SEVERE BILATERAL CLICK

Sir, a few weeks ago, I examined one of our junior dental nurses who has recently joined the practice.

She has a long history of migraines throughout her late teens and now, aged 20, has a severe bilateral click on opening. As we often hear, her migraines began following the removal of all four first premolars and fixed orthodontics in her mid-teens. Her GP has also been aware of her migraines and has been prescribing her amitryptyline for some years.

On examination, there was indeed a hefty click on opening and non-working side interferences on both upper second molars. Some very simple occlusal adjustments removed the interferences and three weeks later her TMJ click had gone and so had the migraines.

I urge us all to be in closer contact with our patients' GPs in such cases. This poor girl has (I think) been prescribed powerful tricyclic antidepressants needlessly for several years.

J. Critchley
Totnes
DOI: 10.1038/sj.bdj.2013.537

SLIGHTLY ROSE-TINTED

Sir, I write in response to the letters *Ticking time bomb* from J. Webber in the *BDJ* (2013; **214:** 274) and *Implants and dementia* by Dr D. Howarth (*BDJ* 2013; **214:** 47). As someone involved in the teaching of dental implants to post-graduate students, I have read Dr Webber and Dr Howarth's views with great interest.

Dr Webber's view that 'endodontically treated teeth require no further intervention' is slightly rose-tinted. He states that the 'survival rates' of implants and endodontically treated teeth are the same but implies that only implants suffer complications. Even the most expertly endodontically treated teeth are subject to periodontal disease, loss of retention of restorations and mechanical failure in much the same way as implants. To include these complications in 'implant survival' and to ignore them in 'endodontic survival' is disingenuous. However, I'm never certain why we compare the survival data of a tooth to an implant. Dr Webber is absolutely correct. Restorable teeth should be retained whenever possible. This applies to periodontal treatment as much as endodontic treatment. Implants should not be considered an alternative to teeth but one treatment option for the replacement of missing teeth. I also suspect that Dr Webber is correct and that all too often endodontic and periodontal treatment is overlooked in favour of implants.

Dr Howarth raises an interesting concern. Well performed implant treatment in an appropriate patient can undoubtedly provide an improved quality of life. Should we withhold this treatment just in case the patient develops dementia? Given the options I personally would choose many years of an improved quality of life over the risk of problems in the last few years of my life should I be unfortunate enough to develop dementia. The real issue here is the responsibility for the provision of long-term care and maintenance of implants.

I have many concerns over 'implantology'. I regularly see the results of poorly planned and delivered implant treatments. If I'm perfectly honest I should hang my head at some of the treatment I have undertaken particularly in my early years, although at the time much of this was considered 'cutting edge'. I worry that increasingly the basic principles of dental treatment planning are losing out to speed, convenience, patient demands and, dare I say it, profit. One example is 'centres' that heavily advertise one specific implant treatment, fixed teeth on the same day. By nature this will attract phobics and poorly motivated patients with neglected dentition. These patients will get a clearance (although I suspect many of these teeth can be restored) and an immediately loaded implant fixed bridge. My concern is that these poorly motivated patients are delivered fixed restorations that can be difficult to clean and require enormous commitment to home and professional maintenance. Is this really in their best interest? I also have concerns over the quality of some of the implant training available and regulation.

Dr Webber may be right. We may be sitting on a time bomb but it is not the fault of the implant or even the implant manufacturers.

R. Adams
Cardiff
DOI: 10.1038/sj.bdj.2013.538

FOOTPATH QUACKS – CORRECTION

The letter *Footpath quacks* published in the *BDJ* on 11 May 2013 (**214:** 429) only listed one of the authors. The full names of the authors of this letter are as follows:

Dr Alankrita Chaudhary, Dr Navin Anand Ingle, Dr Navpreet Kaur, Dr Ajay Nagpal, Dr Kuldeep Dhanker.

We apologise for any inconvenience caused.

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QUALITY OF EVIDENCE

Sir, Dr Faggion raises a number of important issues regarding the reporting of clinical research findings at oral presentations, which deserve wide discussion.[1] However, we are concerned that the reader may be left with the view that the content of major dental meetings is thus somehow tainted by the presence of industry sponsorship and by speakers' conflicts of interests. As organisers of what we anticipate will be the largest conference on periodontology and implant dentistry ever held in Europe - Europerio 8 London 2015 - we welcome the opportunity to comment on some of the points raised, particularly as related to Europerio, which is featured prominently in the article.

Firstly, as correction of fact, at Europerio 7 2012, all invited speakers received clear guidelines on their presentations that included a requirement for disclosure of any conflicts of interest and the avoidance of bias. These guidelines were not posted on the meeting website (and thus not visible to the author when carrying out his investigation). The guidelines referred to in the article were for 'Research Presentations', which were free papers selected for researchers to present individual research projects, as opposed to the invited speakers on the main scientific programme. Secondly, although many of the Europerio sponsors are entitled to organise their own symposia; these are clearly designated as such

and kept completely separate from the main clinical and scientific programme, although their content is still validated and approved by the scientific committee. In contrast, no commercial sponsors directly support any of the presentations within the official scientific programme.

