Letters to the Editor

Send your letters to the Editor,
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Priority will be given to letters less than 500 words long.
Authors must sign the letter, which may be edited for reasons of space.

QUINTESSENTIALLY WRONG

Sir, I read with interest the recent series of articles on the GDC. The final paragraph of the instalment (*BDJ* 2008; **205:** 153-155) was possibly one of the most important and perhaps bravest in the whole series, inviting the reader to consider whether, if the GDC didn't exist, would we have to invent it? The opinion submission in the article was a positive one that we would, but I wonder...

If John Tomes and the separatists hadn't moved dentists away from mainstream medicine then we would probably now be a speciality within medicine with its own sub-specialties and looked after by the General Medical Council (GMC). In the list of functions of the GDC given in the series, I wondered how any was different to the current functions of the GMC on behalf of the patients and professionals within any other medical speciality in contemporary healthcare? This I feel is a valid question and comparison espcially as we almost inevitably follow templates, mandates and protocols set through the GMC for the wider medical profession.

The GDC states 'whilst it is universally acknowledged that dentists subscribe fully to the core values of the doctor, certain features of the practice of dentistry have ensured that the identity of a separate profession has been maintained'.[1] Really? These 'features' are nowhere defined. Can they mean perhaps the iniquitous NHS patient charges that inexplicably apply to oral healthcare but no other part of the person; if not, then what? It's not really part of mainstream healthcare, but some sort of indefinable add-on? Not a 'medical' doctor/surgeon, but certainly expected to behave as one, be a sort of specialist and work alongside colleagues of all specialities especially in hospital trauma departments, the armed forces, reconstructive and restorative practice etc etc? A frankly ludicrous thesis.

Does it make much sense to train dentists as a specific profession (not speciality) through the medium of a parallel training programme? If we were asked today to set up training programmes from scratch for medical professionals to manage specific areas such as obstetrics and gynaecology, radiology, dermatology, dentistry and so forth, I do not think we would do so for each of them and their sub-specialties as entirely separate professions. Yet this is what has been done and continues for dentistry and oral healthcare. The GDC are of course not the cause of the above, but a product of the circumstances.

There is a far from clear mandate for the longevity of the GDC. Were in due course such changes as above to be made, the role of a GDC would be unclear and the validation process for its continuity should then be pan-professionally rigorous and lengthy in the interests of both patients and dentists. Having now been a registrant for more than 44 years in many areas of healthcare I have been privileged to experience much of what is inspiring in oral healthcare. The pathway we have taken nevertheless seems quintessentially wrong. Eventually, perhaps we will see fewer numbers of a new breed of dentist, more therapists and the mouth put back into the body.

K. Marshall
By email

1. General Dental Council. *The first five years – a framework for undergraduate dental education.* London: General Dental Council, 2004.

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PROPRIETARY PRODUCTS

Sir, as the author of the abstract referred to by Dr J. A. Speechley (*BDJ* 2008; **205:** 168), I was interested in her comments. However, I have misgivings over her reference to a proprietary substance, which I accept she made in good faith. A search of several medical databases and of the internet yielded no information on the composition of this product or any clinical studies with it.

Some years ago, the former editor of the *BDJ* asked for my advice on a letter to the journal from a practitioner describing the use of another proprietary product. I advised that the account had certain shortcomings. However, the editor also contacted the practitioner, who stated that the letter had been instigated by the maker of the product in question.

I feel it would be wise to ban all references to proprietary products from the letter pages of the journal. It would otherwise be possible, for instance, for an unscrupulous manufacturer to claim that a product had been 'recommended in the *British Dental Journal*', without mentioning how this had occurred, and notwithstanding the disclaimer of the editor and the BDA on the title page.

T. L. P. Watts, London

Editor-in-Chief's note: I thank Trevor for his letter and respect his thoughts as a recently-retired and long serving 'abstractor' for the BDJ*, whose work has been much appreciated by colleagues and readers over many years. Mention of products in any content of the journal is covered, as Trevor observes, by the disclaimer, which is a standard publishing element. Of course this will not stop the unscrupulous but it does act as a significant deterrent and also provides the muscle*

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to any subsequent action we, or the considerable might of publishing partner Nature, might wish to apply.

