specialist orthodontics but it would be misleading to suggest that difficulties do not arise. Seemingly straightforward treatment with a sectional fixed appliance can be complicated by quite pronounced changes in overbite and overjet or flaring of the canines, all of which can be difficult and time consuming to correct. Further, an inadequate retention protocol following active tooth movement might lead to significant relapse, resulting in costly remedial work for the patient, especially if additional restorative work has been performed.

The concerns raised in this letter are not unfounded; there is evidence to support a rising trend for medico-legal problems in orthodontics. In 2010, 20% of dento-legal claims arose from aligner type treatments with 80-90% of these against general dental practitioners (Dental Protection, *Riskwise UK* 42). Also, in the current issue of *Riskwise* (issue 44), Dental Protection strongly welcomes the underlying principle (stated in the Office of Fair Trading OFT report on the 'dentistry market') of allowing patients to make properly informed decisions, and to encourage them to seek information they need so that they can properly understand what treatment options are being proposed, and what they will be expected to pay. In the same issue, Dental Protection reiterated the importance of the GDC document entitled *Principles of ethical advertising*, which state: 'All information or publicity material regarding dental services should be legal, decent, honest and truthful'.

The author appears on the Six Month Smiles website as an 'Instructor'. This seems to suggest a commercial interest in the particular treatment system which is not apparent when reading the article. If so, in our opinion, this should have been made clear.

R. Slater
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British Orthodontic Society

1. Maini A. Short-term cosmetic orthodontics for general dental practitioners. *Br Dent J* 2013; **214:** 83.

Dr A. Maini responds: Thank you for your letter. The aim of the article was written in a cosmetic dentistry perspective as an aim for dentists to use orthodontics to improve anterior tooth alignment without having to prepare teeth with a restorative solution. You will agree the biomechanical impact of aggressive tooth preparation has far greater impact on the longevity of the teeth than just aligning some anterior teeth. The ethos is to provide far more minimally invasive solutions and as Vice President of the British Academy of Cosmetic Dentistry this is our centred opinion as we try to move the profession away from the 'veneer' smile makeover that typifies cosmetic dentistry. I do teach for a company called Six Month Smiles and that was declared in my bio; also the article was far broader as it discussed many other products including removables.

Every patient who seeks a smile enhancement treatment should be offered all options to achieve correct valid consent; that may include restorative, short term orthodontics or comprehensive orthodontics, any of which could be undertaken by the GDP or referred to a specialist as appropriate according to the GDP's skill set in line with GDC guidelines.

Comprehensive orthodontics remain the 'gold' standard for any orthodontic care in terms of obtaining idealised Class 1 relationships and full root torquing and is the ideal and desired treatment for all patients who may entertain orthodontics. However, from my personal experience, in a clinic which also provides comprehensive orthodontics, a significant number of adult patients decline this option as they would not consider wearing braces for 18 months to two years. These patients would opt for either a restorative solution or do nothing at all if an orthodontic solution of a shorter time frame was not offered as an alternative.

Patients who undergo short-term orthodontics should be made aware fully as a part of the consent process that this is a compromise treatment and there are limits to what it can achieve in comparison to comprehensive orthodontics. Short-term orthodontics or comprehensive orthodontics can be referred to a specialist orthodontist if it is not within the skill set of the general dentist.

In general dentistry, as many of my colleagues will agree, many patients do not always choose ideal dentistry for many modalities such as restorative, implants, periodontics and endodontics; this is a fact of life and general dentists are used to working within a parameter that fits within the wishes of the patient.

The demand for short-term orthodontics will rise as dentists move towards more minimally invasive cosmetic dentistry techniques which is why it is great to see progressive specialist orthodontists like Asif Chatoo, Ian Hutchison and Derek Mahoney offering general dentists courses on short-term orthodontic techniques based on purely achieving anterior tooth alignment so that general dentists may offer this purely cosmetic treatment option with good training and support.

The figures you quote for Riskwise *(issue 44) need to be brought into context. It is inevitable that as a treatment increases in volume there will be a respective increase in claims. Since most aligner treatments are provided by GDPs, with orthodontists offering these treatments to a far lesser degree and therefore the population of GDPs far exceeding the number of orthodontists, the 80-90% GDP claim is not as graphic as it might first appear.*

On the subject of retainers, the philosophy is 'retainers are for life' which is a part of the consent process for short-term orthodontics. A patient who chooses not to do this is a poor candidate for the treatment. Having treated hundreds of relapse cases of adults who had comprehensive idealised orthodontics as teenagers I fully appreciate the importance of this.

