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. Letters should be typed. Authors must sign the letter, which may be edited for reasons of space.

Unusual conditions

Sir, I was most interested to read the case report on the unusual condition of necrotizing sialometaplasia (*BDJ* 2004,**196:**79) and the thorough review of recent literature. In 1985 I reported in the book, *Surgery of the Mouth and Jaws*[1] a rare complication which I had seen of mumps with swelling and necrosis of the palatal glands simulating necrotizing sialometaplasia.

While it is usual for mumps to manifest with bilateral swelling of the parotid salivary glands, it can also involve the maxillary glands or on occasions only one salivary gland is enlarged. Diagnosis can be made by undertaking the S and V antibodies titre.

In this current reported case by Keogh *et al* it may be that only the palatal glands had mumps and necrotizing sialometaplasia. The authors submitted their paper in August 2002 and I wonder if in the interval there has been measurement of the S and V antibodies? I suggest that it would be interesting to pursue this line of investigation if the authors or other dentists discover this condition in another patient.

G. Seward
Bournemouth
doi: 10.1038/sj.bdj.4811495

1. Moore JR (ed). *Surgery of the Mouth and Jaws.* Blackwell Scientific Publications,1985.

The authors of the paper respond: *We would like to thank Professor Seward for his letter and kind comments. In the case reported, a review of the patients notes reveal that she suffered from mumps as a child. However we agree that the investigation of S and V antibodies should be considered by authors in future similar cases.*

The best position

Sir, I was amazed by the paper by Macluskey *et al* (*BDJ* 2004,**196:**225) that only 17% of students ignored the bizarre and archaic teaching in the positioning of the patient. To teach that the patient needs to be nearly upright for extractions reminds me of gunnery officers insisting on standing to attention when firing artillery long after the horses which used to need holding had been consigned to history.

Please put the patient in the best position to see what you are doing – usually nearly flat. The nurse can then see what is going on.

You will have far better control of both the tooth and whatever instrument you are using. The patient will be much better served. The only person who loses out from this is the osteopath!

S. Des Clayes
Herts
doi: 10.1038/sj.bdj.4811496

Learning outcomes

Sir, the article by Clark, Robertson and Harden (*BDJ* 2004, **196:**289-294) was concerned with the specification of learning outcomes in dentistry. In their conclusions the authors referred to the learning outcomes in the General Dental Council's (GDC) document *The First Five Years (TFFY)*[1] in the following terms: 'When they are published they will be readily accommodated within the three circle model...'.

Lest any of your readers might be confused by this statement, we make two points and we write to you as respective chairmen of the Working Groups responsible for drawing up the GDC curricula frameworks concerned in order to dispel any doubts about the existence of, and rationale behind, these documents.

First, the second edition of TFFY was in fact published as long ago as August 2002.

Second, this document brings together (in the fold-out section inside the back cover) the specified learning outcomes under the same twelve domains as are also now listed by Clark *et al*. These domains are grouped into the three essential elements: What the dentist is able to do, How the dentist approaches practice; and The dentist as a professional.

Further, in the final sentence of their article Clark *et al* state that '..defining learning outcomes in the future for the professions complementary to dentistry (PCD) will be made easier by the three circle model'.

Indeed, the GDC has already defined learning outcomes for these professions, modelled on the approach adopted for TFFY and these can be found on the Council's website (Developing the Dental Team)[2]. Publication in hard copy is awaited, though this will not include a similar fold-out section to that in TFFY.

The number of PCD groups involved would make the incorporation of several such inserts a complex matter.

Nevertheless, the example of TFFY is there to be followed for individual PCD groups where this would be helpful.

J. J. Murray
C. J. Smith
London

1. The First Five Years: A Framework for Undergraduate Dental Education. Second Edition. General Dental Council. London August 2002.
2. Developing the Dental Team: Curricula Frameworks for Registrable Qualifications for Professionals Complementary to Dentistry (PCDs). General Dental Council. London 2003.

The authors of the paper respond: *Our paper, which was based on previous work[1], was submitted in May 2002, before the publication of the GDC document* The First Five Years *[2]. This explains the statement to which JJ Murray and CJ Smith refer in their letter.*

However we would like to clarify a misunderstanding in their letter. The three-circle model referred to in our paper is not the same as the twelve-domain medical model that was adopted in the foldout section of the back cover of the GDC's document The First Five Years.

