

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.

Readers may now comment on letters via the *BDJ* website (www.bdj.co.uk). A 'Readers' Comments' section appears at the end of the full text of each letter online.

FULL COVERAGE CROWNS

Sir, the decision to place a full coverage crown can be difficult. An operator needs to be aware of the potential complications of crown placement, as well as the risks of not providing treatment.

There is little consensus as to how frequently endodontic complications arise in previously vital teeth. Certain cohort studies¹ suggest that 98% of vital pulps will remain free from signs or symptoms of pulpal deterioration after five years, whilst other research suggests a far higher complication rate. One seminal study found that 19% of vital preparations (of unknown age) show evidence of peri-radicular disease.²

I would like to present the results of an internal audit in which I have looked at complications arising in crowns over the first five years following placement. The restorations in question were all single unit, full coverage crowns placed in adult patients by an experienced operator between 2003 and 2006 in a general dental practice. I was able to gather data for 510 teeth where the patient had regularly attended routine examination appointments for a minimum of five years following crown placement.

In this cohort, only 6 teeth out of 411 which had not previously been endodontically treated (1.5%) went on to show signs or symptoms of pulpal deterioration within five years.

With adequate water cooling, a good knowledge of pulpal anatomy and conservative preparations the evidence from this cohort suggests that it is possible to place crowns with minimal risk of pulpal complications within five years.

S. Haworth, by email

1. Valderhaug J, Jokstad A, Ambjørnsen E, Norheim P W. Assessment of the periapical and clinical sta-

tus of crowned teeth over 25 years. *J Dent* 1997; **25**: 97-105.

2. Saunders W P, Saunders E M. Prevalence of peri-radicular periodontitis associated with crowned teeth in an adult Scottish subpopulation. *Br Dent J* 1998; **185**: 137-140.

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YELLOW CARD SCHEME

Sir, in the recent paper by Yip *et al.* (*BDJ* 2013; **214**: E22) concerning the reporting of adverse drug reactions by general dental practitioners, a low level of reporting using the yellow card scheme was noted. The scheme is designed for reporting serious suspected adverse reactions to all medicines and all reactions to new products marked with a black triangle in the BNF. The authors conclude that this low level of reporting by dentists may partly be related to dentists rarely seeing or recognising adverse drug reactions. It could also be related to the fact that dentists prescribe from a well-established list of drugs as part of the dental practitioner's formulary. In addition, dentists would rarely be involved in the prescribing of black triangle medications which are more commonly prescribed by a medical practitioner.

Information on the type and frequency of drugs prescribed by dentists in the community in England are published by the Health and Social Care Information Centre each year. The most recent is for 2012 and makes interesting reading.¹ A total of 5.6 million prescription items written by dentists were dispensed in 2012, representing a 20% increase in prescription items since 2005. Dental prescription items represent 0.6% of the one billion items dispensed overall in the NHS in the community in England in 2012. In broad agreement with the figures found by Yip *et al.*, antimicrobial

prescriptions were the most common, accounting for approximately 70% of items prescribed. Antibiotic prescribing in dentistry appears to have been stable since 2005 at between 3,500,000 and 4,000,000 prescriptions per year. The next most common prescription was for preparations containing fluoride at 17% of items (n = 953,000 items) prescribed in 2012. This has increased steadily from a baseline value of less than 0.3% of items (n = 12,000 items) prescribed in 2005, with Duraphat fluoride toothpaste 2,800 ppm and 5,000 ppm being the main drivers of growth since being introduced into the market in 2006.

Dental drug prescribing habits are changing and will continue to change, and with it the potential for new occurrences of adverse drug reactions. The yellow card scheme fulfils a valuable function in helping to identify such reactions when recognised.

J. Taylor, M. N. Pemberton, Manchester

1. Health & Social Care Information Centre. *Prescribing by dentists - England, 2012*. 25 April 2013. Available at: www.hscic.gov.uk/catalogue/PUB10751 (accessed June 2013).

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IMPROVING CANCER CARE

Sir, we write in response to the letter published in the *BDJ* in January 2012 entitled *Unfairness for mouth cancer patients* (212: 3). We wholeheartedly agree with this opinion. Treatment of head and neck cancer involves not only removal of the tumour but also restoration of function. The aim of treatment is to prolong life and restore quality of life as far as possible. Head and neck cancer invariably affects vital structures and consequently can have a profound effect on facial appearance and self-image. When the oro- and nasopharynx

is involved, restoring functions, such as speech and ability to eat, can provide many challenges for the patient as well as the clinician.

With the increase in incidence of oropharyngeal cancers, particularly in those diagnosed as HPV positive, we are now seeing younger, more dentate patients.^{1,2} Patients undergoing treatment for head and neck cancer, particularly involving radiotherapy and chemotherapy, face very difficult challenges including mucositis, dry mouth, radiation caries and an increased risk of osteonecrosis of the jaws as a result of extractions. Many of these challenges are life long, and can result in complex dental treatment being required in the long term with associated considerable cost. Specialist restorative treatment is not universally available within the NHS in England.

