique business idea and want some resources. It may mean that dental hygienists in Saskatchewan should have no barriers to practice and be able to access underserved populations more readily. It may mean that you want to be able to have input in where your profession goes and expand your duties to help you get there. You have an entire organization both provincially and nationally working on your behalf. What may be overwhelming for an individual becomes possible as a profession. It is because of great ideas, questions and desires posed by you, our members that has made dental hygiene in Saskatchewan so advanced.

Dental hygienists are instrumental to the public maintaining a healthy lifestyle. Promoting good oral health by teaching effective homecare and having regular visits with a dental hygienist are essential to maintaining a smile for a lifetime! Occasionally, I have a patient thank me for making a difference in their life. Sometimes it is because I have helped them improve their oral health and sometimes it is because I just listened to them. Sometimes there are bigger things happening in their life that maybe their oral health has been put on hold. Either way, I am so glad that I can make a difference.

I am so proud to be a dental hygienist and to have been the President of a truly great organization. I am thankful to be able to be a strong voice to promote our profession. There is still so much more work that needs to be done. I know that each one of you has a strong voice and I encourage you to promote our profession to government, with dentistry and the public. We need to increase our visibility and let these individuals know that dental hygienists make an incredible difference.

Here are some questions to ask your self:

⇒ "How can I make a difference for our profession?"
⇒ "What can I do to promote dental hygienists?"
⇒ "What can I do to help my association?"

Sincerely proud to be an SDHA member and your President,

Thank you,

Chris Gordon

Continuing Competency Q & A

Kellie Hildebrandt, RDH, MBA - SDHA Registrar - Executive Director

The recent changes to the Continuing Competency Guidelines have been communicated to members since July 2012. Please find below a series of questions and answers relating to these changes and other general policies.

1. What do I need to submit in order to have credit granted for an activity?

For all learning activities, completion of a CC Credit Request Form ***AND*** supporting documentation must be included. Supporting documentation may include:

- Certificate of completion;
- Conference scan-in/scan-out report;
- Forwarded sign-in/sign-out sheet;
- Course schedule and outline of course content;
- Copy of CPR wallet card.

Supporting documentation or proof of attendance is not required for courses offered by the SDHA or other oral health associations (SDAA/SDTA/CDSS); the sign in sheets are sufficient.

2. I have credits/activities that were completed before January 1, 2013 that have not yet been submitted. With this new 120 day rule, when do I have to submit these by in order to receive credit?

April 30, 2013. Courses/activities that were completed prior to January 1, 2013 will not be eligible for credit if received after April 30, 2013.

3. How does the 120 day rule work from here onward?

CC Credit Request forms and supporting documentation must be received within 120 days of the course/activity completion.

4. There are past courses/activities that are not showing up on my CC Transcript. What should I do?

Please contact the SDHA office by phone (206-931-7342) or by email at sdha@sasktel.net.

5. Do I have to submit my Personal Learning (PL) Tools to the SDHA office?

No. PL Tool forms are retained by the member to serve as evidence that you are following the Competencies and Standards of the profession and maintaining evidence of his/her professional development. PL Tool forms are only submitted to the SDHA office, if that member has been selected for audit/review at the completion of their 3-year period.

6. When do we receive a record/ transcript of our CC credits?

CC Transcripts are produced and mailed to members once annually in July. With the new SDHA website, a current record of credits will be available on demand when member's login. This feature is under development and is expected to be available by summer 2013.

7. When does the new CPR requirement take effect?

SDHA members must provide evidence of successful completion of a Cardio Pulmonary Resuscitation (CPR) course once per three-year reporting period. This requirement will be phased in over the next few years and will come into effect when a member begins his/her next reporting period.

For example:

- CCP Reporting period ends December 2012 - CPR course required between January 1, 2013 and December 31, 2015
- CCP Reporting period ends December 2013 - CPR course required between January 1, 2014 and December 31, 2016
- CCP Reporting period ends December 2014 - CPR course required between January 1, 2015 and December 31, 2017

8. What type of CPR course is required?

It is important that the CPR course you take has a hands-on component. Online CPR courses are not acceptable. CPR courses must include classroom instruction and hands-on experience related to:

- One and two rescuer chest compressions for adults, children and infants;
- One and two rescuer adult, child and infant bag-valve mask technique and rescue breathing;
- Relief of choking in adults, children and infants; and
- Use of an automated external defibrillator (AED)

9. How long do I have to keep my CC records and PL Tools?

Members are advised to keep a personal record of program credits and all forms for at least 3 years.

Please contact the SDHA office with any questions or concerns.

New Contact Information???

Please ensure that your contact information is always current with the SDHA.

