LETTERS TO THE EDITOR

Send your letters to the Editor, British Dental Journal, 64 Wimpole Street, London, W1G 8YS
Email bdj@bda.org. 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.

PERIODONTICS

BPE scores

Sir, in the supplement *Oral Health Report* (autumn 2013), Dr Amit Rai's article, *Periodontal care* includes the statement 'the BPE scores do not provide clinical diagnoses'. However, within Table 2 it records that BPE scores of 1 and above signify certain periodontal diseases. For example, a BPE score of 3 signifies 'mild to moderate periodontitis'. I should like to question this as BPE scores are already clearly defined and are limited on what they denote:[1]

BPE	Signifies
0	Healthy periodontal tissues
1	Bleeding on probing
2	Plaque retentive factors such as overhanging restorations or calculus
3	Probing depths of 3.5-5.5 mm
4	Probing score of over 5.5 mm
*	Furcation involvement

The scores do not indicate or signify anything more than this and so, for example, a BPE score of 3 does not necessarily signify 'mild or moderate periodontitis' as there could be false pocketing. Diagnosing periodontitis requires further special investigations, like radiographs. My point is that BPE scores do not signify other periodontal diseases nor should they be linked to certain diagnoses.

P. George, by email

1. British Society of Periodontology. Basic Periodontal Examination (BPE). 2011. Online information available at: http://www.bsperio.org.uk/publications/downloads/39_143748_bpe2011.pdf (accessed 19 March 2014).

Dr Amit Rai responds: I would like to thank Dr George for his letter regarding my recent article Periodontal care – Dr Rai gives a brief review for the general dental practitioner. *Being a 'review', Table 2 was in fact taken from a referenced source, the work of Professor Esmonde Corbet, which Dr George may have overlooked previously in the* BDJ.[1] *Although Dr George justifies my assertion that BPE scores alone do not permit the diagnosis of periodontal conditions, he has misquoted me. Furthermore, he overlooks the fact that I reference Table 2 in the same sentence in which I state 'the BPE does not provide a clinical diagnosis' which I am sure was unintentional since that would otherwise inaccurately infer that my article was contradictory.*

The point that Dr George makes in his letter is already identified in my article where I go on to state that Table 2 'can prove useful for record keeping and patient communication purposes'. However, I recognise his point regarding false pocketing, so in the interests of teamwork, I have highlighted Dr George's observations to Professor Corbet.

1. *Corbet E F. Oral diagnosis and treatment planning: part 3. Periodontal disease and assessment of risk. Table 6.* Br Dent J *2013;* **213:** *111–121.*

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VOLUNTEERING

Lights, lamps and burs

Sir, I am looking for donations of dental equipment to help with my volunteer dental work and I wonder if *BDJ* readers can help. I am a retired community dentist in Wales, and retired from all work dental in the UK. I now work as a volunteer dentist for charities providing free dental work for poor children in under-developed countries.

In 2013 I did volunteer dental work in Vietnam and Ladakh (north India) with a US based charity Global Dental Expeditions (GDE). In 2014 I will be working for GDE in Nepal (in April/May), and in Kenya (in August/September) with the Swedish Rotary Doctors charity.

We work in quite difficult clinical situations using mobile equipment doing the best we can to treat children, who otherwise would not receive dental care. The dental work needed is often extensive, and our equipment is very basic. I need: a dental head lamp – LED cordless; a composite curing light – cordless; high speed diamond burs; and an apex locator. I wonder if any dentist out there has any of these items that could be donated to greatly assist my charity volunteer work? With thanks in anticipation. Please contact me on birgitta@jibi.eclipse.co.uk.

J. Edwards, by email

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DENTIST SUICIDES

Professional investigations

Sir, prompted by recent *BDJ* content on dentists' suicides[1] I instigated a two-question poll on a dental discussion site in an effort to gain a better understanding of profession-related stressors and their effects. The first asked whether the respondent had considered suicide when under severe professional stress and if so, the stage to which it was taken. The second asked which element of a professional investigation a respondent found to be most stressful. The polling system was anonymous and limited in nature and so it is not possible to know if a respondent answered one or both questions or answered one twice.

The poll received a total of 98 votes, 66 for the question on suicide and 32 for that on the greatest stressor. Could this be taken to suggest that approximately half the most stressful episodes experienced by participants were associated with some form of formal investigation? Of the participants who answered the first question, 57.6% (n = 38) had never considered suicide, 36.4% (n = 24) had considered suicide, 4.5% (n = 3) had planned committing suicide and 1.5% (n = 1) had attempted committing suicide. If this is a reasonable reflection of the profession as a whole, then many colleagues suffer a disturbing level of anxiety as a consequence of profession related stress.