We would like to share with you the specialist restorative oncology service delivered to all head and neck cancer patients at Torbay Hospital, South Devon. All patients receive a pre-operative oral screen by the restorative oncology team, and a full and ongoing treatment plan is made. Necessary treatment, prior to cancer treatment, is carried out within the department, and advice on oral care is given to help patients through their cancer treatment. In addition, after cancer treatment, patients receive continuing restorative care and regular hygienist care at no charge. We feel this puts head and neck cancer patients in line with the support received by patients suffering from other types of cancer. This service is of significant benefit to all head and neck cancer patients. With the evolution of new commissioning, this issue needs to be discussed and understood.

Our newly launched website, www.mouthcareincancer.co.uk has been designed to provide information for head and neck cancer patients, health-care professionals and patients undergoing chemotherapy for other cancers.

We would welcome feedback from other head and neck cancer specialist centres regarding their services and experiences in the hope that we can improve the care for these patients across the country.

C. Drysdale, A. Green, Torquay

1. Curado M, Hashibe M. Recent changes in the epidemiology of head and neck cancer. *Curr Opin Oncol* 2009; **21**: 194–200.
2. Lajer C B, von Buchwald C. The role of human papillomavirus in head and neck cancer. *APMIS* 2010; **118**: 510–519.

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VENDING MACHINE THREAT

Sir, the use of vending machines is becoming popular in developing countries such as India and China.¹ Their use is increasingly found in school premises, where the income from them can be used to supplement limited budgets.² The problem is accessibility; students can walk from their classroom and use one coin to obtain a whole range of sugary snacks and carbonated drinks. Young children enjoy this freedom, yet the machines offer them some of the most unhealthy food options and increase snacking frequency during school hours. Indeed, most studies show that the use of school vending machines is positively correlated with confectionery consumption and negatively correlated with fruit consumption.³ Evidence from developed countries shows significant differences in the caries level of children from schools with and without vending machines.⁴

While some schools in some countries are trying to implement rules and programmes that eliminate these unhealthy options, it is often difficult and expensive to offer fresh fruits and vegetables as an alternative.⁵ However, according to the Centre for Science in the Public Interest (CSPI), schools that have switched to selling healthier foods in vending machines have not experienced a reduction in vending machine revenue.⁶

Developed countries have learnt this lesson and adopted a public health approach by developing guidelines and/or legislation about the appointment of bodies responsible for the management of vending machines in school (eg US Department of Agriculture) and what should be loaded in the machines.⁶ Developing countries should not delay in adopting these positive lessons.

M. Masood, Y. Masood, Malaysia
J. T. Newton, London

1. Euromonitor International. *Vending in emerging countries*. Market Research World, 17 May 2013. Available at: www.marketresearchworld.net/content/view/157/77/
2. Damle S G. Fill it, shut it, and forget it!!!! *J Indian Soc Pedod Prev Dent* 2008; **26**: 4.
3. Kubik M Y, Lytle L A, Hannan P J, Perry C L,

- Story M. The association of the school food environment with dietary behaviors of young adolescents. *Am J Public Health* 2003; **93**: 1168–1173.
4. Maliderou M, Reeves S, Noble C. The effect of social demographic factors, snack consumption and vending machine use on oral health of children living in London. *Br Dent J* 2006; **201**: 441–444, 437.
5. American Academy on Pediatric Dentistry Council on Clinical Affairs. Policy on vending machines in schools. *Pediatr Dent* 2008; **30**(7 Suppl): 49–50.
6. Center for Science in the Public Interest. School Vending Machines "Dispensing Junk". Washington: Center for Science in the Public Interest, 2004. Available at: <http://www.cspinet.org/new/200405111.html> (accessed 13 April 2013).

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CEMENT-INDUCED TRISMUS

Sir, a paediatric patient was referred to our A&E department from their GDP for trismus. The 8-year-old patient had attended the dentist two days earlier for occlusal fillings on both his 26 and 36. Immediately on leaving the dental surgery the patient and parent noticed that the young child could not open his mouth and was locked in position. Concerned, they re-attended the dental surgery, and on examination the dentist could not decipher the cause of the trismus and urgently referred the child to the maxillofacial A&E department. The dentist had used two ID blocks to anaesthetise the patient.

On examination in A&E there was no facial asymmetry, swelling or bruising which would indicate any potential trauma caused by an ID block resulting in possible trismus. Furthermore, the mouth opening was less than 1 mm, and this was an unusual acute finding with no extraoral or intraoral signs of swelling. The patient was in no pain, and was quite astonished that the filling had been that 'strong'. This idea of the filling being 'strong' led to further questioning. The child reported that on placement of both the upper and lower filling he had been asked to bite down hard. Nothing was placed in between the teeth when biting down, and the patient left the surgery still biting down. Following this the patient could not open his jaw.

Using a Mitchell's trimmer the contact points between the 26 and 36 were broken. Immediate resolution of the trismus was achieved.

I believe this may be the first case of glass-ionomer cement induced trismus reported in the scientific literature!

M. Basati, by email

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