Incorrect or out-of-date addresses can lead to missed mailings that may include important documents and notices.

Address changes can be completed online at www.sdha.ca. Login to the Members section and choose "Update SDHA Contact Information". Changes can also be submitted via email at sdha@sasktel.net, or by mail.

Implications of Poor Oral Health in Personal Care Homes: A New Role for Dental Hygienists?

Salme E Lavigne, RDH, BA, MS(DH)

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Dental Hygienists in general tend to be employed in traditional dental practice settings across Canada. With the growing numbers of dental hygienists in Canada, perhaps it is time to rethink our roles and put our expertise to use in other more non-traditional settings. With self-regulation, dental hygienists were given the freedom to practice in institutionalized settings throughout the province. However few if any dental hygienists have taken advantage of this option. This is an amazing opportunity for dental hygienists to change the way health care is delivered and in turn, contribute to the eradication of an important public health crisis.

It is a well-recognized fact that the number of seniors worldwide is on the rise. Predictions speculate that by the year 2020, 20% of the population will be 65 years or older and will triple that figure by 2041.[1] Along with this exponential rise in the number of older adults, is a documented rise in chronic diseases as well as an increased demand for personal care homes.[2] Currie & DeCoster reported 70% of seniors in personal care homes having at least 2 or more chronic diseases. [2] In addition, the rising costs of health care have been attributed to the high cost of chronic diseases such as diabetes, cardiovascular disease, stoke, and respiratory diseases.[3,4,5,6,7]

Considerable research has been conducted over the past decade establishing potential links between periodontal disease and numerous chronic systemic inflammatory diseases such as cardiovascular disease, stroke, respiratory disease, diabetes and more recently Alzheimer's and arthritis, suggestive of plausible causal linkages.[8,9] The common denominator in all these diseases including periodontal disease, appears to be the presence of chronic inflammation and the cascade of inflammatory biomarkers that accompany all inflammatory diseases. Periodontal disease is a chronic inflammatory disease that affects a large portion of the world population with higher prevalence reported in older adults.[1] Periodontal disease is characterized by subgingivally located plaque accumulations residing in a dense sticky biofilm complex that is difficult to remove due to its location and composition. Over 500 species of bacteria have thus far been identified in oral plaque biofilms, with some being more aggressive than others. [10,11] These bacteria trigger a powerful immune response that results in a cascade of immunological events that involve both the innate and adaptive immune systems. This precedes the development of chronic inflammation along with a plethora of systemic inflammatory biomarkers such as C-Reactive protein which is one of the major markers present in atherosclerotic heart disease.[12,13]

These recent oral-systemic inflammatory linkages have provided plausible explanations for the development of atheromas in cardiovascular disease and ischemic stroke, strengthened by the concept of metabolic syndrome which now also includes both obesity and periodontal inflammation, as well as posing a lot of other questions in relation to numerous chronic inflammatory systemic diseases. Given the vast extent of periodontal disease worldwide particularly in older adult populations, this group of individuals is more vulnerable to these suggested systemic sequelae. Oral health services have not typically been covered by either the Canadian Health Care System or provincial health authorities, with the exception of a few children's programs and programs for First Nations and Inuit populations. Thirty percent of the Canadian population does not have dental insurance and must pay out of pocket for dental care.[14] Unfortunately, this 30% of the population is comprised primarily of the elderly and the indigent. The majority of Canadians have health insurance through their employers, however once they retire, insurance benefits for most, are discontinued leaving them to carry the burden individually at a time when their income is the lowest.

Without adequate public coverage for the prevention and/or control of periodontal disease, the systemic burden of inflammation will increase in these individuals and elevate their risk for the development of more serious inflammatory diseases. This in turn may increase the burden of cost on the health care system as a whole particularly when those conditions result in lengthy hospitalization. Residents of long term care facilities/nursing homes, have been shown to be particularly vulnerable as the majority do not have dental insurance and evidence suggests that caregivers who are responsible for their daily oral hygiene care, do not perform these tasks regularly and often never. [15,16] Furthermore, access to routine professional oral health services for these individuals is often limited due not only to lack of insurance and finances but also to numerous other barriers such as lack of mobility; uncooperativeness; aggression etc. [16]

One of the most notable barriers to oral care for the institutionalized elderly is the lack of governmental and regulatory mandates. Attempts have been made by numerous governmental and professional groups to develop such guidelines, however none have been put to action as of yet. [17,18] With the rising costs of health care to treat the chronic diseases that affect this population group, along with the evidence that periodontal disease is both preventable and treatable, it will be imperative to develop and implement effective, non-invasive, cost-effective oral health interventions that are targeted for elimination of the oral inflammatory burden for this vulnerable group of individuals. These interventions must be non-invasive, lack compliance issues and be easy to implement, preferably by nursing home staff. Several new non-invasive oral interventions have recently been developed to control the oral microbial load and lower inflammatory markers systemically such as antimicrobial varnishes, rinses and enzyme suppressive agents. Most of these interventions however, have not been tested in an institutionalized older adult population.

