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Dental public health

Supervised brushing/parenting

Sir, whilst agreeing with Sharif Islam¹ wholeheartedly that logically it should be the role of parents to socialise their children, the simple fact is that parents don't. Nurseries, playgroups and other pre-school groups have been reported in the press as commenting and complaining about having to change nappies for untrained children, encourage or teach children to eat with utensils, and show them how to put on shoes and other clothing. It is not surprising therefore that basic oral hygiene procedures may also be neglected.

However, bearing in mind the considerable financial, resource, and psychological burden of dental disease in children, and the responsibility of governments to act for their populations, some action is required. Water fluoridation, the most cost-effective route to reducing decay, appears to be stagnating. Other methods need to be sought.

The York Health Economics Consortium published a rapid review of evidence on the cost-effectiveness of interventions to improve the oral health of children aged 0–5 years in 2016.²

The results were summarised by Public Health England³ including an infographic (Fig. 1) summarising the return on an initial investment of £1. After water fluoridation and targeted provision of toothbrushes and pastes by health visitors, targeted supervised toothbrushing came third with a return of 366%.

The stated aim of health promotion is to enable people to be responsible for and have control over their health (and that of their children). Capabilities, opportunities, and motivations are given as the basic conditions for adopting appropriate behaviours. But as this appears not to be working in practice, surely it is the duty of government to do whatever it can, if only to reduce the financial burden on us, you and me who pay for the health service, and reduce the suffering of innocent children.

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Dental trauma

CDSTs for traumatic dental injuries

Sir, I read with interest the recent case report in the *BDJ* entitled 'Incorrect re-implantation following avulsion'.¹

The author mentions the importance of appropriate assessment and attention to detail particularly in high stress situations, with the aim being to maximise the chances of successful outcomes.¹

One such method to utilise, which has an evidence base, is clinical decision support tools (CDSTs). This is of particular importance since it is not always specialists who happen to attend cases of dental trauma on their first presentation.

There is evidence in the literature to support the fact that CDSTs aid in improving the diagnosis as well as management of dental trauma by expert paediatric dentists and novice clinicians/dental as well as medical students.^{2,3}

These CDSTs may be utilised in different forms such as a print version or mobile app version.^{2,3} Adopting a pathway for decision making in traumatic dental injury scenarios, the utilisation of CDSTs may assist in enhancing outcomes.

The ToothSOS app created by the IADT is free to download on the Apple App Store (iOS) and is meant to provide information to both professionals and patients. It includes information for dental practitioners on treatment guidelines as well as that on prevention and emergency management of dental injuries.⁴

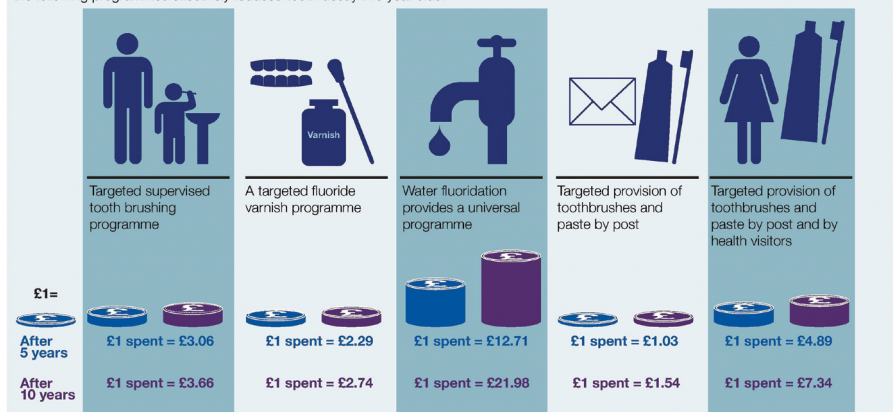
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Reviews of clinical effectiveness by NICE (PH55) and PHE (Commissioning Better Oral Health for Children and Young People, 2014) have found that the following programmes effectively reduced tooth decay in 5 year olds:



*All targeted programmes modelled on population decayed, missing or filled teeth (dmft) index of 2, and universal programme on dmft for England of 0.8. The modelling has used the PHE Return on Investment Tool for oral health interventions (PHE, 2016). The best available evidence has been used in this tool and where assumptions are made these have been clearly stated
PHE Publications gateway number: 2016321

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Fig. 1 Comparison of cost efficiencies of oral health promotion interventions (Image courtesy of Public Health England. ©Crown copyright 2016, under the Open Government Licence v3.0)