Send your letters to the editor, British Dental Journal, 64 Wimpole Street, London W1G 8YS. E-mail bdj@bda dentistry.org.uk
Priority will be given to letters less than 500 words long. Authors must sign the letter, which may be edited for reasons of space.

Illicit drugs for toothache

Sir,— I read with interest the article by J. Sheridan *et al* (*BDJ* 2001; **192**: 453-457) about self-reported oral health problems by illicit drug users. Actually, I wondered why drug users suffering from extensive dental caries did not seek dental care earlier, and how they controlled toothache.

In our hospital drug-addicts clinic, dental examination and treatment including prosthetic rehabilitation are proposed to the patients attempting a withdrawal programme. Thus, during routine dental examination I asked them whether: 1) they had experienced acute pulpitis, 2) they had taken illicit drugs as an analgesic for toothache, and 3) cannabis smoking had analgesic properties regarding toothache. From April to July 2001, fifty long-term parenteral drug-addicts were examined (12 females, 38 males, mean age 35). All these patients exhibited severe carious destruction with a mean number of 10 missing and 10 decayed teeth. 83.3% of females (10/12) and 89.5% of males (34/38) had experienced at least once acute pulpitis. 25.0% of females (3/12) and 60.5% of males (23/38) reported the use of illicit drugs for their toothache.

For this purpose, the most efficient molecules were intravenous heroin and/or cocaine, locally applied cocaine, and to a lesser extent cannabis smoking. These last two methods were generally combined with one or more licit analgesics such as paracetamol with codeine, ibuprofen and other non steroidal antiflammatory agents. Interestingly, 58.3% of females (7/12) and 47.4% of males (18/38) reported pulpitis induction during cannabis smoking. Perhaps pulpitis could be added to the list of vascular adverse effects linked to cannabis use already reported (conjunctivitis, tachycardia, hypotension, angina pectoris and paroxysmal atrial fibrillation), in patients already suffering from deep cavities. Anyway, this unexpected effect of a substance considered to have analgesic properties deserves attention.

In conclusion, it is likely that the hidden use of illicit drugs for toothache explains why, in Sheridan's study, fewer than 29 % of the drug users experiencing oral health problems had consulted a dentist.

I. Madinier, Nice, France

Stigma knows no bounds

Sir,— It is well recognised that sufferers of mental illness are often stigmatised in their day to day life. Such stigma can be present and affect patients in all walks of life. So significant is this problem that it was acknowledged within the National Service Framework (NSF) as a key area for strategy and action. The Royal College of Psychiatrists has spent thousands of pounds on the anti-stigma 'Changing Minds' campaign, targeting both health professionals and the public. Members of the college and fellow mental health professionals have been tasked with educating and changing attitudes of both our medical colleagues and the public and promoting mental health awareness. It is easy for complacency to slip into day-to-day practice, especially assuming that the main area our patients experience stigma is in the social and not health forum.

A recent experience served to quickly re-awaken me to the fact that stigma remains a very real issue in accessing healthcare services. The South Stockton Community Mental Health Team (CMHT) has a service for patients with chronic and enduring mental health problems, which looks at the whole health of the patient; psychiatric, physical and social. This includes health promotion and encouraging patients to access health screening, primary care services and dentistry, as these are areas often neglected. We actively encourage registration and regular check ups with a dentist; indeed, we are looking to have a local dentist present to the service interest session on the importance of oral health. It was with much dismay therefore when I was involved in the following experience.

One of our patients had attended a local non–NHS dental practice to register and obtain a check-up that was overdue. Worthy of note is that this particular patient is currently well, is highly educated and her interpersonal presentation and interactions are such that she would be taken as you or I. When asked about her medical history she reported that she had a diagnosis of schizophrenia and was on a monthly depot medication. She also reported that her last admission had been January of this year but that she was currently well and under ourselves at the CMHT. The dentist promptly informed her that the practice did not have the facilities to treat her and before being considered for treatment she would need a letter from her GP and psychiatrist.

