

# LETTERS TO THE EDITOR

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## ORAL HEALTH

### Spitting evidence

Sir, in a letter J. Hartley wonders where the evidence for 'spit don't rinse' after toothbrushing originates (*BDJ* 2014; 217: 206). A previous article in the *BDJ* explains this well.<sup>1</sup> As long ago as 1992 there was evidence of caries reduction if fluoride toothpaste was not rinsed off.<sup>2</sup> In this study a 6% reduction in caries incidence was found and later studies have shown a larger reduction of up to 16%. Dr Hartley mentions a case in America where ingestion of excess fluoride was a problem. This is easily avoided by using only a pea-sized blob of toothpaste. It has been recommended to rinse with a small amount of water,<sup>3</sup> but the most widely accepted advice is indeed to 'spit not rinse'. *Delivering better oral health* states that there is grade 4 evidence to support it, ie evidence from well-designed, non-experimental studies from more than one centre or research group.<sup>4</sup> This has been taught to many dental nurses on fluoride varnish courses and to avoid confusing our patients it is important that our advice is evidence based, and consistent. I hope that this helps.

M. Wanless, by email

1. Pitts N, Duckworth R M, Marsh P, Mutti B, Parnell C, Zero D. Post-brushing rinsing for the control of dental caries: exploration of the available evidence we should give our patients. *Br Dent J* 2012; 212: 315–320.
2. Chesters R K, Huntington B, Burchell C K, Stephen K W. Effect of oral care habits on caries in adolescents. *Caries Res* 1992; 26: 299–304.
3. Ashley P J, Attrill D C, Ellwood R P, Worthington H V, Davies R M. Toothbrushing habits and caries experience. *Caries Res* 1999; 33: 401–402.
4. Department of Health. *Delivering better oral health: an evidence-based toolkit for prevention*, 2nd ed. BASCD/Department of Health, 2009.

DOI: 10.1038/sj.bdj.2014.1057

### Integral to oral hygiene

Sir, J. Hartley, in a letter published in *BDJ* volume 217 no. 5, asks 'where this new advice, "Spit don't rinse", is coming from'. In their paper, *The influence of toothbrushing and post-brushing rinsing on caries experience in a caries clinical trial* (*Community Dent Oral Epidemiol*

### SEE RUSKIN

Sir, I read the letter from S. Ward<sup>1</sup> with a heavy heart but no great surprise. My own response to similar queries as to the price of my services was to point the patient – and I still regard them as patients – to the writings of John Ruskin:

*'There is nothing in the world that some man cannot make a little worse and sell a little cheaper, and he who considers price only is that man's lawful prey.'*

1998; 26: 406–411), Chestnutt I G, Schafer F, Jacobson A P and Stephen K W reported the beneficial effect on caries increment of spitting rather than rinsing after toothbrushing with a fluoride toothpaste. These authors recommended that the 'spit don't rinse' message should be integral to post-brushing oral hygiene instructions.

D. R. McCall  
Dalbeattie

DOI: 10.1038/sj.bdj.2014.1058

### Toothbrushing evolution

Sir, I read with interest the recently published paper on toothbrushing (*BDJ* 2014; 217: E5). However, I was disappointed that the authors were rather selective in their literature review and somewhat failed to convey the well-documented evolution in toothbrush technology and toothbrushing methods that has occurred over the past 20 years.

In 1998, a European Workshop on Mechanical Plaque Control published a comprehensive review of methods of toothbrushing<sup>1</sup> and reiterated the statements from the 1986 World Workshop<sup>2</sup> that 'improvement in oral hygiene is not as dependent upon the development of better brushing methods as upon improved performance by the persons using any one of the accepted methods'.

In addition, Beals *et al.*<sup>3</sup> evaluated the brushing techniques of adults in three separate geographic regions using video recordings and reported that in an

If Mr Moyes insists that we no longer have patients but customers, how long will it be before we have the equivalent of supermarkets selling horsemeat labelled as beef?

Professional healthcare is not and can never be retailing and if Mr Moyes and the GDC believe that it should, they should not be regulating a profession.

J. Walker, by email

1. Ward S. Unbelievably arrogant. *Br Dent J* 2014; 217: 162.

DOI: 10.1038/sj.bdj.2014.1059

average brushing time of 46 seconds, a combination of three basic movements was used, with the horizontal scrub being employed nearly 70% of the time – in line with other published studies.<sup>4</sup>

Based on the available research Loe concluded in his Millennium Lecture at EuroPerio in 2000<sup>5</sup> that in order to enhance plaque control the time had come to consider new toothbrush technologies and ways to simplify oral hygiene procedures. Towards this end, the cross-action manual toothbrush was developed with the intention of designing a toothbrush which could enhance plaque removal when used with a horizontal natural brushing technique. A 16° bristle angle was demonstrated to improve interproximal penetration, resulting in a significant increase in plaque removal.