Rather, it is the three-circle model, which was adapted for dentistry from Harden's medical model. Dentistry is a highly technical profession with the majority of patient encounters involving some form of interventive treatment, either therapeutic or operative. The outcomes were, therefore, grouped into eleven domains to more naturally follow the pattern of a patient encounter in the dental setting.

In our recently published 'opinion'

paper, The First Five Years – A framework for Dental Undergraduate Education[3]*, we recognise that the specification of learning outcomes in the second edition of TFFY is a significant advance over the previous edition and the three-circle outcome model used in the appendix of the report presents clearly the Council's view of the curriculum.*

However, we suggest that as more experience is gained with an outcome-based approach to education in dentistry, the GDC may wish, in the future, to modify the framework in the appendix to meet the specific needs in dentistry as described in our paper.

doi: 10.1038/sj.bdj.4811497

1. Clark JD, Robertson LJ, Harden RM, Laidlaw JM, McManus NK. 'On Track' - an educational resource to support dental SHO training Accepted for publication by the *British Dental Journal.*
2. General Dental Council (2002) The First Five Years - A Framework for Undergraduate Dental Education 2nd edition. London, The General Dental Council.
3. Clark JD, Robertson LJ, Harden RM. In our opinion: The First Five Years--A framework for Dental Undergraduate Education. *Br Dent J* 2003 **195**:125.

Drugs for vegetarians

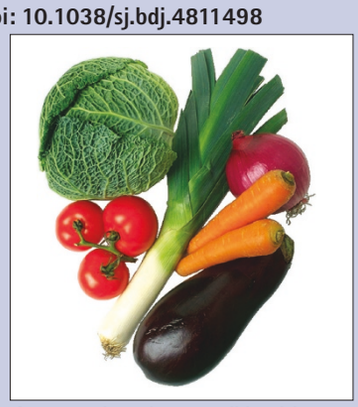
Sir, a 54-year-old strict vegetarian woman presented in general practice complaining of 'weak gums'. On clinical and radiographic examination a diagnosis of advanced generalised chronic periodontitis was made.

As part of her non-surgical periodontal therapy, a course of oral doxycycline was prescribed. On her next visit to the clinic she expressed unhappiness about the prescription because in her own words 'one of the contents of doxycycline is gelatin made from pigs hoofs.'

In view of the multicultural society we live in, I wonder if anybody knows of drugs compatible with vegetarians or indeed religious beliefs in general.

D. Sadoh
By email

doi: 10.1038/sj.bdj.4811498



Are some drugs incompatible with a vegetarian diet?

A clear message?

Sir, having read both the editorial (*BDJ* 2004, **196:**375) and then the review article by Wilson and Banerjee (*BDJ* 2004, **196:**395) it seemed to me that the questions posed by the editor may have some relevance to dentists trying to make sense of occlusion and the retruded contact position.

It is no fault of the authors of the paper that they had to contend with a subject full of contradictory opinions, and also one that has been so badly taught in the UK for so long. However it was their choice.

The reader of the article might have no clear message on how to further the clinical practise of occlusion. Having met many dentists in general practice it is my firm belief that most qualified dentists have no clear notion of how to deal with occlusion, articulators and reorganising an occlusion, and who can blame them either.

In America, those wishing to study occlusion have no shortage of gurus to follow. When you combine the American flair for explanations together with an appetite for excellence at all costs (particularly where a commercial angle can be found), occlusion starts to make sense.

Newer concepts and well-made systems of equipment can truly allow the experienced dentist to begin occlusal registration and conservative treatments.

I notice, as an example, that the review makes no reference to Dr Robert Lee and a lifetime of pioneering work on the subject. I also notice that only in the last page is a fleeting reference to any type of splint therapy made, but with no details. Many contemporary experts in the field of occlusion support the concept of the most superior anterior position of the condyles as a reproducable and comfortably stable position to record.

