

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



Primary dentition

Sir,- It is a matter of profound regret to me that in spite of reading 'Does the dental profession know how to care for the primary dentition?' (*BDJ* 2003, **195**: 301) three times that I remain at a complete loss to understand what is being suggested.

However I am certain of one thing. To suggest that High Street dentists treating the deciduous dentition are at risk if they do not follow BSPD policy in respect of a comprehensive restorative approach because expert specialists in paediatric dentistry think otherwise is totally misleading. The authors go on to suggest that non-intervention is seen by many paediatric specialists as complacency, or at worst, neglect.

Thank goodness neglect is still decided by the courts who allow High Street practitioners treating the primary dentition to be judged by their peers and not by paediatric specialists, or worse still, consultants in Dental Public Health.

E. Gordon
Finchley

The authors of the paper K. M. Milsom, M. Tickle and D. King respond: The main purpose of writing the opinion paper was to call for more high quality research to be undertaken in the field of paediatric dentistry and the authors agree that GDPs are likely to find the BSPD guidelines a somewhat challenging document. In particular the BSPD statement that stainless steel crowns are the 'restoration of choice'¹ for the primary molars with two surface caries is difficult to accept, given the available evidence.

However, in the event of a GDP being challenged over his care of the primary dentition, it is unlikely that a peer of the GDP will be called, but rather it is more likely that a paediatric specialist will be asked to give his/her opinion. The British Society of Paediatric Dentists is very clear what constitutes optimal restorative care and will judge the performance of the GDP accordingly. We have to ask ourselves whether the guidance, produced by specialists in paediatric dentistry is a

reasonable benchmark against which to judge the performance of High Street dentists.

1. Fayle S A, Welbury R R, Roberts J F. British Society of Paediatric Dentistry: a policy document on the management of caries in the primary dentition. *Int J Paediatr Dent* 2001; **11**: 153-7.

doi: 10.1038/sj.bdj.4811147

Sir,- In their article 'Does the dental profession know how to care for the primary dentition?' (*BDJ* 2003, **195**: 301) the authors compare the equally dismal outcomes of care provided by GDS practitioners and paediatric dental specialists. They commend practitioners for their holistic, minimalist approach whereby 80% of decayed teeth exfoliate without causing pain. The more worrying statement is that 48% of children experienced at least one episode of pain – one could hardly call that holistic!

The same edition of the *BDJ* contains the article dealing with professionally applied topical fluorides (*BDJ* 2003, **195**: 313). Strong evidence confirms its effectiveness in reducing smooth surface caries in permanent teeth. Only limited evidence is available to confirm reports that similar benefits are achieved in deciduous teeth. What an indictment of our profession that, after all the years that this simple measure has been available, we are still short of evidence.

Included in the same packaging as this *BDJ* was *Evidence Based Dentistry* containing a summary highlighting the effectiveness of supervised toothbrushing for high caries risk children. (*EBD* 2003, **4**: 49). Why are not more of our salaried services trying this with their high risk groups? While primary prevention should be paramount, with its prescription based on the degree of caries risk for groups and individual children, there remains the problem of the established lesion.

We need a reliable way of arresting these lesions so that affected teeth remain symptom free. In pre-fluoride days this was often achieved with self-cleansing and silver nitrate. Topical fluoride has a satisfactory effect on superficial lesions but does not seem to prevent more

extensive caries progressing to pulpal involvement. Ozone therapy offers promise but let's get on with the research to find the facts.

The debate as to the best approach to caring for the primary dentition is long overdue. The forthcoming changes to the systems for delivering dental services gives a golden opportunity to, at last, put pro-active prevention at the heart of our approach, for the benefit of future cohorts of child patients. There is a third way to be included in the debate.

R. V. Crowley
Birmingham

The authors of the paper K. M. Milsom, M. Tickle and D. King respond: The authors feel that with a success rate of 80%+, GDPs' performance as it applies to the primary dentition can hardly be called dismal. A near identical figure was reported by Levine in a study of unrestored primary teeth¹.

Almost half of the children in the study (48%) experienced dental pain. All of these patients had at least one interproximal lesion in a primary molar tooth and so it is not surprising that a large proportion experienced pain. Perhaps it is more surprising that over half of these high caries patients experienced no pain. We have little information about the severity of the reported pain, however we do know that increased restorative care did not lead to reduced pain experience.

