

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.

Readers may now comment on letters via the BDJ website (www.bdj.co.uk). A 'Readers' Comments' section appears at the end of the full text of each letter online.

TWO SIDES TO THE STORY

Sir, as a member of the British Association for the Study of Community Dentistry (BASCD) I was surprised to read in the *BDJ* that a letter¹ had been sent on my behalf to the Secretary of State for Health stating that 'BASCD is formally opposed to the Bill' and listing 'three points to be addressed at minimum'.

It is unfortunate for the reputation of a scientific association that the positives for dentistry in the Bill were not itemised. For the record these include:

- Public Health Outcomes Framework, measure of decay in 5-year-olds, means that Local Authorities will be monitored on this with respect to their public health responsibilities
- The entirety of dental commissioning (both primary and secondary) in one place (ie NHSCB)
- Single operating framework enables consistent approach to commissioning dentistry
- Dental local professional networks which enables local sensitivity and a responsible professional input to discussions.

There are always two sides to any story: that even includes the NHS Health Reform Bill!

M. Seward DBE
By email

1. Robinson P G. Open letter. *Br Dent J* 2012; 212: 205.

DOI: 10.1038/sj.bdj.2012.319

UNDIAGNOSED TEMPORAL ARTERITIS

Sir, dental surgeons may be the first health care professional to which a patient with undiagnosed temporal arteritis may present.



Fig. 1 Patients often present with a palpable, thickened and tender temporal artery (marked on this patient)

Although the classical presentation of this condition is with temporal headache and tenderness with associated systemic symptoms, atypical facial pain may also be a feature.

As maxillofacial surgeons, we are often involved in the investigation of temporal arteritis by performing temporal artery biopsy.

In our clinical practice, we have seen several cases initially presenting with atypical facial pain from presumed maxillary teeth, and these patients had primarily visited their dentist.

It is often the high risk cases with impending ischaemic complications that frequently have significant orofacial pain resulting from jaw or tongue claudication. In a recent review of 390 reported cases from 81 studies, 31% presented with a history of jaw claudication and pain.¹

As an acute vasculitis, ciliary and retinal arteries may also be affected, a delay in diagnosis can lead to acute blindness which can occur in up to 20% of patients.

For this reason, dental surgeons should have a high index of suspicion and consider this in their differential diagnosis in the older patient presenting with facial pain, particularly with tenderness

over the temporal region.² Prompt referral is indicated in these cases.

C. J. Mannion, R. Greenhalgh, Hull
N. Shah, York

1. Sheldon C A, White V A, Holland S P. Giant cell arteritis presenting with bilateral loss of vision and jaw pain: reminder of a potentially devastating condition. *J Can Dent Assoc* 2011; 77: b55.
2. Scully C, Felix D H. Oral medicine – update for the dental practitioner orofacial pain. *Br Dent J* 2006; 200: 75–83.

DOI: 10.1038/sj.bdj.2012.320

NO TO DIRECT ACCESS

Sir, I am writing with a petition of signatures from myself and my fellow young dentists of the South Yorkshire deanery. We are writing to express our concern at the proposal of direct access for dental patients to be seen and assessed by dental hygienists and therapists.

Whilst we recognise the utilisation of dental care professionals in our practice, we are concerned that the introduction of direct access would not be in the best interests of patients. Therapists and hygienists have a considerably shorter professional education than dental surgeons and as a result, it is rightly deemed as beyond their competency to diagnose dental conditions. As well as this, dental surgeons are often the health professional patients see most frequently, so we are relied upon to diagnose oral conditions such as oral cancer and mucosal disorders. Surely giving non-suitably trained professionals responsibility to diagnose such conditions is bordering upon neglecting patients' rights to proper treatment?

As well as this issue of competence there is also an issue highlighted in the *BDJ* (*Direct line lack of assurance*; *BDJ* 2012; 212: 53) that the public perception

is such that many people are unaware of the differences between different dental professionals and their roles. To change this would add further confusion. It is unacceptable to place the public in a situation where their capacity to provide informed consent is impaired due to not knowing by whom they are being treated and what their role is.

To blur the distinction between different dental professions would be an irresponsible move that would negatively influence the practice of dentistry in this country and would not benefit patients in any way.

