

# Letters to the Editor

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## UNJUST, RELATIVELY IGNORED

Sir, how refreshing to read A. Holden's paper *Public opinion* in the *BDJ* (2013; 214: 383–385). What an enlightened young GDP. As a GDP and visiting Professor of Community General Dental Practice at the University of South Wales I was totally in tune with his opening statements, particularly: '...I like dental public health. My friends and colleagues (GDPs) give me a strange look when I tell them this.'

The paper informs the reader that the oral health problem is presently social inequality, a reality which many GDPs are aware of but in reality is it their problem? The question is do GDPs have a role in addressing social inequality? Do GDPs treat populations or individuals?

Dr Holden clearly describes the barriers that individuals from deprived populations have in order for them to choose healthy pathways.

He then identifies that his FD1 training omitted community dentistry implying that these aspects of training were unimportant compared with other clinical hands-on specialities. As a recent trainer of FD1s I agree with his sentiments.

If GDPs are to have a role in addressing social inequalities in oral health then clearly they need to be equipped with the tools to help them do this and they need to be rewarded for their actions. The pilots for developing new contracts for GDPs may address appropriate rewards. However, there is little in the narrative in how to influence behaviour change, particularly with regard to individuals from disadvantaged groups becoming regular attenders. There is almost a 'hidden' assumption that these individuals do not want this pathway.

In order to facilitate change with

individual patients the skills of health behaviour change (HBC) need to be identified, acquired and practised by GDPs and their teams. One key skill is that of motivational interviewing (MI).<sup>1–3</sup> MI is based on autonomous collaborative relationships in which the leader (GDP) values the four principles of empathy, self-efficacy, discrepancy and 'rolling with resistance'. I take no responsibility to further expand here and understand if readers feel frustrated but this possibly demonstrates the need for training.

Dr Holden is correct in identifying that the social determinants of health are beyond the individual practitioner but he does say that the dental profession should not rest upon their laurels because of the observed improvement in population oral health. The improvement means that the gap between the best and worse is wider and this situation is unjust and relatively ignored.

When we know that caries and periodontal disease are preventable for most individuals it is particularly unjust if disadvantaged groups are not able to access appropriate dental care. While appropriate care does not mean emergency treatment at an access centre, a care pathway underpinned on the principles of HBC and MI may facilitate better health outcomes for this sub-group.

Ignoring the wider influences that affect oral health in society could generate a negative public opinion of dentists. Treating individuals in the surgery in the context of an understanding of disease distribution in the population and applying HBC modalities is likely to generate a positive public opinion of dentists.

Before an appreciation of the reality of the social determinants of health can be achieved, as Dr Holden states, greater

support for dental public health theory is required by the dental profession. Then the principles can be transferred into practice, particularly the skills of HBC.

W. Richards  
By email

1. Mason P, Butler C C. *Health Behaviour Change: a guide for practitioners*. Churchill Livingstone Elsevier, 2010.
2. Ramsier C A, Survan J E. *Health behaviour change in the dental practice*. Wiley-Blackwell, 2010.
3. Richards W. Patient-centred dental practice: a behavioural approach. *Dent Nursing* 2010; 8: 443–447.

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## NEEDLESS NEEDLE LOSS

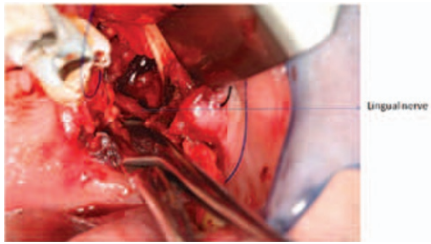
Sir, we would like to bring this case report to the attention of your readers as a timely reminder to them of the small but significant risk of needle breakage during inferior alveolar nerve block. This has serious implications for the patient and practitioner.<sup>1</sup>

A 62-year-old male was referred to the local maxillofacial team by his dentist following the breakage of a dental needle in the pterygomandibular space while administering an inferior alveolar nerve block. Plain radiographs showed the presence of the needle high in the ramus.

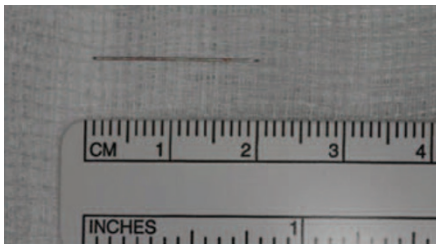
The needle was electively removed under general anaesthesia. Surgical exploration of the pterygomandibular space was carried out with the aid of image intensification in theatre<sup>2</sup> and the needle was found positioned medial to the lingual nerve (Fig. 1). Recovery was uneventful.

