

# Letters to the Editor

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## RISKING OUR LEGITIMACY

Sir, I write in response to Dr McKeever.<sup>1</sup> 1) We are in agreement that during the last epoch of human development (from farming to civilisation) malocclusion, or deviation in dental arrangement, has changed from rare to endemic and this is largely due to the environment. 2) Dr McKeever also suggests that any debate would have to consider a more complex aetiology pointing out that open bite and Class III malocclusions predated this period and that we should align our terminology. To which I would respond that the helicoidal wear pattern associated with the heavy levels of attrition would largely explain these malocclusions and terminology is a detail that could easily be resolved.

He raises some good points but it is only through engagement in debate and scientific exchange that it can be possible to find the truth.

However esoteric, or dull, we must remember that currently 30% of the population are treated with inter-ventive orthodontic therapy including major surgery, while it is openly acknowledged the cause is unknown for most patients. There is solid (if not overwhelming) evidence supporting an environmental influence and little suggesting a genetic aetiology (despite gargantuan efforts) from which it may be concluded that current orthodontic treatment, which is based on the genetic assumption, is not evidence-based. It would be unethical to call for more publications when adequate evidence has already been published; it is time for a debate!

Three and a half years ago I made a challenge to the BOS for a debate to test

the proposal 'Malocclusion is caused by the environment and modified by the genes'. I have alerted the GDC, the CHRE, the All Party Dental Committee and the Minister of Health to my concerns; all have disclaimed responsibility and suggested that the only route is through the BOS.

I understand the reluctance of any established organisation to engage in a debate that it could lose but this is our duty: to engage and to search for the truth, whatever and wherever that leads. If we chose not to engage in this debate we risk our legitimacy and the very foundations of our self-governing profession.

The importance of this issue cannot be overstated and as such may I ask the BOS to please give a clear and open response in this journal, as is normal scientific protocol, as to whether they will engage, and if not, why they feel that a debate should not be held or what the alternative should be.

M. Mew, by email

1. McKeever A. Genetics versus environment in the aetiology of malocclusion. *Br Dent J* 2012; 212: 527-528.

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## HANGING ON THE TOOTH

Sir, tooth wear due to abrasion has been attributed to detrimental habits including pipe smoking, pencil chewing, nail biting and the habit of holding various objects between teeth. In a 50-year-old male patient that recently visited our dental clinic, severe abrasion was seen particularly on both the lower central incisors (Fig. 1). Upon enquiring, the patient was embarrassed to confess that he possessed a life-long habit of using his lower teeth to hook clothes hangers



Fig. 1 By hook or by hanger

while adjusting his wardrobe ... with the clothes still on them! This was a very unusual cause of such severe tooth wear. The patient claimed to have no functional or aesthetic concerns but was interested to learn about the treatment options for restoration of these teeth. Of course, before proceeding with any restorations, one must be cautious of the fact that the patient might not let go of such a deep-rooted habit very easily, which might leave the dentist hanging!

S. Adnan, Karachi

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## EVIDENCE TRANSPARENCY

Sir, I read Martin Kelleher's opinion article (*The difficulties of making 'CPD verifiability' a legitimate measure of learning outcomes*; *BDJ* 2012; 213: 383-384) with interest. It rightly identifies the difficulty of translating new knowledge into sustained behaviour change. The field of knowledge use/implementation/translation (call it what you will) has much work to do on reliable and valid measures of process or outcomes resulting from educational interventions among many others.<sup>1</sup>

But the piece also made me think about the knowledge being imparted. After sitting through many CPD courses myself I have started to wonder what

level of evidence is supporting that which I am being served up. I recently listened to an entertaining presentation in which survival rates and factors associated with success of root canal treatment were identified. As I contemplated how much effort it would take me to apply what I was being told I began to ask myself how strong the evidence was for each of the recommendations being suggested. Is it worth the effort of changing the way I manage patients if the recommendations are based on studies at high risk of bias or not on studies at all but the presenter's opinion?

I recognise that there is much that we do that is not grounded in high quality research and that we perform dentistry well despite this. There is much to be learnt from the experience of others and reflection of our own practice. But I think we need to be more transparent about the level of evidence that supports what we teach, whether it is in CPD programmes or, indeed, in the dental undergraduate curriculum.