On this occasion I thought that the mention was justified by the impressive results that the author of the letter described, especially in the particularly challenging setting of a women's prison. Of course, as with many techniques and materials used in our profession, it may only work in the hands of a particular individual. However, on balance, I thought that sharing the experience of this reader and the potential benefit to patient care outweighed concerns over mentioning a specific product. In the final analysis it is for the individual clinician to decide what and what not to use for the benefit of her or his patients. I find the notion of banning things potentially fraught with restrictive difficulties, as there are always exceptions to the rule. I have previously removed product references before publishing letters and other journal content and will continue to apply such judgement to the best of my ability.

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SEXUAL HISTORY

Sir, amongst the wide range of aetiologic factors implicated in glossodynia or burning mouth syndrome (BMS) are hematologic or vitamin deficiencies, denture factors, endocrinological disorders and psychological factors – such as anxiety, depression and phobias, though depression has been discounted by some.[1,2] BMS typically affects older women,[1,2] and very occasionally has been recorded in them as a delusion of having AIDS.[3] We encountered a young adult male patient with BMS and, suspecting that there might have been concern on his part as to a sexually transmitted infection (STI), pursued a history in that direction, eliciting that the BMS appeared to have been triggered by 'lap dancing' (sometimes termed 'exotic dancing').

A series of six patients with a similar history were seen over the subsequent two years (see Table 1). All were young adult males, non-smokers, with no serious medical history, and all had had brief oral contact with lap dancers, mostly kissing the mouth or breast.

Concern about contracting STIs increased with the appearance of HIV/AIDS and many have adopted strategies to avoid these,[4] but concern may persist and can even be delusional.[5] There is very little scientific literature on lap dancing but it is clear from the internet that bodily and even sexual contact may be involved and can give rise to anxiety about STIs, since several websites contain questions relating to this, and a number specifically mention burning of the tongue or mouth. Whether other factors, such as contact with perfumes or oils, might play a role, remains unclear. It would seem reasonable therefore, for the history in some patients with BMS to tactfully include the question of sexual history.

C. Scully CBE
By email

1. Barker K E, Savage N W. Burning mouth syndrome: an update on recent findings. *Aust Dent J* 2005; **50:** 220-223.
2. Ott G, Ott C. Glossodynia – psychodynamic basis and results of psychopathometric investigations. *J Psychosom Res* 1992; **36:** 677-686.
3. Lewis M A, Jagger R G. Delusion of having AIDS. *Br Dent J* 1993; **175:** 278-279.
4. Donovan B, Ross M W. Preventing HIV: determinants of sexual behaviour. *Lancet* 2000; **355:** 1897-1901.
5. Mahorney S L, Cavenar J O Jr. A new and timely delusion; the complaint of having AIDS. *Am J Psychiatry* 1988; **145:** 1130-1132.

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BEAT THAT

Sir, on a more lighthearted note than the usual correspondence I would like to claim a record, but of course would be delighted to learn that a colleague could better this.

Patient	Birth date	Occupation	Main complaint	Other oral complaints	Prior treatment	Trigger	Medical history	Tobacco use	Stated sexual preference	Examination findings	Other comments	Progress
1	1965	Computer programmer	Burning tongue	Green coating	Amphotericin	Lap dance 1 year	-	No	Heterosexual	-		Declined serology
2	1968	Physicist	Burning tongue	Sore lips, coated tongue, gingival tingling, dryness	Miconazole	Lap dance 1 month	Allergy to penicillin and septrin	No	Heterosexual	Ankyloglossia, fluorosis, tetracycline stain	No letters to be sent home or to GP or GDP	Declined serology
3	1957	Journalist	Burning tongue	White coated tongue	Penicillin, amphotericin, ciprofloxacin, nystatin, fluoxetine, vitamin B	Lap dance 3 months	GGT and AST raised: admitted alcoholism. Anxiety, asthma, allergy to cats and feathers	No	Heterosexual	Erythema migrans	Multiple consultations	Repeated HIV tests
4	1970	Marketing strategist	Burning tongue	White coated tongue	-	Stag night orgy and lap dance 6 months	Penicillin allergy	No	Heterosexual	Torus mandibularis	Multiple consultations	Declined serology
5	1951	Historian	Burning tongue	Dry mouth, bad taste	-	Lap dance on several occasions	Post-traumatic arthritis	Virtually none	Heterosexual	Pronounced linea albae		Previous HIV serology negative
6	1961	Teacher	Burning tongue	Coated tongue	Amphotericin	1 month after lap dance	-	No	Heterosexual	Leucoedema	Multiple consultations	

