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.

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THE CARIES BURDEN

Sir, I am grateful for your persisting interest in epidemiology and for pointing us to the fascinating report of Public Health England on the prevalence and severity of dental decay of 5-year-old children in 2012 (*BDJ* 2013; **215:** 313). You highlight the painful finding, that, in spite of a moderate general decline in prevalence, unacceptable differences in caries experience between deprived and better-off regions remain, which are symptoms for, or results of, broader social and economic inequalities within British society.

Your editorial prompted me to read the full text of the report, which contains even more revealing facts: the average care index across England for 5-year-olds was 11.2%, meaning that 88.8% of decayed teeth remained untreated. Unfortunately, the UK figure of untreated decay in children is not unusual and very much in line with other countries, be it high-, middle- or low-income countries.[1]

The concept that dental care can 'treat away' disease is short-sighted, outdated, and addresses only the tip of the iceberg. There will always be more cavities than professionals to fill them. This situation is even worse in low- and middle-income countries, where oral care is either not available or not affordable. Still, many countries are trying to address the problem by training more and more dentists. Sure, many regions of the world are in desperate need of more trained oral health professionals, but the crux is not their mere number, but the type of work they do and the balance between prevention and clinical care. The FDI World Dental Federation's Vision 2020 document states that 'the approach to oral health has focused overwhelmingly on treatment rather than on disease prevention and oral health promotion. This approach has, however, limitations. Globally, the burden of oral diseases remains high and the traditional curative model of oral health care is proving too costly, in terms of both human and financial resources, to remain viable in the light of the increasing demand.'[2]

The Editor's questions as to whether we (as a dental profession) 'can [...] treat our way towards eradicating the problem' and if we have 'been at the vanguard of preventing the vast majority of dental decay' are simple to answer, as there is clear evidence that dental care alone only contributed little to improvements in oral health status that we have seen over the last decades across Europe and other regions.[3] It is a recognised fact that we owe much of the decline of dental decay to the widespread use of fluoride toothpaste or other ways of exposure to appropriate fluorides, as well as to changes in the broader determinants of oral health.

Interestingly, the report of Public Health England also suggests three reasons for the modest decline in overall prevalence from 2008 to 2012. All of them revolve around fluoride: following official NHS recommendations toothpastes containing levels below 1,450 ppm of fluoride were phased down; dentists are prescribing fluoride containing products more often or apply fluoride varnish; and, lastly, the impact of public dental health programmes may be reflected in the statistics (though there is no evidence as yet for this assumption).

In order to control the current caries burden, to prepare for the future and to maintain professional credibility, the shift from curative to preventive dentistry – announced already decades ago – needs to finally become a reality and find its way into contemporary dental education, remuneration systems and the professional culture of every oral health professional. Without such a profound change, all ambitions to prove that dentistry is more than the drilling and filling of teeth will be seriously challenged.

H. Benzian, by email

1. Baelum V, van Palenstein Helderman W, Hougson A, Yee R, Fejerskov O. The role of dentistry in controlling caries and periodontitis globally. *In* Fejerskov O, Kidd E A M (eds). *Dental caries: the disease and its clinical management*. p 581. Oxford: Blackwell Munksgaard, 2008.
2. Glick M, Monteiro da Silva O, Seeberger G K *et al.* FDI Vision 2020: shaping the future of oral health. *Int Dent J* 2012; **62:** 278–291.
3. Sheiham A. Impact of dental treatment on the incidence of dental caries in children and adults. *Community Dent Oral Epidemiol* 1997; **25:** 104–112.

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VACCINATING BOYS AGAINST HPV

Sir, the Joint Committee on Vaccination and Immunisation (JCVI) is currently considering whether the current human papilloma virus (HPV) vaccination programme should be extended beyond its current target group (12/13 year old girls). This is very relevant to dentists because HPV does not only cause cervical cancer –it is also a cause of oropharyngeal cancers as well as cancers of the anus, vagina, vulva and penis.