DOI: 10.1038/sj.bdj.2013.333

LOBBY FOR BETTER ORAL CARE

Sir, I was very interested to read D. Howarth's letter discussing the problems of implants and dementia (*BDJ* 2013; **214:** 47). I completely agree that older people are a dental time bomb and that oral hygiene in residential care homes is often suboptimal to say the least, but I cannot agree that this is likely to cause more problems for patients with dental implants than it

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is for those without. Oral hygiene is equally important for patients with or without dental implants as is attention to diet. But in my experience peri-implant infection is much less common than periodontal disease, and significantly implants do not suffer from root caries which is a large part of the problem of the ageing dentition and which is why your correspondent is seeing teeth decayed to roots around sound implant supported restorations. The logical conclusion is to provide more implant supported restorations not fewer.

I am unsure as to what D. Howarth is referring when he writes of restorative jewellery but I presume he is implying that dental implants are provided for cosmetic reasons. Virtually all dentistry has an aesthetic component but in my experience many more implants are placed for functional reasons than for purely aesthetic reasons. I am sure no dentist would deprive a patient of the huge benefits, possibly over many years, of implants used to retain full lower dentures, which have no aesthetic value at all. Even in a case with a high aesthetic component, such as replacement of a single central incisor, it is difficult to imagine persuading a 20-year-old that the advantages of implant replacement over the alternatives are outweighed by the prospect of possible maintenance difficulties 60 years or more in the future.

Many elderly patients will present in the future with not just implant supported restorations but also complex tooth supported restorations and the oral care for either should be very similar. The treatment planning for these patients earlier in life should include both where appropriate.

The answer to the problem is not to use fewer implants but to lobby for better oral care for the elderly and to try to preserve both natural and restored dentition whether implant or tooth supported. The only alternative is to resort to full clearances and full dentures which I am sure no dentist would like to see again.

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DOI: 10.1038/sj.bdj.2013.334

IMPROVING STEADILY

Sir, the 2009 Adult Dental Health Survey (ADHS) is the fifth in a series of national dental surveys that have been carried out every ten years since 1968. It covers the adult population in England, Wales and Northern Ireland. Since Scotland decided not to participate in the ADHS 2009, it has been impossible to make any UK wide comparisons.[1]

Bespoke analyses, however, were carried out across a small number of measures using the data from the ADHS 2009 and the Scottish Health Survey (SHeS) in 2008[2] and 2009.[3] These comparisons were recorded on Excel spreadsheets which can be accessed from the Health and Social Care Information Centre website.[4]

In 1972, the level of total tooth loss among the Scottish population was 44%.[5] By the time of the SHeS 2009, the figure for this population had dropped to 12%.[3] Nevertheless this figure for Scotland[3] is still worse than those for the rest of the UK (England 6%, Wales 10%, Northern Ireland 7%).[4]

In Scotland, the target of the 2005 *Dental Action Plan* was that 90% of all adults would possess some natural teeth by 2010.[6] The SHeS reports in 2010[7] and 2011[8] noted that the proportion of all adults possessing some natural teeth was 89% and 90% respectively. This means that the Scottish target has been met in 2011.

In 2009, 71% of the adult population in Scotland had 20 or more natural teeth.[3] Compared to the rest of the UK, this figure[3] is also lower (England 81%, Wales 73%, Northern Ireland 77%).[4] Subsequent SHeS reports have shown that the percentage of all adults with 20 or more natural teeth increased by one percentage point each year, from 72% in 2010[7] to 73% in 2011.[8]

This implies that oral health has improved steadily for the adult population in Scotland. A greater proportion of adults has now retained their teeth and maintained a minimum functional dentition. These could be attributed to the following key initiatives in Scotland:

- Development of oral health promotion programmes
- Introduction of free dental checks for adults
- Changes to the structure of dental services for adults including extending dental registration
- Opening of a new dental school in Aberdeen, and steps to attract more dental professionals to work in Scotland.

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Bothwell

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DOI: 10.1038/sj.bdj.2013.335

LACK OF ATTENTION

Sir, I wanted to comment about the letter from K. Parker and J. Patel (*BDJ* 2013; **214:** 93-94). The comments I would wish to make are a) the tooth in question is clearly a lower right seven (not a six as stated) and (b) had the post been placed inside a healthy distal root of a restorable permanent second molar tooth its length and diameter would probably have been acceptable. This case clearly illustrates not the importance of using a correctly sized post, but inadequate knowledge of dental anatomy and a woeful lack of attention to detail by all concerned.

K. F. Mills
By email
DOI: 10.1038/sj.bdj.2013.336

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