A. C. L. Holden

By email

DOI: 10.1038/sj.bdj.2012.321

A FASCINATING INSIGHT

Sir, the authors of *Contemporary dental practice in the UK in 2008* (BDJ 2012; 212: 63-67) offer a fascinating insight into some key aspects of general practice and speculate on why there appears to be a 'gulf' between what is taught to undergraduates in dental school and what is practised on the high street.

There are of course a number of reasons why evidence-based practice has not found its way into the mouths of general practice patients including time constraints (real or perceived) of the remuneration system, habit, resistance to change, costs to the patient and a lack of knowledge or engagement with CPD other than that obtained online.

The real message should be: whatever the cause of the gulf, undergraduates should be prepared for their DF1 year. Teaching the use of composites for example, almost to the exclusion of understanding that amalgam is used widely in practice (75% for permanent molars according to the study), is a disservice to this generation of students. Knowing how to build marginal ridges in amalgam, undercutting existing amalgams to repair broken molar cusps and dare I say it, knowing that sometimes, just occasionally, a well placed pin is not the slippery slope to the devil's lair, is something all undergraduates would benefit from before facing the realities of an NHS practice in an inner city area.

L. D'Cruz, Woodford Green

DOI: 10.1038/sj.bdj.2012.322

DEVASTATING DENTIFRICES

Sir, a patient aged 20 years reported to the Department of Periodontology with the chief complaint of sensitivity to hot and cold food. On examination, abrasion was noted on the facial surfaces of the canines and premolars of all four quadrants of the mouth being more pronounced on the incisal third and middle third of the crowns (Fig. 1), a few of which were tender to percussion due to pulpal involvement.



Fig. 1 Abrasion due to tobacco based tooth powder



Fig. 2 Tobacco-based toothpowder (Nirala Manjan)

The patient gave a history of brushing twice daily using a tooth powder (Nirala, a tobacco-based dentifrice) for two years. He was advised to stop using the dentifrice, instructed in tooth brushing technique and referred for endodontic and restorative treatment.

Nirala manjan (Nirala tooth powder) (Fig. 2) is available in some parts of northern India. The dentifrice (which also smells like tobacco) claims to contain tobacco dust, clove, black spice, geru powder (a red brown powder used for topical application in ayurvedic medicines), dried ginger powder and salt. Use of tobacco in toothpastes and tooth powder was banned by the Indian government in 1992 and the ban upheld by the highest court of the land.¹ However, use of these dentifrices (under different trade names) still continues,

especially among rural and uneducated populations.² Ill-effects caused include oral cancer, oral mucosal lesions, caries, periodontal disease, impaired healing after periodontal treatment and gingival recession.³ Usually, abrasives make up approximately 50% of any toothpaste but the abrasiveness of Nirala must be far higher than required resulting in severe destruction of the hard tissues in the short span of two years.

We feel that the war against tobacco-based dentifrices could be won more by creating awareness among masses and educating patients, rather than by fighting for stricter legislation or by requesting its more stringent implementation. Patient education and oral hygiene instruction should include the devastating effects of using dentifrices containing tobacco.

S. R. Srinivas, R. Ritu, K. D. Jithendra
India

1. Simpson D. India: tobacco toothpaste squeezed out. *Tob Control* 1997; **6**: 171.
2. Sinha D N, Gupta P C, Pednekar M S. Use of tobacco products as dentifrice among adolescents in India: questionnaire study. *BMJ* 2004; **328**: 323-324.
3. Winn D M. Tobacco use and oral disease. *J Dent Educ* 2001; **65**: 306-312.

DOI: 10.1038/sj.bdj.2012.323

PA AND FISH OIL

Sir, I write this as a letter to the *BDJ* in order to communicate an interesting new treatment for trigeminal neuralgia. This distressing and intractable condition was recently diagnosed in a 47-year-old call centre operative and was the reason for her ceasing her daily work which involved almost continuous closely timed calls for eight hours a day. Treatment with tegretol did little to alleviate the right sided numbness of lips, cheek and tongue and had no effect on the shooting pains characteristic of the condition. The lady was asked to try a treatment currently on pre-trial for arthritis, namely lemon fish oil 5 ml/day and palmitoyl ascorbate (PA) 1 g/twice daily. Within 90 minutes of the first dose the numbness started to recede reminiscent in the patient's words of 'a local anaesthetic wearing off after having a filling'. The normal sensation returned fully a short time later but receded after eight hours or so. Since then periods of stopping this treatment for three days at a time whilst