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Implications of Poor Oral Health in Personal Care Homes: A New Role for Dental Hygienists? Salme E Lavigne, RDH, BA, MS(DH)

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Reduction of oral inflammation must become a primary "point of care" within all personal care homes utilizing a comprehensive "risk reduction" approach to health and wellness.[19] Although challenging, this approach presents multiple opportunities to work within well-structured interprofessional teams utilizing a syndemic approach to combat this serious situation within personal care homes. Dental Hygienists are primary candidates for taking a leadership role in the development of these proposed interprofessional teams. Ideally, every personal care home should have a dental hygienist on staff to develop and guide daily oral programming for the residents in order to control their inflammatory burdens and help combat this alarming public health crisis.

The rewards of such an approach will be numerous and will have far-reaching public health implications in the reduction of systemically-related health care costs and at the same time improving the quality of life of this older adult population.

Bibliography
1. Petersen PE, Yamamoto T. Improving the oral health of older people: the approach of the WHO Global Oral Health programme. Community Dent Oral Epidemiol 2005;33:81-92.
2. Currie RJ, DeCoster C A Summary of: Assessing Manitoba's Nursing Homes: Is good good enough? Manitoba Centre for Health Policy. 2006.
3. Finlayson GS, Reimer J, Dahl M, Stargardter M, McGowan K-L. The cost of hospitalizations in Manitoba. The Cost of Hospitalizations in Manitoba. Manitoba Centre for Health Policy, 2009.
4. Spending on Health Care to reach $5,170 per Canadian in 2008. Canadian Institute for Health Information, 2008. Accessed online on 11/11/2009 at: http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=media13nov2008_e
5. Executive Summary: Tracking Heart Disease and Stroke in Canada. Public Health Agency of Canada. 2009. Accessed on-line on 11/11/2009 at: http://www.phac-aspc.gc.ca/publicat/2009/cvd-avc/summary-resume-eng.php
6. Executive Summary: Life and Breath: Respiratory Disease in Canada. Public Health Agency of Canada. 2007. Accessed on-line on 11/11/2009 at: http://www.phac-aspc.gc.ca/publicat/2007/lbrdc-vsmrc/index-eng.php
7. Report from the National Diabetes Surveillance System: Diabetes in Canada, 2008. Public Health Agency of Canada, 2008.Accessed on-line on 11/11/2009 at: http://www.phac-aspc.gc.ca/publicat/2008/ndssdic-snsddac-08/pwdd-iaddeng.php
8. Van Dyke TE. Inflammation and periodontal disease: A reappraisal. J Periodontol 2008;79:1501-1502.
9. Iacopino AM. Maintaining oral health in the aging population: The importance of the periodontal-systemic connection in the elderly. Grand Rounds in Oral-Sys-Med 2006;3:25-37e.
10. Loesche W.J. Association of the oral flora with important medical diseases. Current Opinion in Periodontology 1997;4:21-28.
11. Marsh PD. Dental plaque:biological significance of a biofilm and community life-style. J Clin Periodontol 2005;32(Suppl. 6):7-15.
12. Van Dyke TE, Kornman KS. Inflammation and factors that may regulate inflammatory response. J Periodontol 2008;79:1503-1507.
13. Dave S, Van Dyke T, Suzuki JB. Chronic inflammation in periodontal diseases: Immunopathogenesis and treatment. Grand Rounds in Oral-Sys Med. 2007;3:10-17a.
14. Canadian Institute for Health information. Exploring the 70/30 Split: How Canada's Health Care System is Financed. Chapter 7 Oral Health Care Services. CIHI, 2005;Ottawa: pages 75-82.
15. Dharamsi S, Khairun J, Dean C, Wyatt C. Journal of Dental Education. 2009;73(5):581-588
16. Coleman P. Oral care provided by certified nursing assistants in nursing homes. J Am Geriatr Soc 2006;54:138-143.
17. Leake JL. The history of dental programs for older adults. J Can Dent Assoc 2000;66:316-9.
18. A Canadian Oral Health Strategy. Federal Provincial and Territorial Dental Directors. Last revised in 2004. Accessed on-line at: http://www.fptdwg.ca/assets/PDF/Canadian%20Oral%20Health%Strategy%20-%20Final.pdf

Call for Nominations

At this time, the SDHA is extending a Call for Nominations for two (2) Registered Dental Hygienists who are interested in serving on the SDHA Council for a three (3) year term (2013 – 2016). The election to fill the Council vacancies will occur at the SDHA Annual General Meeting (AGM), planned for Saturday, May 4, 2013.

