

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

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### 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  
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### 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.<sup>1</sup> However, use of these dentifrices (under different trade names) still continues,

especially among rural and uneducated populations.<sup>2</sup> Ill-effects caused include oral cancer, oral mucosal lesions, caries, periodontal disease, impaired healing after periodontal treatment and gingival recession.<sup>3</sup> 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.

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India

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### 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

maintaining the tegretol have shown conclusively that it is the PA and fish oil that are responsible for the recovery.

PA is a food additive aka E-304 (EU) or ascorbyl palmitate (USA) and as a powerful, lipid soluble anti-oxidant is widely used in the food industry as a preservative and freshener in meats and salads. It is cheap (£45/kg) and safe (LD50 3,000 mg/kg). It is freely available in bulk or personal quantities online.

The result shown in this case is similar to that we have found in some cases of rheumatoid arthritis with rapid reductions in swelling and pain in finger joints and long-term reduction of back pain.

This result must be of interest to researchers and to dentists and their patients with intractable trigeminal neuralgia. We look forward to an explanation in due course. I will be happy to correspond with any interested parties on [andrew@brainhelp.info](mailto:andrew@brainhelp.info).

A. Carmichael  
By email

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## NEW REVIEW NEEDED

Sir, the number of papers proposing a link between periodontal disease and systemic disease is ever increasing. The latest area under investigation is breast cancer. A recent study by Soder *et al.*<sup>1</sup> looked at whether patients with periodontal disease have an increased breast cancer incidence if they had lost molar teeth. The inference was that the missing molars were purely an indication of the previous severity of the periodontal disease. What if the extraction sites themselves were the source of the increased disease incidence? Lechner and Mayer<sup>2</sup> investigated areas of poorly healed extraction sites and found them to contain pro-inflammatory mediators such as IL1- $\alpha$  and RANTES. These lesions were histologically an avascular necrosis of the medullary bone and have been reported in the dental literature as far back as 1915 by G. V. Black. If this is the case then it may be that some of the previous papers on periodontal disease and systemic disease need to be reviewed in a new light.

J. Ahearne, Poole

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associate with breast cancer. *Breast Cancer Res Treat* 2011; 127: 497-502.

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## AN ALTERNATIVE REACTION

Sir, I am writing to bring attention to the case of a 47-year-old male smoker initially diagnosed with aggressive periodontitis. The patient presented with what was deemed to be approximately 70% generalised horizontal bone loss affecting his remaining teeth (Fig. 1). Upon looking at the radiograph closely, particularly at the lower jaw, there does not appear to be loss of bone height *per se* in the mandible, just a loss of bone surrounding the teeth, making the teeth appear extruded – see height of bone above inferior dental canal and anterior mandible. In light of this and other similar observations, could tooth extrusion be an alternative reaction of the periodontium to the effects of dental neglect, smoking and other patient factors?

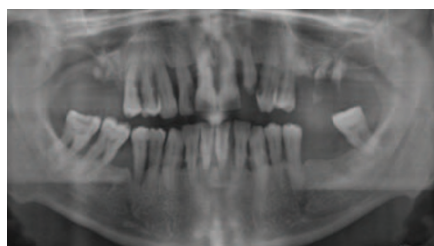


Fig. 1 Orthopantogram showing 70% generalised horizontal bone loss

V. Weblin, J. Yates, Manchester  
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## STRUGGLE FOR EXPERIENCE

Sir, I am currently studying for my A-levels and hoping to pursue a career in dentistry. I have been actively seeking work experience for a while now and have contacted many dentists in my area with no success. The most frequent responses are: '*my insurance will not allow it*' and '*there are issues with confidentiality that prevent me from allowing it*'. Although I can completely sympathise with the practitioners, how are the potential dentists of the future to gain much needed experience of their preferred profession?

I hope this letter may encourage your readers to give students the opportunity

they need, even if it only involves sitting on reception and a chat at lunch.

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## CONTROLLABLE FLUORIDE

Sir, I am writing in response to the letter from A. McKay published on your website on 9 March (*Organic toothpaste*; *BDJ* 2012; 212: 206) in which the correspondent criticises our fluoride-free children's toothpaste, claiming that this product is 'potentially harmful', 'unnecessary', and that dental care professionals should 'discourage its use'.

We are well aware of the undoubted benefits of fluoride in the prevention of dental caries, and the fact that many children are deficient in this essential mineral. However, we are also aware of the potential adverse effects of excessive fluoride intake, in particular the risk of dental fluorosis and the psychological impact that this can have on children.

Taking into account the widely differing fluoride intakes due to regional variations in water fluoridation and dietary intakes, we feel that fluoride supplementation should be assessed on an individual basis rather than given in a rather arbitrary way through toothpaste. In particular, we are concerned that the dosage levels achieved through toothpaste are prone to very wide fluctuations. The amount of toothpaste used, the frequency of use, whether the toothpaste is spat out or swallowed, and whether the mouth is rinsed after brushing will all affect the potential dose of fluoride received from this route.

We believe that a safer and more accurately controllable means of administration is through the use of fluoride tablets or drops which can be given to children in need of supplementation with this mineral. Assuming that is done, there is no reason why children should need to use a fluoridated toothpaste with the attendant risk of excess fluoride intake that these bring, and instead can benefit from using our totally natural and certified organic toothpastes.

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