Evidence-based guidelines and journals such as *Evidence-Based Dentistry* provide an example of how this can be done, though a CPD course need not go to the same detail. However, I think it is only respectful of the adult learners who attend our courses and our universities to give them the information necessary to decide on the likelihood that, should they change their behaviour, this will result in meaningful improvements for their patients.

D. Hurst, London

1. Estabrooks C A, Squires J E, Strandberg E *et al*. Towards better measures of research utilization: a collaborative study in Canada and Sweden. *J Adv Nurs* 2011; **67**: 1708–1718.

DOI: 10.1038/sj.bdj.2013.168

## PEER-REVIEWED CPD

Sir, I have followed with interest the articles on *The difficulties of making 'CPD verifiability' a legitimate measure of learning outcomes*<sup>1</sup> as well as Stephen Hancocks' editorial on *How gullible are we?*<sup>2</sup> following my recent experience.

As lead clinician for facial pain, I attended a seminar on pain management (advertised extensively in the *BDJ*) as some of our patients have had splints provided by the company conduct-

ing the seminar and I thought it would be useful to find out more. The course was CPD approved and along with 68 other participants I paid my fee and received a certificate at the end which I can put into my portfolio of verified courses. We were issued with extensive promotional material as well as handouts which stated the aims and objectives of the seminar. I was astounded by the content and advertising that was contained within the seminar and I did not consider any of the stated aims and objectives to have been addressed in a scientific evidence-based way.

In dental schools it is compulsory that all teachers are peer-reviewed on their teaching on a regular basis. Is it not time that some of the courses that are offered are equally peer-reviewed by experts rather than just the participants? Martin Kelleher argues that we should be able to 'demonstrate that they (participants) understood more than for example, 60% (that is, better than an even chance) of the relevant points' from an educational experience. I would hope that participants at the course I attended did not understand such a high percentage for the content of this CPD activity as it would not 'produce safer or better treatment outcomes for patients'.

Could I suggest that in the future participants attend our facial pain section 63 course organised through the London Deanery which is patient centred and evidence based? Sadly it is only attended by a handful of dentists perhaps because we do not have high quality glossy advertisements in the *BDJ*.

J. M. Zakrzewska, by email  
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## THE CURIOUSLY ITCHY TOOTH

Sir, as part of recent training in the use of computer controlled anaesthetic delivery techniques it was agreed that participants could trial this for themselves. As a consequence of this, I felt compelled to highlight a personal experience using this widely available commercial system.

The device is designed to target a wide audience, especially dental phobic patients and patients in whom regional blocks are medically contraindicated. The equipment can deliver a slow intraligamentary injection, giving audio

and visual feedback to the operator, to ensure correct location.

Delivery itself is reasonably comfortable if not brief – instructions suggest giving over the course of approximately two to three minutes. Once anaesthetised, having only a single lower tooth numb, with limited soft tissue, anaesthesia is a curiosity. Even more curious is the sensation of a tooth that feels raised into supraocclusion. Indeed, if the anaesthetic has been delivered correctly, hydrostatic forces will have elevated the tooth in the socket, a feeling that lasted until the next day.

Over the hour following delivery, all which had experienced the injection felt a sensation that was only possible to describe as 'itching'. This sensation lasted for about an hour after symptomatic onset, and out of all postoperative sensations, was the most uncomfortable.

As someone who has experienced palatal injections, ID blocks and tooth extractions, my expectations of this system were fairly high. Having had the experience (admittedly only one) I can understand that patients are more likely to accept the equipment over traditional syringes. However, I struggle to see a dental phobic or paediatric patient tolerating the potential post-operative effects well. Especially as most occur after a patient would have left the surgery, and may not have been warned about.

Thought must also be given to the operator who may be unable to correctly contour restorations as the tooth is artificially raised at the time of finish.

Dr Veerkamp highlighted in a recent commentary<sup>1</sup> that there does exist a potential for such equipment. However, the specific situations in which this method provides benefits is in need of highlighting to operators. I am looking forward to seeing the progress of 'pain free' anaesthesia over a working lifetime and I wonder whether this type of system will have a place, or whether conventional techniques will withstand the test of time.

R. Hague, Manchester

1. Veerkamp J S J. Summary of: Comparing the onset of maxillary infiltration local anaesthesia and pain experience using the conventional technique vs the Wand in children. *Br Dent J* 2012; **213**: 460–461.

DOI: 10.1038/sj.bdj.2013.170