Now is the opportune time to consider the difference your participation on SDHA Council could make. If you or someone you know is interested in contributing their time, talent and wisdom to the growth of the SDHA, ***please submit the Biography Form (enclosed) to the SDHA office no later than Tuesday, April 23, 2013***

SDHA Council Role and Responsibilities:

- Attending all Council meetings and the AGM. Council meetings will be held 3-4 times per year at a time mutually agreeable to all.
- Providing governance and leadership to the SDHA through administration of the Act, Regulations and By-Laws.
- Exercising the rights, powers and privileges of the SDHA.
- Establishing and monitoring registration and continuing competency requirements.
- Appointing and overseeing the work of the committees established.
- Establishing and monitoring Regulations, By-Laws, Standards of Practice and Competencies.
- Providing direction to the Registrar.

Please see the information sheet with this newsletter for more information.

A Year in the Life of an SDHA Council Member

Leanne Huvenaars, RDH

I can hardly believe how fast time flies. It seems like yesterday that I received the nomination for an SDHA Council Member position. I was very happy and excited to be nominated. To be honest, I was a bit nervous, and didn't know what was involved.

Being that I like to learn new things and never back down from a challenge, I thought - why not? I filled out my nomination form with pride. As the emails started coming in about the AGM in Regina in May 2012, I started to panic.

I prepared my little speech and said it over and over in my head until I could say it flawless. When I was asked to come to the front at the AGM I could feel my face getting red and my blood pressure rising. I spoke, and yes you could tell I was nervous but speaking in front of these peers made me start a new goal - to become a better public speaker. After my short speech, the election was held, and I hoped that I would be chosen. Low and behold - I was!

I had an idea of what sitting on a board/council would be like as I have sat on them before for other organizations, but every board/council is different. I hoped I would be valuable to this board. I knew that the people that sat on the SDHA Council were very passionate about our profession. I too am passionate about the SDHA and the future of dental hygiene in Saskatchewan. I thought why not, the timing is right to give back to our association and our profession.

I looked forward to the first meeting that was scheduled for October 2012 in Saskatoon. When I arrived at the meeting, I was flabbergasted at the members on Council and the three new public representatives. What an amazing group of people! They were all from different backgrounds and all different areas of the province. When I thought of Council before, I doubted whether it would work for me and thought that it was only for those people who lived in the bigger cities. I was so wrong.

There are people from Regina, Prince Albert, Nipawin, Saskatoon, Tisdale and so forth. I knew I was lucky to be apart of this group at the first meeting. I wondered why I had not volunteered to sit on this council before and what took me so long to get involved.

The meeting agenda, documents and dates of meetings are provided well in advance to allow adequate time to prepare for the upcoming meeting. The council meets face to face three times per year and special committees may meet in person, online or via teleconference as needed between meeting dates. After our first day of meetings, we got together for a team building supper. We got to know each other a bit better and I left thinking what smart, funny, passionate, busy people I sat amongst.

The meetings so far have been great. I have learned so much about Policy Governance®. Susan Rogers, our Governance Coach, has left me speechless on many occasions. This woman is so intelligent., and has made learning this policy material easy to follow and understand. She is truly gifted. I come away from each meeting with the appreciation for how fortunate we are to have Kellie Hildebrandt as our Registrar -Executive Director. She is smart, professional, organized and connected. She knows people everywhere. This enables the SDHA Council to be well educated in all areas needed. Kellie's effectiveness is unbelievable.

Each person on Council brings with them knowledge, professionalism, and a unique opinion. This makes for a diverse group of people. I love that every person feels they can share in the discussions. It makes me feel welcome. I never feel like what I am asking is stupid or that I will be judged. I leave these meeting feeling glad that I was at them and look forward to the next time we meet. The members of the SDHA Council all share one thing, a passion to move SDHA forward in a positive direction. We strive to look forward in our profession while never losing sight of our members desires or the safety of the public.

S - Know you are **SUPPORTING** your progressive, dynamic profession.

D - Be part of the **DECISION-MAKING** to move your profession forward.

H - Join council and make **HEADWAY** with the advancements of your profession.

A - There is always a true sense of **ACCOMPLISHMENT** following each Council meeting.

C - **COLLABORATION** with other members and health professionals.

