

are competent to recognise and manage a range of acute dental problems (such as infectious diseases, oral mucosal diseases and salivary gland disorders). The proposed targets also promote the early detection and appropriate referral pathway for a variety of oral conditions, including dental trauma and oro-pharyngeal cancer.

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1. Anderson R, Thomas D W. Out-of-hours dental services: a survey of current provision in the United Kingdom. *Br Dent J* 2000; **188**: 269–274.
2. Anderson R, Thomas D W, Phillips C J. The effectiveness of out-of-hours dental services: I. pain relief and oral health outcome. *Br Dent J* 2005; **198**: 91–97.
3. Ball G E. Out-of-hours emergency dental services in Scotland – a national model. *Br Dent J* 2008; **205**: 485–487.
4. Scottish Dental Clinical Effectiveness Programme. Emergency dental care: dental clinical guidance. Dundee: Scottish Dental Clinical Effectiveness Programme, 2007.
5. Hobdell M, Petersen P E, Clarkson J, Johnson N. Global goals for oral health 2020. *Int Dent J* 2003; **53**: 285–288.

DOI: 10.1038/sj.bdj.2013.443

## FRESH EXTRACTION SITES

Sir, a patient attended with acute pain associated with a provisional bridge replacing the 22 using the 23 as an abutment. The bridge had been placed approximately two weeks previously by an emergency dentist whilst the patient was on holiday. The dentist had extracted the 22 and constructed a chairside acrylic replacement. Upon examination both 22 buccal sulcus region and the 23 were tender to percussion. Radiographic examination revealed radio-opacity of mixed density in the extraction site with considerable acute local osteitis. An apical rarefying osteitis was associated with the 23. This tooth had been root canal treated but the obturation was suboptimal in both length and condensation.

A diagnosis was made of persistent periapical periodontitis of the 23 and a possible foreign body in the extraction site. Surgical exploration and simultaneous re-root canal treatment was performed and a hard, off-white 'pellet' of acrylic removed from the site. It is most likely that this extrusion of acrylic occurred after the 22 had been removed and during the fabrication of the temporary bridge. The 23 and 22 area healed uneventfully.

The ability to provide immediate

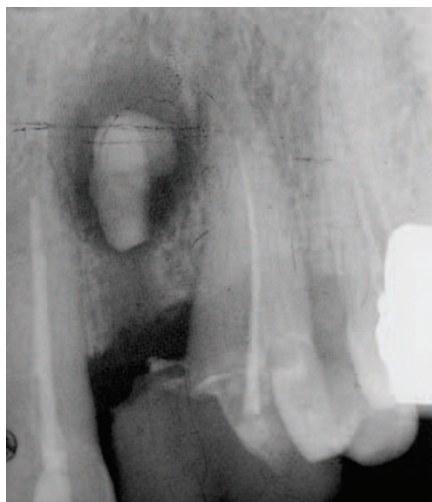


Fig. 1 Pre-operative radiograph showing radio-opaque material in the 22 site

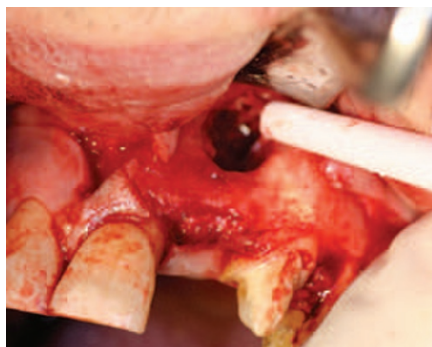


Fig. 2 Surgical exposure and removal

provisionalisation is essential in the aesthetic zone when extractions are planned. Given that post extraction and provisionalisation radiographs are rarely justified, an outcome such as this would be easy to miss. Perhaps, however, clinicians should approach fresh extraction sites with more caution, ensuring adequate clot formation or placing a resorbable haemostat prior to temporary construction. This should not be considered a novel technique for ridge preservation!

J. Darcey, by email

DOI: 10.1038/sj.bdj.2013.444

## GROSSLY DEFORMED BODIES

Sir, the report about *Growing bodies linked to gammy gums* (*BDJ* 2013; **214**: 221) seems to miss the elephant in the room (metaphor completely intentional).

People normally become obese by simply eating too much and moving too little. Rather than the proposal to spend money searching for a chemical excuse for their gammy gums perhaps the more obvious cause would be the sheer volume, frequency and quality of food and drink

being stuffed into the mouth to maintain such a body size. Also, anyone capable of allowing their body to become so grossly deformed is not concerned with their health and so the oral hygiene is likely to be fairly dire. The causal link for this self-inflicted disease seems perfectly obvious: poor diet and oral hygiene.

A patient of mine is a shining example of how it is possible for such a person to turn their life around. He was morbidly obese and decided nothing more drastic than 'to eat a little less and to move a little more'. Within six months he had lost vast amounts of weight and his body and oral health had dramatically improved. Having made his own decision to alter his lifestyle, his weight has stayed off and his health has continued to improve.

C. Marks, by email

DOI: 10.1038/sj.bdj.2013.445

## IDEALLY PLACED

Sir, I read with interest the opinion piece on the delay in diagnosis in the *BDJ*.<sup>1</sup> I commend the author in raising the profession's awareness of oral cancer screening and diagnosis. I noted with surprise that GDPs reported lack of remuneration and training to be major barriers to performing routine oral cancer screenings. Interestingly a survey in Ireland found that 89% of GDPs routinely performed intra and extraoral soft tissue examinations and 27% providing tobacco smoking cessation advice.<sup>2</sup>

With this in mind I would like to point you all towards an article in the *Journal of the Irish Dental Association*,<sup>3</sup> which goes through a simple and efficient method of performing an intraoral and extraoral examination. Those of us in primary care must remember we have a large exposure to the public and are ideally placed to screen for oral cancer or potentially malignant disorders.

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1. Dave B. Why do GDPs fail to recognise oral cancer? The argument for an oral cancer checklist. *Br Dent J* 2013; **214**: 223–225.
2. Decuseara G, MacCarthy D, Menezes G. Oral cancer: knowledge, practices and opinions of dentists in Ireland. *J Ir Dent Assoc* 2011; **57**: 209–214.
3. MacCarthy D, Flint S R, Healy C, Stassen L F. Oral and neck examination for early detection of oral cancer – a practical guide. *J Ir Dent Assoc* 2011; **57**: 195–199.

DOI: 10.1038/sj.bdj.2013.446