Although needle breakage is rare, it can and does occur. Evidence shows breakage is most common during administration of an inferior alveolar nerve block with a short 30-gauge needle.<sup>3</sup>

Prompt referral to the maxillofacial team is essential due to the risk of needle



**Fig. 1** The needle was found positioned medial to the lingual nerve



**Fig. 2** The 20 mm retrieved needle

migration into vital structures and also to minimise long term morbidity for the patient. Complications include trismus, pain, infection, and damage to the inferior alveolar and lingual nerves.<sup>1</sup>

To prevent needle breakage practitioners should use 27-gauge 35 mm needles for IAN block, avoid inserting to full length or burying the needle in the tissues, ensure patient cooperation thus avoiding sudden movements, and avoid bending needles or changing direction while still located deep in the tissues or exerting lateral pressure on withdrawal.<sup>3</sup>

A. Bawor-Omatseye, A. Majumdar  
By email

1. Ethunandan M, Tran A L, Bowden J, Seal M T, Brennan P A. Needle breakage following inferior alveolar nerve block: implications and management. *Br Dent J* 2007; **202**: 395–397.
2. Thompson M, Wright S, Cheng L H, Starr D. Locating broken dental needles. *Int J Oral Maxillofac Surg* 2003; **32**: 642–644.
3. Augello M, von Jackowski J, Gratz K W, Jacobsen C. Needle breakage during local anaesthesia in the oral cavity – a retrospective study of the last 50 years with guidelines for treatment and prevention. *Clin Oral Invest* 2011; **15**: 3–8.

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## TONGUE CANCER SUBGROUP

Sir, we are writing to share our concerns about the delayed diagnosis of oral cancer among non-smoking women in Jordan which we think may have wider implications.

Over the last year, we have seen four female patients with tongue cancer (Fig. 1). They were aged over 40 except one who was 38 years old. None of them had the classical risk factors for

oral cancer; they were non-smokers and non-alcohol drinkers. They were seen by a substantial number of physicians and dentists mainly for the same complaint of a non-healing ulcer on the right aspect of the tongue posteriorly. No-one suspected that this was oral cancer because the patients were female and non-smokers. In each case biopsy was delayed and eventually diagnosis was reached at a late stage when the cancer became advanced, worsening the prognosis.



**Fig. 1** A 70-year-old female had been complaining of a sore tongue for eight months. No treatment was provided by her physician apart from mouthwash and antibiotics. Later on, her tongue became immobile, numb and she suffered difficulty with speech and swallowing

A recent Australian study pointed to a growing subgroup of oral cancer patients who are non-smokers and non-drinkers. According to Koo *et al.*,<sup>1</sup> this group of patients has a significantly worse disease-specific mortality, and they explain this by the presence of certain aetiological and genetic differences in tumours between this and the smoker group, resulting in either more locally aggressive disease or an increased likelihood of nodal and distant spread. Environmental exposure to secondhand smoke could be a major confounding factor. Kansy *et al.*<sup>2</sup> suggest that high-risk HPV infection is a predominant factor in the development of oral squamous cell carcinoma (OSCC) in patients who do not smoke or drink. On the other hand, Koo *et al.*<sup>1</sup> suggest that HPV may confer a worse prognosis in tumours of the tongue, and as tobacco use decreases, they predict that the proportion of this group among OSCC patients will increase.

Dentists and physicians alike should be aware that female non-smokers can get oral cancer, and that of those diagnosed, the prognosis can be poor. Diagnosis

should be established as early as possible by not neglecting any persistent lesion, particularly if it is an ulcer affecting the tongue. Patients would probably go to their physicians or dentists for reassurance regarding such lesions. Appropriate procedures like early referral and histopathological examination could save a patient's life or at least improve treatment outcomes and quality of life.

N. Dar-Odeh, O. Abu-Hammad, Amman

1. Koo K, Barrowman R, McCullough M, Iseli T, Wiesenfeld D. Non-smoking non-drinking elderly females: a clinically distinct subgroup of oral squamous cell carcinoma patients. *Int J Oral Maxillofac Surg* 2013; **42**: 929–933.
2. Kansy K, Thiele O, Freier K. The role of human papillomavirus in oral squamous cell carcinoma: myth and reality. *Oral Maxillofac Surg* 2012; DOI: 10.1007/s10006-012-0383-0.

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## DIFFERENT PERSPECTIVES

Sir, in response to Mr Roy Abrahams (*BDJ* 2013; 215: 4), it is interesting how easy it is for people to remember events from different perspectives. David DiBiase did indeed agree with me to undertake a pilot project comparing the correction of ten millimetre overjets (OJ) by straight wire or orthotropics. It was a shame that he never released the facial images of the end results which was the intended purpose of the study, and also that he did not agree to progress to the main study, despite a highly significant 25° difference in growth direction. Prospective orthodontic comparisons are rare enough and this unfortunately gave the impression of exclusion.

Personally I do not remember any other offers of research and there has certainly never been an independent assessment of orthotropics. However, it is never too late, and considering that Roy is correcting 12 mm OJs as bread and butter may I again offer to cooperate with him in a comparative orthodontic and orthotropic research project of ten millimetre overjets as it really matters to know the truth?

J. Mew

The London School of Facial Orthotropics

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## DIODONTIC IMPLANT

Sir, a male 41-year-old army officer presented for a periodic dental inspection. On examination a metal ceramic crown was noted on the upper right central