O - **OPPORTUNITIES** to work with and learn from the wonderful governance coach, executive director and public reps

U - Council work is a **UNITED** effort to achieve the same goals.

N - Council **NETWORKS** with other health professionals.

C - **CHALLENGES** are viewed as opportunities of motivation for the possibilities in the future of your profession.

I - Council has **INCREDIBLE** vision of where your profession could go in the future thanks to the help of the members.

L - Council meetings are a lot of work, however there is always time for **LAUGHS** and the **LUNCHES** are so good!

oraqix®

(lidocaine and prilocaine
periodontal gel) 2.5% / 2.5%

Prescribing Summary

Patient Selection Criteria

Product mongraph PART I: Health Professional Information
SUMMARY PRODUCT INFORMATION

Route of Administration	Dosage Form / Strength	All Non-medicinal Ingredients
Topical Periodontal Administration DO NOT INJECT	Gel / Lidocaine 25 mg/mL; Prilocaine 25 mg/mL	Hydrochloric Acid, NF, Ph Eur Poloxamer 188, purified Poloxamer 407, purified Purified Water, USP, Ph Eur

INDICATIONS AND CLINICAL USE

Adults

ORAQIX® (Lidocaine and Prilocaine Periodontal Gel) is indicated for topical application in periodontal pockets for moderate pain during scaling and/or root planing.

ORAQIX® should NOT be injected.

Geriatrics (> 65 years of age): There are limited data available on the use of ORAQIX® in the elderly. Greater sensitivity of some older individuals cannot be ruled out. Caution is advised in dose selection for the elderly (see WARNINGS and PRECAUTIONS, Special Populations, Geriatrics).

Pediatrics (< 18 years of age): ORAQIX® is not recommended to be used in children (see WARNINGS and PRECAUTIONS, Special Populations, Pediatrics).

CONTRAINDICATIONS

ORAQIX® (Lidocaine and Prilocaine Periodontal Gel) is contraindicated:

- in patients with a known history of hypersensitivity to local anesthetics of the amide type or to any other component of the product;
- in patients with congenital or idiopathic methemoglobinemia

Safety Information

WARNINGS AND PRECAUTIONS

ORAQIX® (Lidocaine and Prilocaine Periodontal Gel) must not be injected.

ORAQIX® (Lidocaine and Prilocaine Periodontal Gel) should not be used with standard dental syringes.

General

Allergy: Allergic and anaphylactic reactions associated with lidocaine or prilocaine can occur. These reactions may be characterized by urticaria, angioedema, bronchospasm, and shock. If these reactions occur they should be managed according to standard clinical practice.

Methemoglobinemia: Prilocaine can cause elevated methemoglobin levels particularly in conjunction with methemoglobin inducing agents. Methemoglobinemia has also been associated with amino- or nitro-derivatives of benzene e.g. aniline, dapsone and lidocaine although reports on the link between lidocaine treatment and methemoglobinemia are limited. Methemoglobinemia is well documented in relation to prilocaine and lidocaine combination treatment and correlated with exposure to prilocaine and the plasma levels of its metabolite *o*-toluidine.

Patients with glucose-6-phosphate dehydrogenase deficiency or congenital or idiopathic methemoglobinemia are more susceptible to drug-induced methemoglobinemia. ORAQIX® (Lidocaine and Prilocaine Periodontal Gel) should not be used in those patients with congenital or idiopathic methemoglobinemia.

Patients taking drugs associated with drug-induced methemoglobinemia are also at greater risk for developing methemoglobinemia. Treatment with ORAQIX® should be avoided in patients with any of the above conditions or with a previous history of problems in connection with prilocaine treatment (see DRUG INTERACTIONS, Methemoglobinemia).

The development of methemoglobinemia is generally dose-related. Levels of methemoglobin observed after application of the ORAQIX® in clinical trials did not exceed normal values (i.e. <2% of the individual patient's total hemoglobin). The individual maximum level of methemoglobin in blood ranged from 0.8% to 1.7% following administration of the maximum dose of 8.5 g ORAQIX® (see OVERDOSAGE, Methemoglobinemia).

Cardiovascular

ORAQIX® (Lidocaine and Prilocaine Periodontal Gel) should be used with caution in patients with severe impairment of impulse initiation and conduction in the heart (e.g. grade II and III AV block, pronounced bradycardia) since these subjects may be particularly sensitive to local anesthetics and potential cardiac depression (see also DRUG INTERACTIONS – Antiarrhythmics)

Ear/Nose/Throat

ORAQIX® should not be used in clinical situations where it can penetrate or migrate into the middle ear. Tests on laboratory animals (guinea pigs) have shown that a cream formulation containing lidocaine and prilocaine has an ototoxic effect.