Understandably our patient was distressed by this and could not comprehend what the problem or difference was in respect of her case to any others, and indeed had we not encouraged her to attend? She subsequently telephoned the CMHT to ask if we could explain what the problem was. The dentist was contacted, and it became evident that she had no appreciable understanding of mental illness and was relying purely on stereotypes of the 'schizophrenic'. The dentist explained her concern that the patient might suddenly become 'unwell' in the surgery, not comply with treatment, and they would be unable to contain the situation. She felt larger premises eg. the health centre, would be more appropriate. Asked why she thought the patient might become ill she could not answer. Asked how the patient had presented she said, 'Well, but she could've just been saying that'. Asked if they would treat any other category of patient in the same manner, a long convoluted answer clearly illustrated not. Asked whether she had any experience of patients with mental illness the answer was no.

The dentist was imparted with some psycho-education about mental health problems and informed how her handling of the case had caused distress. She agreed to re-contact the patient to inform her that she would be happy to treat her and would apologise for any distress caused. She did indeed inform the patient she

would treat her, but did not apologise or acknowledge the unnecessary distress caused. She also declined our invitation to attend one of the well–being sessions to meet other patients which might have helped inform her views.

How can we as professionals expect the general public to be impartial and non-judgemental in their approach to people with mental illness when some among us are still riddled with stereotypes that are imposed upon patients rightly accessing services? How can CMHTs countrywide actively promote health issues such as dentistry when patients come up against this sort of treatment and barriers to care? At what level do we need to tackle the lack of understanding and knowledge that surrounds mental illness and so damages our patients?

I am unaware of what training and teaching, dentistry and other allied medical professions receive in mental health, but this experience from a fairly recently qualified practitioner raises concerns. Medical, dental, and other allied schools/courses are often changing and re-organising the content and structure of teaching programmes, I would suggest that mental health is an area that needs particular attention if we are to improve the experience of our patients.

M. J. Temple, Stockton–on–Tees

Private dentistry pricing

Sir,— I read with interest your editorial regarding the Consumers Association's request to the Office of Fair Trading that they investigate private dentistry pricing (*BDJ* 2001; **191**: 535). While I agree wholeheartedly that 'consumers' should be given an accurate idea of the likely cost ot treatment, how do we ethically differentiate between justifiable costs and over charging? While it is relatively easy to differentiate between an NHS and private denture on technical rather than professional grounds, it is extremely difficult to make a differentiation between, say, root treatment — one practitioner may make do with a quick scrape and a single GP point while another may have invested in the latest imaging equipment, apex locator, NiTi rotary files (and handpiece), ultrasonic canal preparation systems and thermal GP condensing equipment, not to mention the courses to make it all work. All the patient knows is that they have had a root filling and paid privately for it.

At present, we are not in a position to say one is 'better' than the other, but to my mind it all bears as much relevance as the basic cost of the treatment. Perhaps 'league tables' are around the corner, where we have to disclose our success rates for each item of treatment and compare it with national and local averages. In many ways this may be a good thing, but, as we have seen with school and hospital tables, it can lead to all sorts of problems and greater dissatisfaction if you are in the 'losing' team. Being a professional is about trust, honesty and putting the client interests first.

We, along with many other 'professions' have had to compromise over the years, mainly due to financial restrictions imposed by third parties. The real issue here is not simply the cost of treatment but 'value for money' — consumers want to know that they are not being 'ripped off'. The challenge facing the profession is how to communicate this information without it degenerating into a slanging match.

P. S. Mike must know some good plumbers; I have never known one give an estimate and stick to it!

D. Meacher, Anglesey

Mike Grace responds:
I would like to thank David for his letter which raises the issue of quality and over-charging. While this is obviously important I do not think this is what the Consumers Association is mostly concerned about with regard to the content of my leader.

The concern is simply that many professionals (not just dentists) seem very shy about admitting the actual cost to the client/patient. To my mind this is what the issue is about, and I was trying to point out the illogicality that dentists think one way when they are buying (I like to know how much it costs) and when they are selling (I am not so happy about telling people how much it will cost.)

Incidentally, I do have a good plumber!

Questions, questions

Sir,— Being involved with the survey on cavity liners I would like to thank M. R. Yewe-Dyer for completing the questionnaire (*BDJ* 2001; **191**: 595).

The problem with many such surveys is that they are usually carried out by final year students as part of their final BDS examination. Once the BDS hurdle has been overcome the students are subsumed into vocational training and valuable research is never published.

The cavity liner survey has been presented for publication but if the results from the hairline recession survey are known then please advise me as to whether being follicullarly challenged affects my dentistry.

S. A. Bhatti, Crumpsall