A temporary deprogramming splint is frequently used to help break neuro muscular attitudes. The Bioesthetic splint is one device I have real experience in using. The MAGO (Maxillary Anterior Guided Orthotic) is just one example of a modern attempt to aid identification and then recording of a stable condylar position. Rather than complain about the shortcomings of a review article, which can do no more than collect a selection of previous publications, I would ask both the editor and the authors what kind of paper would best help dentists really understand more about occlusion.

H. Stean
London

doi: 10.1038/sj.bdj.4811499

No fly zone

Sir, being a relative outsider in the controversial political discussions on the use of conscious sedation (CS) including passive restraint on one hand and general anaesthesia (GA) on the other, it occurs to me that both authors of the recent papers in *BDJ* 2004, **196:**133 are trying to create 'no fly zones' without offering other alternative methods of transport.

Obviously traumatic situations for children due to dental treatment have to be avoided but the other option, general anaesthesia, is further out of reach due to the increased safety rules.

It seems as if the use of a papoose board during sedation and the associated behavioural management has to struggle against the medical benefits or disadvantages of general anaesthesia; impossible since they are incompatible when they should be complementary to each other.

Dr Kupietzky who is advocating the CS routine with passive restraint starts his plea on an evidence-based basis but weakens his points by ending with more emotionally oriented anecdotic reports. Dr Manley writes a more general outline on the UK problems, in an attempt to defend a lost battle.

Believe me, in the Netherlands we have a limited GA capacity and – though not forbidden – we do not use papoose boards. However, following guidelines and the literature, we know that single aversive dental events do not cause long-term dental anxiety unless combined with other child characteristics or subjective reports.

However, sedation, undoubtedly the link between a single treatment and the more extended GA, should not be barred due to unsupported paradigms on wrapping up children. Just like GA cannot be banned because of a sore throat after treatment, it should be rewarded as to its merits with proper indications and treatment protocols.

It is for certain the duty of (amongst others) the American Academy of Paediatric Dentistry to come up with comprehensive research on the efficacy and the long-term benefits on the use of CS including passive restraint.

Though I know the treatment approach was installed long ago before randomised clinical trials became a daily routine, when a treatment is not evaluated continuously the clinicians are often overruled by medical or psychological protocols using their own behavioural criteria to look at the treatment.

The fact that this technique has been available for so long without known

psychological disadvantages should itself have been a reason for supportive research. In the UK a comparable situation has occurred.

Strong and valid medical reasons have changed the regulations on anaesthesia when the dental profession could not solve the disadvantages of this method of treatment. Since anaesthesia is only available in hospital now, GA has become a single event, a trick without supporting behavioural management before, during and after the treatment.

I am not going to re-open an emotional discussion on wrapping up children but we do need passive restraint as part of behaviour management techniques just as we need GA for extensive treatment of patients with very limited capacities. Paediatric dentistry needs treatment strategies of increasing weight for different categories of child dental patients.

When the UK does develop possibilities to increase the use of GA, for instance using short-stay programmes based on anaesthesia with propofol and a laryngeal mask (for example), and the US can prove the long-term benefits of the CS with passive restraint and some mild medical support, then the child will benefit from the best paediatric dentistry can offer next to preventive dentistry.

J. S. J. Veerkamp
Amsterdam
doi: 10.1038/sj.bdj.4811500

Reading list
Berge M ten. *Dental fear in children: prevalence, ethiology and risk factors.* Amsterdam 2001.
Klingberg G, Broberg A. Temperament and child dental fear. *Pediatr Dent* 1998; **20(4):** 237-43.
Locker D, Liddel A, Dempster L, Shapiro D. Age of onset of dental Anxiety. *J Dent Res* 1999; **78(3):** 790-
Locker D, Shapiro D, Liddell A. Negative dental experiences and their relationship to dental anxiety. *Community Dent Health* 1996; **13(2):** 86-92.
Thomson WM, Locker D, Poulton R. Incidence of dental anxiety in young adults in relation to dental treatment experience. *Community Dent Oral Epidemiol* 2000; **28(4):** 289-94.
Townend E, Dimigen G, Fung D. A clinical study of child dental anxiety. *Behav Res Ther* 2000; **38(1):** 31-46.

Hemorrhagic tendencies

Sir, in *BDJ* 2003, **194:**537, the authors have made a statement that infective endocarditis prophylaxis and bleeding tendencies are the most relevant factors in patients with congenital heart disease. However, they do not go into details explaining these bleeding tendencies.