HPV is believed to be the causal agent in 5% of all human cancers[1] and is now the major cause of oropharyngeal cancer in developed countries, detected in up to 90% of cases.[2] HPV infection additionally causes genital warts, which can sometimes appear on the lips and mouth. Genital warts and many of the HPV-related cancers affect males as well

as females, raising the issue of whether HPV vaccination should now be routinely offered to boys as well as girls.

An increasing number of patient and professional groups, as well as individual clinicians, believe it is time to follow the lead of the Australian government and extend the HPV vaccination programme to boys. HPV Action, an advocacy collaboration representing 22 organisations, including the British Dental Health Foundation (BDHF), the Mouth Cancer Foundation and the Throat Cancer Foundation, supports this. The Faculty of Public Health and Cancer Research UK also believe it is time for a change.

The arguments for vaccinating both boys and girls are clear. Even though the UK's HPV vaccination programme reaches over 80% of girls, there are many communities (both geographic and sociocultural) where coverage rates are much lower. Vaccinating males would therefore help to protect females in these groups from cervical cancer and other HPV-related diseases. Males themselves would also be protected from HPV infection by non-vaccinated females, whether they are from the UK or other countries, and by other males. The current girls-only vaccination programme leaves men who have sex with men (MSM) at particular risk of infection because they do not benefit from any 'herd protection'.

It would be untenable to extend the programme just to MSM because it would be unlikely to reach most of this population and because optimal protection occurs only if vaccination is administered before sexual debut. It would not be possible to target MSM at the age of 12/13 because sexual preferences are not established and it would in any event be unethical to question boys about this.

The cost-effectiveness of extending the programme to boys is difficult to ascertain because of uncertainties about the cost of the vaccine and also whether the evidence for switching from a 3-dose to a 2-dose schedule proves compelling. Cost-effectiveness is also influenced by the range of diseases taken into account. The Throat Cancer Foundation estimates that it would cost about £2 million a year to vaccinate boys in Scotland; if this is correct, the costs for the whole of the UK would not be significant compared to the major long-term public health benefits.

Readers who support HPV vaccination for boys can write to their MP and/or the public health minister Jane Ellison MP at the Department of Health. HPV Action's website, www.hpvaction.org, contains further information.

P. Baker, Campaign Director, HPV Action

1. Stanley M. Vaccinate boys too. *Nature* 2012; **488:** S10.
2. D'Souza G, Dempsey A. The role of HPV in head and neck cancer and review of the HPV vaccine. *Prev Med* 2011; **53:** S5–S11.

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NOT JUST THE JOINTS

Sir, I read the letter *Lack of TMJ knowledge* (*BDJ* 2013; **215:** 443) with interest. I completely agree that teaching in diagnosis and management of temporomandibular disorders is sadly lacking in undergraduate teaching and also with the sentiment that 'examination, knowledge and pathology is not well understood and more training ... is warranted'. I do, however, have some issues with the emphasis of the letter. When addressing the issue as a 'Lack of TMJ knowledge' this excludes the implication of the mandibular muscles and the occlusion which are the other two parts of the trilogy. The term temporomandibular disorders (TMD) is a better generic term which involves the articulatory system, not just the joints (TMJ). This letter is written from a surgeon's viewpoint and I feel general practitioners must remain aware that the treatment of TMD falls into a conservative, not surgical, regime. Surgical intervention is necessary in less than 1% of all TMD patients seen on a clinic dedicated to the management of 'TMD' patients who are secondary or tertiary referrals therefore the incidence in general practice of such a necessity is remote. I agree, however, that practitioners should always be aware of the place surgery has to offer in the rare instances it is required. The Cochrane analysis that the author refers to did not include soft splints in its consideration. This therefore does not give justification for suggesting that the soft vacuum formed splint provides a 'good alternative' to a splint specifically designed for an individual patient's needs. It does not.

R. Gray, by email

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