

LETTERS TO THE EDITOR

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DIRECT ACCESS

Conflict between sub-groups

Sir, I read with great interest the research article by Northcott *et al.* (*BDJ* 2013; 215: 607–610) relating to direct access for dental hygienists and therapists. As I read the article as someone who believed that they understood the current status of scope of practice and direct access, I was struck by how complex and confusing it actually is. At a time when the General Dental Council have proposed to remove the honorary 'Doctor' title from dentists so that patients are not confused and muddle us up with their GMP, it seems that patients may be put at risk by assuming that all levels of dental health professional have the same ability to screen, diagnose, order special tests and perform treatment. That is, unless a structured, integrated and collaborative approach is taken in which each member of the dental team has a clearly defined role.

In September, I attended a national conference at which I was joined, for the most part, by dentists. At that conference a programme director for a BSc in oral health sciences took to the podium to expound the benefits of using therapists as part of the comprehensive treatment of paediatric patients. Instead, the presentation seemed to be a call to train more therapists and fewer dentists. Whilst a lot of what was said was valid in terms of economics and indeed patient care, the delivery was very antagonistic towards dentists as a group. We were repeatedly told that therapists could do periodontal treatment and direct restorative work to a higher standard than dentists. We were reminded that, with training, many additional skills could be acquired by therapists that would render dentists surplus to requirements, perhaps with the exception of some advanced restorative work and complex dentoalveolar surgery. While a lot of the above may be true, it does not benefit anybody – patients, therapists, hygienists, dentists or taxpayers – if each group relentlessly seeks to promote their own role, skills and 'market position' to the exclusion of others.

What is needed is a mature, respectful and collaborative dialogue with patient care at its focus. Professional associations, regulators, academic institutions and policy makers must work together to develop a framework for the future delivery of dental care in the NHS which meets the needs of our patients first and foremost. The future dental workforce must be able to cope with our population's present and future oral health needs.

I am grateful that the authors of this study have highlighted some of the issues in the Netherlands in relation to direct access. I hope that as a group of dental healthcare professionals we can learn some of the lessons from the Netherlands to ensure that patient care is not compromised by conflict between sub-groups of dental professionals.

C. Levey
Glasgow

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ORTHODONTICS

Not a causative agent

Sir, I am writing to express my concern regarding your recent *BDJ* paper regarding prevention and treatment of demineralisation during fixed appliance therapy (*BDJ* 2013; 215: 505–511).

The body of the article correctly associates orthodontic fixed appliance systems as a risk factor in the development of enamel demineralisation. I further support their view that disregard of the aetiology and development of this process in orthodontic patients leaves clinicians at risk of being clinically negligent and the subject of litigation.

It was with some surprise therefore that I read Figure 1 showing a patient who has enamel demineralisation 'caused' by fixed appliances. This demineralisation has not been caused by the fixed appliance. It is associated with the process and is a risk factor in its progression but it is not a causative agent and there is not a cause-effect relationship between the two.

This misunderstanding of the relationship between orthodontic

appliances and enamel demineralisation sets a concerning precedent with the ever-growing threat of litigation from the legal profession. May I suggest an amendment to the paper to reflect an association rather than a causative effect between these two variables?

S. Lovel
Sunderland

Mr Colin Chambers, the corresponding author of the article, responds: Many thanks for your concerns regarding Figure 1 in our article. I would be more than happy to amend the Figure 1 legend to 'Demineralisation associated with fixed appliance treatment'.

However, the article does clearly explain the disease process that results in enamel demineralisation and should not result in any misunderstandings.

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PIERCINGS

Grossly swollen tongue

Sir, a 45-year-old male presented to the emergency medicine department from an ambulance with a 12-hour history of a grossly swollen tongue. The patient was experiencing difficulty in swallowing and shortness of breath. The severity of the swelling posed a risk to his airway and an anaesthetic opinion was promptly obtained. After administration of steroids and antihistamines the airway was assessed as safe and the patient was seen by the maxillofacial team.

He had a gastric band fitted, took no regular medications and had no known allergies. He could not recall eating any foodstuffs or taking any medications that could have triggered an allergic reaction. On further questioning the patient remembered that he had his tongue pierced ten years ago. The piercing was a stainless steel tongue bar with a spherical bead at either end of the bar. The tongue bar was removed by the patient soon after placement, but when the bar was removed only one of the beads was retrieved. To investigate further, a lateral soft tissue radiograph was taken. This

EDUCATING PATIENTS

Sir, we recently conducted a survey, the aim of which was to assess patient awareness of tooth wear and its risk factors. Fifty consecutive adult patients were seen in two general practices in south-east London. After examination tooth wear grade was determined by a simple method where upper anterior tooth surfaces (buccal, palatal and incisal) were checked for wear and the highest grade recorded; 0 = no wear, 1 = mild wear exposing enamel only, 2 = moderate wear exposing dentine and 3 = severe wear where pulp or secondary dentine is exposed.¹ Questions and discussion then followed to determine patients' knowledge of tooth wear, its risk factors and whether their dentists had discussed this.

The patients (mean age 41 years; 66% female), all with some degree of tooth wear, were from diverse ethnic backgrounds; 44% African and Afrocaribbean origin, 24% White British, 18% Asian origin, 10% Continental Europeans and 2% Irish. The percentages with grades of tooth wear were: grade 1 – 16%, 2 – 74% and 3 – 10%; 40% indicated grinding their teeth at night, 50% brushed their teeth aggressively, 52% consumed large amounts of acidic drinks, fruits and carbonated drinks, 20%

crushed bones in their diet, and 24% suffered from heart burn.

Tooth wear and its risk factors were known about by 56% but only 20% indicated that their dentist had discussed this with them.

The prevalence of tooth wear and its severity is increasing and dentists should play an important role in educating patients on it and its prevention. Questions about tooth wear and its causes as well as advice on prevention should be part of each dental visit. Patients eventually present with tooth wear symptoms, such as sensitivity or an aesthetic problem, and that is usually too late.² Complex tooth wear indices are used in research and laboratory work but are not suitable for basic screening in a general practice setting. Simple tooth wear indices such as the basic erosive wear examination index would help GDPs detect and grade tooth wear easily and effectively.³

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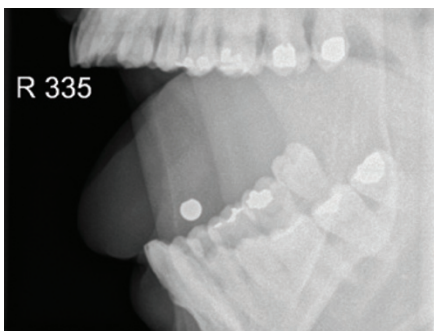


Fig. 1 Lateral view of tongue with spherical bead *in situ*

revealed a spherical bead embedded in the body of the tongue (Fig. 1).

The patient was admitted for intravenous antibiotics. Soon after admission, he had incision and drainage of the tongue with removal of the embedded bead under local anaesthetic.

There are a variety of complications associated with tongue piercings including pain, swelling, prolonged bleeding, chipped, fractured or abraded teeth, gingival recession and mucosal trauma.¹⁻³ There is also a reported case

of a Ludwig's angina that developed secondary to a tongue piercing.⁴ The case we present demonstrates the risks that a dormant foreign body can pose in the tongue. As dental professionals we have an important role in educating patients about the risks of tongue piercings. If a patient discloses that they have an unwanted part of a piercing embedded in the oral cavity, referral to a local maxillofacial unit should be instigated promptly so that removal can be arranged and future complications avoided.

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