Review of the literature reveals that bleeding in patients with congenital heart disease can be a result of coagulation abnormalities, thrombocytopenia, qualitative platelet defects, accelerated fibrinolysis and disseminated intravascular coagulation[1].

These haematological abnormalities are directly related to the degree of polycythemia observed in such patients[1]. Abnormality in the clotting mechanism can be caused by decrease in the coagulation factors synthesized in the liver, that is vitamin-K dependent factors (factor II, factor V, factor VII factor IX and factor X).

Deficient production of these clotting factors can be explained by decreased synthesis resulting from the hypoxic damage to the liver and from sluggishness of the microcirculation caused by the high blood viscosity[1,2].

Platelets can have quantitative defects like thrombocytopenia or qualitative defects due to defects in the adhesion receptors like glycoprotein Ib that can result in bleeding[3]. In addition, disseminated intravascular coagulation and primary fibrinolysis[1] can also occur in such patients leading to subclinical hemorrhagic tendencies.

Hence there is a need of performing pre-operative haematological screening tests in patients with CCHD to prevent postoperative bleeding by predicting the subclinical hemorrhagic tendencies. A detailed case history, symptoms of CCHD and abnormality in the screening tests like CBC, haematocrit, prothrombin time and activated partial thromboplastin time should alert the dentist of such hemorrhagic tendencies.

A. Auluck
By email

1. Tempe DK, Virmani S. Coagulation abnormality in patients with cyanotic congenital heart disease. *J Cardiothoracic Vasc Anesth* 2002; **16:** 752-756.
2. Goel M, Shome DK, Singh ZN, Bhattacharjee J, Khalil A. Haemostatic changes in children with cyanotic and acyanotic heart disease. *Indian Heart J* 2000; **52:** 559-563.
3. Rinder CS, Gaal D, Student LA, Smith BR. Platelet leukocyte activation and modulation of adhesion receptors in pediatric patients with congenital heart disease undergoing cardiopulmonary bypass. *J Thorac Cardiovasc Surg* 1994,**107(1):** 280-8.

The authors of the paper respond: *We thank the author for their interest in the series on General Medicine and Surgery for Dental Practitioners and for the useful information they have supplied.*

It was always our intention that this series should provide a broad overview of the salient points related to various systems.

The level of detail provided in this correspondence, if extrapolated through the whole series would have undoubtedly significantly lengthened the articles. The level of detail we supplied was never intended to be exhaustive but we hoped to achieve a balanced approach that general dental practitioners would find useful.

doi: 10.1038/sj.bdj.4811501

Incidental finding

Sir, could the following be an incidental finding on radiograph or artefact? This 17-year-old man was referred to us by the accident and emergency department following an alleged assault.

His radiograph (orthopantomogram, Figure 1) showed a non-displaced incomplete fracture of the right mandibular condyle. It showed a supernumery tooth on the right side which seemed to be in the ramus of mandible and a shadow of a molar similar to the supernumery that can be seen in the laft ramus area.

The clinical examination did not reveal any abnormalities. His occlusion was satisfactory. The patient had no sensory deficits. A further radiograph was requested (posterior anterior – mandible) to assess the mandibular injury in a different plane. Due to an administrative error, another radiograph, (orthopantomogram, Figure 2) was taken instead. On the second film, the supernumery is no longer visible, proving that it was only an artefact.

The differential diagnosis of the radiopacity would include a supernumery tooth or odontoma. Therefore, panoramic radiographs may show artefacts.

Y. Z. Zanganah
Worcester
doi: 10.1038/sj.bdj.4811502

1. Morrel IC, MacDonald-Jankowski D. An extra molar?: An unusual artefact produced on a panoramic radiograph. *Proc Br Soc Dent Maxillofac Radiol* 1994;**(6):**50-2.