When the same animals were exposed to the cream formulation in the external auditory canal, no abnormalities were observed. Minor structural damage to the tympanic membrane in guinea pigs was observed when a lidocaine-prilocaine cream formulation was applied directly to the membrane.

Care should be taken to avoid excess ORAQIX® from spreading to the oropharyngeal mucosa.

Special Populations

Pregnant Women: ORAQIX® should be used during pregnancy only if the benefits outweigh the risks. There are no adequate and well-controlled studies to evaluate ORAQIX® during pregnancy. Animal reproduction studies are not always predictive of human response.

Lidocaine and prilocaine cross the placental barrier and may be absorbed by the fetal tissues. It is reasonable to assume that lidocaine and prilocaine have been used in a large number of pregnant women and women of child-bearing age. No specific disturbances to the reproductive process have so far been reported, e.g., an increased incidence of malformations or other directly or indirectly harmful effects on the fetus. However, care should be given during early pregnancy when maximum organogenesis takes place.

Nursing Women: Lidocaine and, possibly, prilocaine are excreted in breast milk, but in such small quantities that there is generally no risk to the infant being affected at therapeutic dose levels due to low systemic absorption.

Pediatrics (<18 years of age)

Safety and effectiveness in pediatric patients have not been studied. Very young children are more susceptible to methemoglobinemia associated with prilocaine treatment and this is related to the development of the enzyme methemoglobin reductase which converts methemoglobin back to hemoglobin. Methemoglobin reductase reaches adult levels at between 3 and 6 months.

Geriatrics (> 65 years of age): Of the total number of subjects in clinical studies of ORAQIX®, 7% were aged 65 and over, while 1% were aged 75 and over. No overall differences in safety or effectiveness were observed between these subjects and younger subjects. Other reported clinical experience has not identified differences in responses between elderly and younger patients, but greater sensitivity of some older individuals cannot be ruled out.

In general, dose selection for an elderly patient should be cautious, usually starting at the low end of the dosing range, reflecting the greater frequency of decreased hepatic, renal, or cardiac function, and of concomitant disease or other drug therapy.

ADVERSE REACTIONS

Adverse Drug Reaction Overview

The clinical safety database included 559 subjects, 391 of whom were exposed to ORAQIX® (Lidocaine and Prilocaine Periodontal Gel) and 168 to placebo gel. In a crossover study, 170 patients exposed to ORAQIX® also received an injection of 2% lidocaine with epinephrine.

The most frequent adverse reactions in clinical trials were local reactions in the oral cavity. The frequency and type of reactions were similar for ORAQIX® and placebo-treatment patients.

The treatment-emergent adverse events observed in three placebo-controlled parallel studies (B1 – B3) are summarized in Table 1.

Table 1: Treatment-Emergent Adverse Events for ORAQIX® in placebo controlled parallel studies (B1 – B3) (≥ 1% and more frequent than placebo)

Adverse Event	ORAQIX® n = 169 (case, %)	Placebo n = 168 (case, %)
Application Site Reaction	25 (15)	20 (12)
Headache	4 (2)	3 (2)
Taste Perversion	4 (2)	1 (1)
Accident and/or Injury	2 (1)	2 (1)
Application Site Edema	2 (1)	1 (1)
Respiratory Infection	2 (1)	0 (0)

Allergic Reactions: In rare cases, local anesthetics have been associated with allergic reactions and in the most severe instances, anaphylactic shock (see WARNINGS AND PRECAUTIONS, Sensitivity, Allergy) Allergic reactions were not reported during clinical studies with ORAQIX®. Very rare cases of anaphylactic or anaphylactoid reactions associated with the use of ORAQIX® have been reported.

For more details on adverse events reported during clinical trials, see ADVERSE REACTIONS in the Supplemental Product Information.

To report a suspected adverse reaction, please contact DENTSPLY Canada Inc. by:
Toll-Free Number: (800) 263-1437
Fax: (905) 851-9809
By regular mail: DENTSPLY Canada Inc.: 161 Vinyl Court, Woodbridge, ON L4L 4A3

Administration

DOSAGE AND ADMINISTRATION

Dosing Considerations

ORAQIX® is for TOPICAL USE ONLY. DO NOT INJECT. ORAQIX® should not be used with standard dental anesthetic syringes. Only use this product with the ORAQIX® Dispenser, which is available from DENTSPLY Canada.

Conditions where dosing may require adjustment:

- In patients who are administered other local anesthetics or amide type local anesthetics (see DRUG INTERACTIONS).
- In elderly patients or those with impaired elimination, dose selection should be cautious, usually starting at the low end of the dosing range to avoid toxicity due to increased blood levels of lidocaine and prilocaine.

