COMMENT

# Letters to the editor

Send your letters to the Editor, *British Dental Journal*, 64 Wimpole Street, London, W1G 8YS. Email 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.

## Special care dentistry

### Frailty scale

Sir, the challenges that the ageing population will present to the dental profession have long been forecasted and the word 'frail' is often bandied about. But what does this word mean? The British Geriatrics Society define frailty as 'a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves'.[1] Do we eyeball a person and say they are frail? Is it a binary decision: frail/not frail?

In my search for answers, I came across the Rockwood Clinical Frailty Scale[2] (Fig. 1) which is widely used in geriatric medicine on a global level. Clinical descriptors and pictographs allow clinicians to recognise and quantify frailty.

The Clinical Frailty Scale is validated, quick to apply and avoids bias. The tool can particularly help newly-qualified clinicians to evaluate the risk/benefits of treatment options and justify their clinical decision-making. Recording a frailty score in patient notes could also be used in defence of 'supervised neglect'.

Dental treatment planning for the ageing population can be complex and sometimes the decision between radical anticipatory care or the carefully-considered option of not treating disease is a grey area. The Clinical Frailty Scale provides a reminder of the heterogeneity of ageing. It's not a panacea to treatment planning for the ageing population – but it's another tool to have in the toolkit when dealing with complexity.

*M. Young, Tayside, UK*


### References

1. British Geriatrics Society. Introduction to Frailty, Fit for Frailty Part 1. 2014. Available at: https://www.bgs.org.uk/resources/introduction-to-frailty (accessed October 2019).
2. The 9-point Clinical Frailty Scale was adapted from the 7-point scale used in the Canadian Study of Health and Aging (*CMAJ* 2005; **173:** 489-495) and has been reprinted with the permission of The Geriatric Medicine Research, Dalhousie University, Halifax, Nova Scotia.


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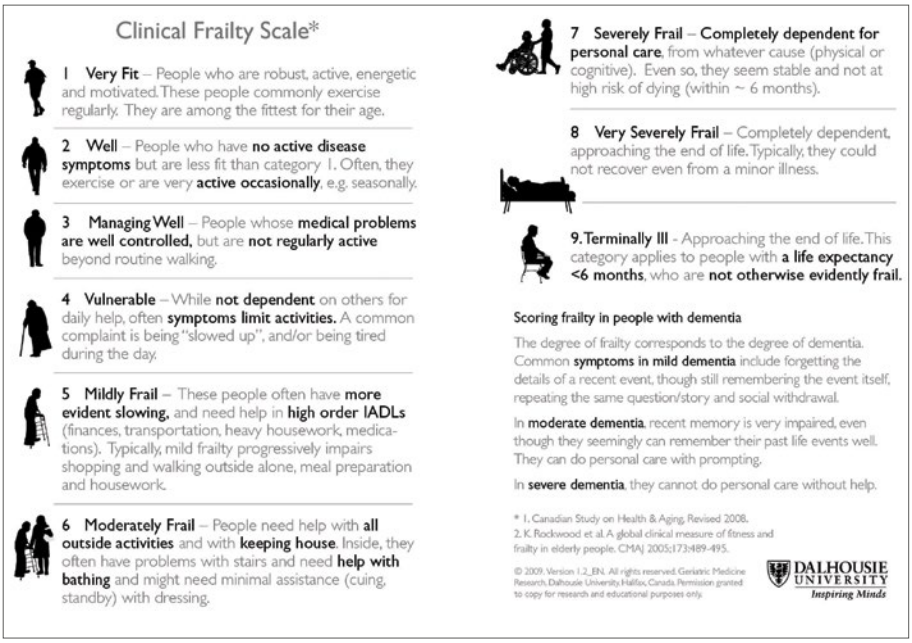


Fig. 1 The Rockwood Clinical Frailty Scale.[2] Reprinted with the permission of The Geriatric Medicine Research, Dalhousie University, Halifax, Nova Scotia

## Green dentistry

### Throwing out the baby...

Sir, I write further to a recent letter published in the *BDJ* on 'Green dentistry: Single use plastic' (2019; **227:** 327).

Having been employed in the dental profession for some decades I was somewhat amused by the comments regarding the ways in which plastic can be reduced within the dental industry. How many practitioners still remember the glass (autoclavable) dapons pots, glass mouth rinse beakers and metal aspirator tips? These items are still in use in some practices if you look hard enough. I feel that we have in recent decades, along with many others, denegrated the 'old' ways in the belief that 'new' is always better. Within this thought I must also urge the dental chair/unit manufacturers to review aspects of the modern dental chair. How many times within a single appointment is an operator compelled to alter the position of the operating light? Compare the modern lighting to the old, large mirror edged operating lights of half a century ago. How often was it necessary to adjust their angles? Could not manufacturers produce a light with the illumination of the modern bulb with the light arc of the old? With such a fast changing profession, I feel we are sometimes at risk of throwing out the baby with the bath water.

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## Emergency dentistry

### Tongue trapped in lid

Sir, a non-verbal, 28-year-old gentleman with autism and severe learning difficulties presented at the Ipswich accident and emergency department (ED), with his tongue trapped in the lumen of the lid of a re-usable plastic drinking bottle. The patient attended with two carers. They had attempted to remove the bottle by unscrewing it from the

Fig. 1 The engorged tongue trapped in a drinking bottle lid

lid. The patient's medical history revealed he was taking Carbamazepine and Diazepam. By the time he arrived the tongue had been trapped for approximately four hours. He was clearly in a significant amount of pain and was showing signs of distress. The anterior third of the tongue was severely engorged. It was firm to touch and showed signs of necrosis (Fig. 1). It was impossible to remove the bottle lid manually.

In order to prevent potential loss of the anterior third of the tongue, the lid needed to be removed urgently. Due to the patient's poor compliance, this could only be performed under a general anaesthetic. Access to the airway was restricted because of the large foreign body and this made bag mask ventilation and oral endotracheal intubation challenging. Therefore, preparation was made to perform a tracheostomy. Fortunately, the anaesthetic team were able to secure a nasotracheal airway, via an awake fibre optic intubation, with the assistance of ketamine.

Initial attempts to remove the bottle lid with orthopaedic wire cutters were unsuccessful due to the density of the plastic. The lid of the bottle was drilled through with a fissure bur attached to a surgical dental drill (Fig. 2). A Howarth's periosteal elevator was placed between the tongue and the bore of the lumen throughout to protect the tongue. On removal of the lid, the swelling from the anterior aspect spread posteriorly to the oropharynx. The patient was given two doses of Dexamethasone IV, peri-operatively and six hours later. Due to airway concerns, the patient was kept intubated in ITU for 12 hours. After this time, the swelling had reduced significantly so the patient could be safely extubated. He was discharged home the same day and had no subsequent complications.

Fig. 2 The lid of the bottle after it had been drilled through with a fissure bur attached to a surgical dental drill

Tongue entrapment within a lumen of a bottle is caused when a vacuum is created because the tongue remains in the lumen for too long. The vacuum is formed because the patient places their tongue inside and starts to 'play with' the inside of the bottle, sucking the air out. Once the vacuum has formed, the tongue can then become oedematous and the lid will subsequently strangulate the tongue. If the lid is not removed quickly, venous return is impaired leading to further oedema and, on rare occasions, ischaemia or necrosis.

There are other cases in the literature concerning mostly children and alternative methods for removal have been described. Most of the previous cases involved metal or glass bottles. The authors would like to draw attention to this case as incidents are likely to increase as more plastic reusable bottles are used.

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