Of the respondents who answered the second question, 34.4% (n = 11) reported GDC investigation as the greatest cause of stress, for 31.3% (n = 10) it was communicating with the patient, for 21.9% (n = 7) their defence body, for 9.4% (n = 3) counter fraud investigation and for 3.1% (n = 1) it was their non-defence body legal team. It should be acknowledged that other stressors such as family, financial and social effects might have been most relevant to some colleagues.

If the responses for these two questions are representative of the profession as a whole, then it should be assumed that approximately two in five will at least contemplate suicide and that over 5% may plan or attempt suicide. When

DEFLUORIDATING WATER

Sir, fluorosis is an important clinical and public health problem in several parts of the world where natural levels of fluoride are high, with global prevalence of about 32%.[1,2] Water fluoride levels in India range from 2-29 ppm, whereas the permissible level in drinking water according to the WHO standard is 1.0-1.5 ppm.[3]

The conventional methods of fluoride removal include: precipitation, ion-exchange, reverse osmosis and absorption but all these methods are relatively expensive.[2] Consequently, there is continuous research into a relatively inexpensive, easy and faster method of defluoridation. The use of natural products has recently been rediscovered by water-supply technologists and is being further developed with more scientific rigour.[1] Recently, researchers in India have developed a filter system based on a medicinal herb, which can quickly and easily remove fluoride from drinking water. Tridax procumbens – a medicinal herb has been tested for the extraction of heavy metals from water. Singanan has suggested this medicinal herb as a biocarbon absorbent for fluoride.[4] When this herb is loaded with aluminium ions it is possible to create a safe biocarbon filter that readily absorbs fluoride ions from water. These trials show that it takes just three hours to remove 98% of fluoride with just 2 g of the biocarbon filter, which might provide an inexpensive way to defluoridate water in regions where the natural level of this mineral is high including in India, China, Sri Lanka, the West Indies, Spain, Holland, Italy, Mexico, North and South America.[4]

N. Anand Ingle, H. Vardhan Dubey, N. Kaur, A. Nagpal, by email

1. Kharb P, Susheela A K. Fluoride ingestion in excess and its effect on organic and certain inorganic constituents of soft tissues. *Med Sci Res* 1994; **22:** 43–44.
2. Puthenveedu Sadasivan Pillai Harikumar, Chonattu Jaseela, Tharayil Megha. Defluoridation of water using biosorbents. *Natural Science* 2012; **4:** 245–251.
3. Anurag Tewari, Ashutosh Dubey. Defluoridation of drinking water: efficacy and need. *J Chem Pharm Res* 2009; **1:** 31–37.
4. Malairajan Singanan. Defluoridation of drinking water using metal embedded biocarbon technology. *Int J Environmental Engineering* 2013; **5:** 150–160.

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considered together the results for both questions suggest that all professional bodies associated with professional investigations should be aware of the potentially severe psychological effects on the dentist. They also suggest that there are grounds for early referral to appropriate support services in such circumstances.

Paul V. Mc Crory, Stockport

1. Renshaw J. Dentist suicides. *Br Dent J* 2013; **215:** 593-594.

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We live longer than politicians

Sir, the debate about the apparently high suicide rate of dentists is nothing new and just as inaccurate now as it has always been. Public perception, for as long as I can recall, is that dentists have the highest suicide rate of all professions but this is not so and never has been the case.

In the early 1990s the *BDJ* acknowledged the need for a book compiling an index of risks and hazards to the dental team and in its own words to list 'an indication of when to flap or not'. Subsequently a book was published by BDJ Books: *Occupational hazards to dental staff*, which included a review of causes of early death.

I was asked to review this book in 1993 for a professional dental journal, and clearly recall that we fare much better than other health professionals including doctors, opticians and pharmacists, all of whom have (or had?) a higher incidence of suicide, heart disease and cirrhosis than the dental team. My only concern was that even then, these statistics were compiled in 1972.

However, perhaps we should be more gratified to learn that the life expectancy of a dentist is actually marginally better than an MP!

R. Kitchen
Bristol

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FACT OR FICTION

Horse-chestnut toothpaste

Sir, I attended a school in the early 1960s which had many horse-chestnut trees within the grounds. We were told that during WWII, conkers were collected by staff and students alike for use in toothpaste manufacture.

Was this true? Or were they in fact being used for cordite production, with the toothpaste story a cover? Can any reader enlighten me?

M. Yewe-Dyer, by email

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