Recommended Dose

Typically, one cartridge (1.7 g) or less of ORAQIX® (Lidocaine and Prilocaine Periodontal Gel) will be sufficient for one quadrant of the dentition. The maximum recommended dose of ORAQIX® at one treatment session is five cartridges, i.e. 8.5 g gel containing 212.5 mg lidocaine base and 212.5 mg prilocaine base.

If additional local anesthesia is needed in combination with ORAQIX®, please refer to the product monograph of each adjunctive anesthetic. Because the systemic toxic effects of local anesthetics are additive, it is not recommended to give any further local anesthetics during the same treatment session, if the amount of ORAQIX® administered corresponds to the maximum recommended dose of five cartridges.

The use of ORAQIX® in children and adolescents has not been assessed and therefore its use is not recommended in patients less than 18 years old.

Administration

Apply ORAQIX® on the gingival margin around the selected teeth using the blunt-tipped applicator included in the package, then fill the periodontal pockets with ORAQIX® using the blunt-tipped applicator until the gel becomes visible at the gingival margin.
Wait for 30 seconds before starting treatment. A longer waiting time does not enhance the anesthesia. Anesthetic effect, as assessed by probing of pocket depths, has a duration of approximately 20 minutes (individual overall range 14 - 27 minutes). If the anesthesia starts to wear off, ORAQIX® may be re-applied if needed.

At room temperature ORAQIX® stays liquid; it turns into an elastic gel at body temperature. If it becomes excessively viscous in the cartridge, the cartridge should be placed in a refrigerator until it becomes a liquid again. When in the liquid state, the air bubble visible in the cartridge will move if the cartridge is tilted.

Instructions for application of ORAQIX® using the ORAQIX® Dispenser are provided in the package insert supplied with the ORAQIX® Dispenser.

OVERDOSAGE

For management of a suspected drug overdose, contact your regional Poison Control Centre.

STORAGE AND STABILITY

ORAQIX® (Lidocaine and Prilocaine Periodontal Gel) is a liquid at room temperature and transforms to an elastic gel at body temperature in the periodontal pockets.

Store at room temperature 15° - 30°C.

SPECIAL HANDLING INSTRUCTIONS

DO NOT FREEZE. Some components of ORAQIX® (Lidocaine and Prilocaine Periodontal Gel) may precipitate if cartridges are frozen. Cartridges should not be used if they contain a precipitate.

Do not use dental cartridge warmers with ORAQIX®. The heat will cause the product to gel.

DOSAGE FORMS, COMPOSITION AND PACKAGING

ORAQIX® (Lidocaine and Prilocaine Periodontal Gel) is a microemulsion in which the oil phase is a eutectic mixture of lidocaine and prilocaine base in a ratio of 1:1 by weight. This eutectic mixture has a melting point below room temperature, therefore both local anesthetics exist as liquid oils rather than as crystals. ORAQIX® contains poloxamer excipients, which show reversible temperature-dependent gelation. Together with the lidocaine-prilocaine 1:1 mixture, the poloxamers form a low-viscosity fluid system at room temperature and an elastic gel in the periodontal pocket. ORAQIX® is administered into periodontal pockets, by means of the supplied special applicator. Gelation occurs at body temperature, followed by release of the local anesthetics, lidocaine and prilocaine.

ORAQIX® is supplied in single-use glass dental cartridges that provide 1.7 g gel (42.5 mg of lidocaine and 42.5 mg of prilocaine). Each gram of ORAQIX® contains 25 mg lidocaine base and 25 mg prilocaine base. The gel also contains poloxamer 188 purified, poloxamer 407 purified, hydrochloric acid, and purified water. The pH of ORAQIX® is 7.5-8.0.

Individually blister-packaged cartridges of ORAQIX® are distributed in a carton of 20. Each individual blister package also contains a sterile blunt-tipped applicator. The applicator has a blunt-tip end for ORAQIX® application and a sharp-tip end for piercing the rubber top of the ORAQIX® cartridge. Each blunt-tipped applicator is for single use only. Any unused periodontal gel should be discarded.

Product Monograph is available on request:
DENTSPLY Canada Inc.: 161 Vinyl Court, Woodbridge, ON L4L 4A3

CC Corner: Supporting Professional Development

SAVE THESE DATES!!

1. **April 6, 2013 - Oral Cancer-An Emerging Pandemic? & Communicating with Impact: The Silent Power of A Great Team—Jo-Anne Jones**

   There has never been a greater sense of urgency to adhere to close examination of the oral cavity for early discovery of mucosal abnormalities. The historic etiologic patterns related to exposure to alcohol and tobacco are being challenged by a more recently identified etiology being viral in nature and sexually transmitted. Both the medical and dental communities have been alerted to this emerging pandemic.