A recent systematic review on the efficacy of manual toothbrushes by Slot *et al.* reported that 'clinical studies have consistently demonstrated that a brush with an angled bristle tuft configuration is significantly more effective'<sup>6</sup> Contemporary power toothbrushes are proving to be even more efficient in removing plaque, specifically brushes with an oscillating rotating head, which have been consistently shown in a Cochrane systematic review<sup>7</sup> and two subsequent updates<sup>8,9</sup> to be more effective than manual brushes in removing plaque and reducing gingivitis in both the short- and long-term.

L. Mackenzie, by email

- Jepsen S. The role of manual toothbrushes in effective plaque control, advantages and limitations. In Lang N P, Attström R, Løe H (eds). *Proceedings of the European Workshop on Mechanical Plaque Control*. pp 121–137. Chicago: Quintessence Publishing Co., 1998.
- Frandsen A. Mechanical oral hygiene practices. In Løe H, Keinan D V (eds). *Dental plaque control measures and oral hygiene practices*. pp 93–116. Oxford, Washington DC: IRL Press, 1986.
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DOI: 10.1038/sj.bdj.2014.1060

## ERGONOMICS

### The only way

Sir, I was interested to read the abstract from the *Lancet* (*BDJ* 2014; **217**: 183) on the result of a study of the efficacy of paracetamol for lower back pain. A median time of 17 days to recover is far from acceptable.

How long is it going to take for the message to get across that the only way to reduce the incidence of back pain (caused by working in distorted posture) is by PREVENTION? ie by teaching dentists how to work in correct and undistorted posture. Pills are not the answer.

Why, after all these years, will the profession not accept this but instead allow thousands of dentists to suffer a lifetime of pain?

E. Paul, by email

DOI: 10.1038/sj.bdj.2014.1061

## MOUTH CANCER

### A mnemonic

Sir, following an article in the *BDJ*,<sup>1</sup> as a general dental practitioner attempting to apply defined, repeatable and predictable techniques to my patient examination and management, I have devised a mnemonic (with peer review strongly encouraged) for use when describing oral lesions especially in reference to early recognition of oral cancer as shown in Figure 1.

As identified in the article,<sup>1</sup> urgent development is required in both

Dental professionals – Duration (+)  
 Should – Site (+)  
 Refer – Rolled borders? (\*)  
 Suspected – Size (+)  
 Oral – Obvious cause ruled out (\*)  
 Cancer – Colour (+)  
 For – Firmness or fixation (\*)  
 Urgent – Uniformity (+)  
 Specialist – Social history eg smoking (+alcohol), areca nut, HPV (\*)  
 Assessment – Associated features eg pain, bleeding, lymphadenopathy (\*)

Key:

(+) General descriptive features

(\*) 'Red flag' features

Fig. 1 Mnemonic for use when describing oral lesions

public and professional awareness and knowledge, preventive strategies and tools for earlier diagnosis. This system, if given broad exposure (and amended appropriately following peer review if necessary), has the potential to deliver on the latter three points and, hopefully, go some way to reducing the burden of mouth cancer in the UK.

K. Durman, Exeter

- Scully C, Kirby J. Statement on mouth cancer diagnosis and prevention. *Br Dent J* 2014; **216**: 37–38.

DOI: 10.1038/sj.bdj.2014.1062

## ORAL SURGERY

### Dividing opinion

Sir, the optimum management of mandibular third molars (MTM) that pose a risk of injury to the inferior dental nerve (IDN) is unresolved. Part of the problem is that the true risk of injury with different radiographic appearances has not been quantified in anything near a scientific approach that has credence. Nerve injury has become an accepted accompaniment to MTM removal but with modern approaches this perspective is increasingly open to challenge.

When a patient presents with an impacted MTM that obviously poses a risk to the IDN a number of surgical approaches have been proposed. One is the use of cone beam CT (CBCT) to gain 3D information on the relationship of the IDN canal to the tooth roots. An alternative option is to avoid encroaching on the nerve-root interface by performing a coronectomy. There is no consensus on how these options should be applied.

In the event of nerve injury the medico-legal response is to claim a failure of care if either one or both options have not been