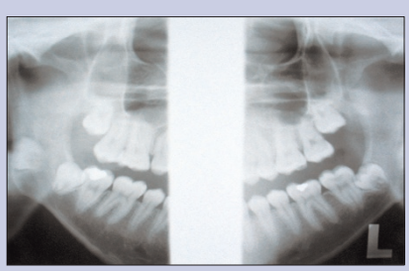


Figure 1

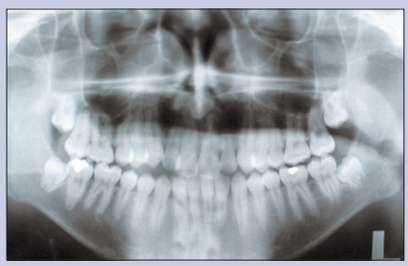


Figure 2

Clinical techniques

Sir, a response, if I may, regarding the Review of Clinical Techniques article in *BDJ* 2004, **196:**395. The authors have made great strides in describing many of the techniques involved in determining a posterior border position of mandibular movement as originally described by Posselt more than 50 years ago.

The introduction promises to consider its importance. My question is this; unless I am mistaken, the reason given for its importance is reproducibility. So is twisting someone's arm behind them, which may be reproducible, but is not comfortable, nor is it a physiologic position. Indeed the authors very fairly described its lack of long term stability, which would be important in restorative dentistry, especially since many of the the public find maleable metals unacceptable, as they were the materials which were forgiving of this instability.

The mechanical methods described, from a mechanical and not necessarily physiologic viewpoint, were well researched, the descripiton of the myomonitor, however, were incorrect.

The myomonitor has never been able to provide the RCP, unless it is misused and a mechanical (shove) added. As mentioned some proponents may suggest that 'jaw-closer' muscles act simultaneously, via reflex contraction, to produce a reproducible retruded mandibular position, but alas they would not be correct, this according to the makers of the instrumentation. I would be happy to provide a short article to explain its use (and abuse) in clinical practice if so wished.

S. Bray
By email
doi: 10.1038/sj.bdj.4811503

Editorial policy

Sir, I wish to challenge as I hope will others, your editorial policy for the *British Dental Journal* (*BDJ* 2004, **196:**511). It is hardly the duty/job of the editorship of the *BDJ* to stifle and censor dental opinion by not printing suitable articles, which may later be misinterpreted and used by the popular press. Surely, it is for the editorship of the popular press to be answerable for what they publish as Piers Morgan of the *Daily Mirror* has learned to his cost.

Surely the purpose of the *BDJ* is to inform its readership of appropriate current research, audit and opinion relevant to the dental profession, irrespective of how it may be perceived elsewhere. Once a paper is published (albeit having previously gone through a selection process of some kind) and is later found to be wanting, the fact that it was published and opened to criticism could increase knowledge and understanding. Surely this should be *BDJ* policy. It is after all a subscription-only professional journal.

Do I detect a hint of fear of personal criticism in what you might publish, especially in the light of *The Lancet* and the MMR scandal? Is it not your duty/job to publish for debate contentious issues? Should it not now be that the BDA Representative Board especially in view of your editorial openly debates this policy?

Is this letter to be censored by the editorship for fear it is too contentious? So many questions that all need answers.

G. D. Wood
By email
doi: 10.1038/sj.bdj.4811504

Non-payment

Sir, having been ignominiously removed from the Dentists Register or as the press might put it 'struck off' for non payment of my precious £388, may I join the furore and bring up yet another consequence of no longer being 'on the Register'?

For 42 years I have served on just about every dental committee that there is in this part of the world, and have been Chairperson of most, together with being a member of assorted other organisations such as the BDA, the Faculty of GDPs and the Glasgow Odontological Society to name but a few. I do not have access to the constitutions of these illustrious bodies but I would be fairly certain that the words 'membership is open to Registered Dental Practitioners' figure somewhere therein. Having written in January to the secretariat of two of the above to clarify the position of continuing membership following upon non registration, but not having received a reply, can I assume that the action of GDC has introduced another, but not thought of dilemma?

I refer of course to the loss of the previously quoted figure of a thousand or so from the register and the associated loss of revenue from membership fees to dental groups and societies all over the globe, should membership be denied to non-dentists. It is reported in the press that the UK has fewer dentists than any other country in Europe. Could it be that this sudden discovery is brought about by the removal from the register of we unwanted stalwarts of the hey days of the NHS who spent our entire working lives saving the dental health of Britain for a financial pittance?

G. Webster
Ayr
doi: 10.1038/sj.bdj.4811505