The authors agree that effective, evidence based prevention is the key to the treatment of the primary dentition and fluorides are likely to have a major role to play. The benefit of ozone in dental care is, as yet, unproven and further research is required. We share the view that an evidence based approach to the care of the primary dentition is long overdue. The point of the *BDJ* article is to draw this issue to the attention of the profession and generate a rational debate about how we can improve the evidence base that supports the dental care of the primary dentition.

doi: 10.1038/sj.bdj.4811148

1. Levine R S, Pitts N B, Nugent Z J. The fate of 1587 unrestored carious deciduous teeth: a retrospective general dental practice based study from Northern England. *Br Dent J* 2002; **193**: 99-103.

A lecturer's dilemma

Sir,- As a part of my work, I deliver postgrad management lectures to GDPs throughout the UK. Now I admit that I might have a slight Birmingham accent, that I do try and introduce a little humour into a potentially dreary subject and that I occasionally add some spice with a few poignant one liners.

An evaluation of some delegate appraisal comments revealed; 'Jasper Carrot comes to Bournemouth', 'The least boring lecture I have ever been to' and 'Sexist!! but knows it!'. After all my conscientious preparations should I be pleased or have a big rethink?

D. Thomas
Wolverhampton
doi: 10.1038/sj.bdj.4811149

Acronyms

Sir,- Your plea for 'Readable writing' in Opinion (*BDJ* 2003, **195**: 671) is utterly vitiated by your journal's addiction to incomprehensible acronyms!

G.H. Sperber
Canada
doi: 10.1038/sj.bdj.4811150

Bilateral rotation

Sir,- We would like to share this rare case of bilateral 180° rotation of mandibular first molars. A 30-year-old male was referred to the Department of Periodontics, Faculty of Dental Sciences, King George's Medical University, Lucknow, India, for oral prophylaxis. Our attention was drawn towards his first mandibular molars during the clinical examination, which instead of being in their normal positions, were rotated through 180°.

Both left and right mandibular first molars had normal eruption with five cusps but had three cusps on the lingual side and two cusps on the buccal side i.e. the reverse of what normally is found (Fig 1 and 2). The three cusps on the lingual side included a small cusp resembling a distal cusp, which is normally found on the buccal side of the mandibular first molar. But this small cusp was not present distally, instead it was present in between mesiolingual and distolingual cusps. Similarly the buccal side had two cusps resembling the lingual cusps of a normal molar. The mandibular second premolar of the left side was 90° rotated, the buccal cusp towards the mesial side and the lingual cusps towards the distal side in the arch. The mandibular second premolar of

the right side was about 50° rotated.

There was no recent or past history of trauma or any systemic disorder. Family members of the patient could not be examined since his family resided in Madhya Pradesh state.

On examination, the remaining dentition showed that all the maxillary molars had normal cusp alignment. The maxillary left first molar had decayed due to caries. Crowding in upper and lower anterior teeth was present. There was a cross bite on the left side in the premolar region and the maxillary left lateral incisor was palatally placed.

Though it is fairly common to find teeth rotated through arcs of varying degrees, it is extremely rare to find one rotated round 180°. Some of the rotations of teeth of varying degrees can be explained on the basis of space discrepancy in the arch. But this explanation cannot be extrapolated to 180° rotation of teeth. Moore¹(1953) has attempted to explain the 180° rotation with the so called 'theory of axial gradients'.

Part of this theory suggests that polarity of a cell is determined by its metabolic rate. The pole with the highest metabolic rate develops into the 'head', and other into the 'tail'. According to this theory it can be said that through some 'accidents of nature' the lingual portion of the tooth germ has grown at a faster rate than the buccal portion and thus the lingual portion of the tooth germ developed into the buccal cusp. Thus this case is a rare developmental anomaly and its aetiology needs further explanation.

C. S. Saimbi, A. Jain, S. Verma
India
doi: 10.1038/sj.bdj.4811151

1. Moore W.A. *Dent Dig*, 1953; **59**: 348.



Figure 1



Figure 2