Table 1 Details of six cases of burning mouth syndrome apparently triggered by lap dancing

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I qualified in June 1956 at Birmingham Dental School and am still in practice one halfday a week. I have the privilege to regularly see a patient (my ex-wife) who first came to see me when I was a student just starting clinical work in 1953.

She has been attending virtually without a break every six months for the last 55 years. Her dental condition is excellent with no periodontal problems or caries.

She still has about a dozen single and two-surface gold inlays that I produced in my student days. Due largely to her own care and attention they look as good as the day they were inserted. Beat that!

W. R. Field
Dorset
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CONTINUING CONCERNS

Sir, firstly, many congratulations on the fascinating counterbalance you have managed to achieve between the recent online publication *A patient notification exercise following infection control failures in a dental surgery* (*BDJ* 2008; **205:** E8), the review commentary from Millership, Irwin and Cummins, and your own insightful summary (*BDJ* 2008; **205:** 194-195).

Serving, as it does, over 70% of UK dentists and over 50,000 dental health professionals worldwide, Dental Protection is well placed to appreciate both sides of this story, and we have fought to protect the rights of infected healthcare workers in many countries over many years – including the UK case of H (a Healthcare Worker) *vs* Associated Newspapers Ltd, which confirmed a healthcare professional's right to confidentiality as a professional, as a citizen and not least as a patient.

We can well understand the public health dilemma faced by those whose role it is to protect the public against transmissible disease. Many of these public health consultants are also members of this organisation. We also invest a great deal of time, money and effort in encouraging our members to maintain high standards of infection control, and we too take patient safety very seriously.

When confronted with suggestions of poor infection control practices, and/or a clinician who is known to be infected, there is an undeniable weight of public perception to deal with. These judgements are not easy. The cost of patient notification exercises (PNEs) is high in both financial and operational terms, as well as in terms of the stress and anxiety caused for those patients who are contacted and screened but later found not to have become infected by a transmission from the clinician in question. But as one meticulously-conducted and wide-ranging PNE after another demonstrates the absence of any transmission – even from healthcare professionals where all the main risk factors are present – there are continuing concerns that the costs we are all counting are not those of public safety at all, but those of research. The unpalatable reality is that many past PNEs were not based on evidence, but searching for it.

It is suggested that the day may be fast-approaching when the healthcare worker would be required to personally fund the PNE that they have 'caused'. If this were to be the case, then Trusts and individual public health consultants could similarly find themselves in the courts, facing huge claims for lost careers, massively reduced practice values, and stress and subsequently unnecessary anxiety caused to individual patients who are included in a PNE which subsequently reveals no transmission.

It is true – as stated in the commentary which appeared alongside this article – that the risk of transmission (though small) does still exist, but with each additional PNE that yields no demonstration of any transmission, despite meticulous science and diligent application, the evidence is growing to make such litigation a realistic prospect and any 'public interest' and 'public safety' defence will need hard evidence to support it. Another factor, surely, to place in the 'mix' of the suggested debate on this important subject?

In this same context of PNEs, I would also suggest that we should consider the implications of most of dentistry being categorised as 'exposure prone procedures' especially in respect of dentists with HIV.

K. J. Lewis
Dental Director
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