   AND Do not ever underestimate the power of a great team and their ability to drive a business to the top. Positive communication and sup-port for one another through day to day challenges and opportunities of working in today's dental practice is key. Through the effective handling of the most common challenges such as last minute cancellations and insurance driven thinking, learn how to re-energize your practice and enjoy your chosen profession.

   - **9:00am to 3:30pm, Western Development Museum, Saskatoon**
   - **Contact the SDAA for registration (306-252-2769)**

2. **May 4, 2013—SDHA AGM and Professional Development Day (See page 1 for more details)**
   - **The Willows, Saskatoon, 9 am to 4pm**
   - SDHA AGM
   - SHIRP Presentation
   - Privacy in Oral Health
   - Trends and Treatment: Esthetics as a Gateway to Oral Health - Mariana Leon

3. **June 1, 2013—Prairie Rhapsody (see details on page 10 or at www.ConEdGroup.com)**

4. **September 19—21, 2013—Saskatchewan Oral Health Professions Conference: Let's Get Engaged**
   - **Evraz Place, Regina**
   - **See brochure included with this newsletter**

SDHA Licenses Lapsed since January 15, 2013

The following list includes those individuals that have allowed their SDHA dental hygiene license to lapse; either through not meeting CCP requirements, not renewing their SDHA license as of January 15, 2013, or through voluntary license cancellation in good standing. The individuals listed below, currently *do not* hold an SDHA dental hygiene license and are not eligible to be practising dental hygiene in SK at this time. If you are knowingly aware of anyone listed below practising dental hygiene, they are doing so illegally . Please contact the SDHA office immediately. Thank you.

Tianna Albrecht
Lyla Rae Andre
Cathy Bevans
Jillian Beyea
Chelsa Blerot
Lisa Boutin
Sandi Boyd
Stefanie Cannella
Kathy Eshghi-Sanati
Danielle Farley
Alexa Forsyth
Andrea Friesen
Paula Gilchrist
Jolene Hillier
Carol Laverdiere
Melinda Lee
Colleen McKennitt
Colleen Nagel
Shannon Nichol
Sharlene Rach
Jasmine Roberts
Connie Robins
Ashley Schlamp
Mohammad Uddin
Binzy Varghese
Evelyn Vermette
Randi Wehr

Become a Peer Tutor !!

The dental hygiene students at SIAST are looking for experienced dental hygienists in the Regina area to be peer tutors. If you have some spare time in the evenings and/or weekends and would like to earn some extra money, please contact SIAST Wascana Campus (Regina) Learning Services, Room 207.12 (library) at 306-775-7729 or email LACwascana@siast.sk.ca.
CCP credits are also granted for tutors.

New eBookstore!

the CDHA eBookstore

Introducing the CDHA eBookstore in partnership with LOGIN Canada.

The CDHA eBookstore is now open! CDHA members save 5% on a multitude of titles, including dental hygiene, pharmacology and so much more! And CDHA benefits from LOGIN Canada at no additional cost to you. To access this special discount and browse thousands of relevant and comprehensive book titles, please visit the new CDHA eBookstore.

Visit
www.cdha.ca/ebookstore

CDHA 2013 National Conference

CELEBRATING OUR ROOTS, OUR WINGS

October 3-5, 2013 - Toronto

- Internationally acclaimed expert presenters
- Celebrating Our Roots…Our Wings with professional networking and special events
- Thursday evening Dance Party and Exhibit Extravaganza
- 50th anniversary Birthday Bash
- Past presidents through the decades discussion panel
- Golden Anniversary Awards Gala

For more information visit **www.cdha.ca/2013conference**

April 7 - 13, 2013

National Dental Hygienists Week™

Oral Health For Total Health!

What is National Dental Hygienists Week™?

The month of April is Oral Health Month and an important part of this celebration is National Dental Hygienists Week™, April 7-13. Focusing on the importance of maintaining good oral health practices and helping Canadians understand the role and importance of the dental hygiene profession, this annual event is sponsored by the Canadian Dental Hygienists Association (CDHA). The week's theme, **"Oral Health for Total Health"** reminds all of us that taking care of our mouth, teeth and gums positively impacts on other aspects of our lives.

Thousands of dental hygienists across the country will come together to celebrate National Dental Hygienists Week™ in diverse and creative ways, with community outreach events, contests, classroom presentations, mall displays, tours of dental offices, and much more!

Check out www.cdha.ca for resources and ideas!