The proposed guidelines tend to assume that presentations take a common format where a question is posed and then subjected to an oral systematic review. Whilst it is recognised that this is one approach for an oral presentation of a topic, we believe that a narrative review approach with expression of personal opinions is also legitimate. A format where these opinions are discussed and tested by an active session chair and distinct speakers may be particularly appropriate for many topics and is a format we intend to adopt widely at Europerio 8. The 'narrative' oral presentation with expression of opinions is particularly relevant where the body of high quality evidence is low, as is often the case in most areas of clinical dentistry.

The guidelines as set out make an important point about considering the quality of evidence in an oral presentation and we concur that speakers should be encouraged to consider these issues within their presentations, notwithstanding the caveats above.

As the author notes, a large conference such as Europerio is not sustainable without the generous support of industry sponsors, but we, like other conference organisers, are very aware of the need to avoid commercial bias. However, we are all affected by conflicts of interest (which may not only be related to links to industry) and whilst we strongly agree with the idea of full disclosure, it must also be recognised that a disclosed conflict of interest is not in some way considered a 'bad thing' rather than simply seen as an open declaration.[2] A wider debate on this issue deserves to be encouraged, as has occurred to some extent already by our medical colleagues.

F. Hughes, London
M. Sanz, Madrid

1. Faggion Jr C M. Are there guidelines for reporting clinical research findings in oral lectures and seminars at dental meetings ? *Br Dent J* 2013; **214:** 281-283.
2. Smith R. Conflicts of interest: how money clouds objectivity. *J R Soc Med* 2006; **99:** 292-297.

DOI: 10.1038/sj.bdj.2013.540

ARGUMENT BY ANECDOTE

Sir, this morning I have a little time before the first patient arrives so there is an opportunity to catch up on the latest journals. First the current newsletter from HealthWatch, the organisation devoted to promoting evidence based clinical practice; most interesting.

Then to the current *BDJ*, to find yet another letter from J. Mew (*Jaw surgery alternatives*; *BDJ* 2013; **214:** 376). What is it this time? It is argument by flimsy anecdote. Surely the *BDJ*, a peer-reviewed journal, can do better than this.

R. Reed
By email

DOI: 10.1038/sj.bdj.2013.541

LEADERSHIP ROLES

Sir, the paper *What is clinical leadership and why might it be important in dentistry?* (*BDJ* 2013; **214:** 243) is a timely contribution to an area that, I believe, requires further discussion within the profession. 'Clinical leadership' is a phrase we hear increasingly often, especially in the context of the recent reorganisation of the NHS and the emergence of Local Professional Networks. It is perhaps easy for dentists, DCPs and the wider practice team to consider leadership as relevant to only a few but when leadership, as the article points out, is described as 'a process of influence of one individual over a group of individuals'[1] then leadership is relevant to all members of the profession as we seek to influence the behaviour of our patients.

The trend within dentistry is towards larger teams working together and, and whilst the implications of direct access are still being explored, the expectation is that dental teams should work together in the interests of the patient with leadership a key feature of such a team.[2]

Many members of the profession are ill-prepared for such a role and many of us have had to learn 'on the job', with mistakes along the way. This has been highlighted for me by participating in a pilot leadership development scheme by the North Western Deanery. The LEAD programme (Leadership Exploration and Discovery) is facilitated by experienced leadership development coaches who allowed the participants to explore their own leadership roles and styles and, most importantly, learn how to work as part of a diverse team.

I would urge those responsible for undergraduate and foundation dental training to consider how we can prepare new colleagues for this role and it is my experience that it is never too late to explore this issue in whatever role you find yourself.

I. Redfearn
Nelson

1. Northouse P G. *Leadership theory and practice*, 3rd ed. London: Sage Publications, 2007.
2. General Dental Council. *Principles of dental team working*. London: GDC, 2006. Reprinted 2009.

DOI: 10.1038/sj.bdj.2013.542

OVERWHELMING GENEROSITY

Sir, I write with gratitude to the BDA following a Charity Auction during this year's Conference. I was recently informed of the outstanding contribution to Bridge2Aid and am simply overwhelmed by the generosity of the UK dental family.

Whilst visiting Tanzania in 2002, my wife and I observed suffering, pain and chronic disease caused by dental decay and knew from that moment that we couldn't walk away. We followed our dream to provide access to dental pain relief in developing countries where otherwise there is none.

As we stand today, our dream - Bridge2Aid – has created said access to over 2.4 million people in Tanzania. We have trained over 240 local healthcare workers in emergency dentistry and have directly treated nearly 20,000 during our Dental Volunteer Programmes.

As we move forward, increase access and expand our work into other East African countries, I thank you and your readers for their continued support. May I conclude with one thought: it costs Bridge2Aid approximately 50p to provide access to safe dental pain relief for one person in Tanzania. The BDA's contribution of over £4,000 will enable us to provide sustainable access for an entire community of over 8,000 people. Incredible. Thank you.

I. Wilson
Bridge2Aid Founder

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