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.

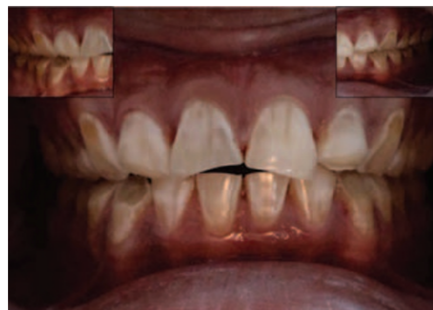

Fig. 1 Abrasion due to tobacco based tooth powder

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

© 2012 Macmillan Publishers Limited. All rights reserved.