LETTERS TO THE EDITOR

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DENTAL GRADUATES

Not all doom and gloom

Sir, I agree with Lewney[1] that it is currently a strange time in dentistry where the younger generations are finding it difficult to secure their dream jobs in general dental practice. When I joined dental school in 2008, job security was almost a guarantee, making one almost exempt from the uncertainty of future employment. Nowadays, with the implementation of national recruitment and only limited dental foundation (DF) training posts, UK graduates are being pushed out by the competition, finding it harder to secure a DF post and subsequent associateships.

I guess after five long years at dental school we expected some remuneration and feel hard done by in the current dental jobs market. For us young dentists, deciding whether to stay in general practice or to specialise can be a tough decision to make. With the contract reform coming along, it seems the general dentist will have to take extra measures, ie postgraduate training, to prove they are capable of carrying out the more complex treatment plans for patients. The days of having just a BDS are diminishing.

However, I do feel it is not all doom and gloom; there are a lot of other professions and jobs with far worse prospects than ours and we need to get out of our bubble and learn to beat the competition to secure that ideal job. We should build our CV by attending courses, undertaking postgraduate training, build a portfolio with high quality clinical photographs, write articles, become a member of the LDC, ask patients to write testimonials and observe local specialists to learn new skills ... the list goes on!

Now is a better time than ever to connect with each other and support one another as a profession and that's why I started www.thedental-network.com. I saw a need for all dental professionals (nurses, dentists, hygienists, specialists and technicians) to come together as one big supporting team by creating a dental directory website. The purpose of this idea was to allow dental professionals to easily seek information about fellow colleagues or dental practices, to open doors and build on a career pathway. I would like to encourage *BDJ* readers to join the network.

A. Patel
By email

1. Lewney J. Are these the good old days? *Br Dent J* 2014; **216:** 221–222.

DOI: 10.1038/sj.bdj.2014.405

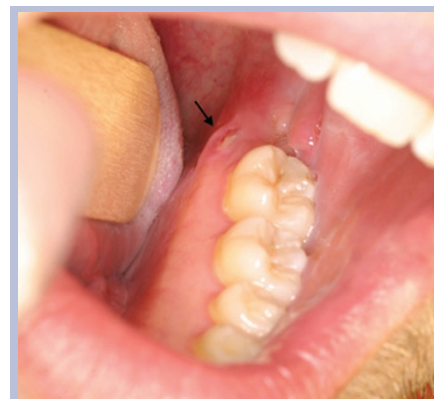
ORAL SURGERY

Prominent bone shelves

Sir, the majority of reported cases of mandibular osteonecrosis and bone exposure have been associated with bisphosphonate use or radiation therapy. However, three publications in the *BDJ* have reported such findings in the posterior and medial aspect of the mandible not being associated with medication or radiation.[1–3] We wish to present another interesting case.

A healthy, non-smoking and non-medicating 31-year-old Caucasian male underwent uncomplicated surgical removal of partially erupted mandibular third molars on both sides. Five weeks post-surgery, the patient presented with discomfort and moderate pain of two days duration from both sides of the posterior and medial aspect of the mandible. Examination revealed bilateral necrotic bone exposure on the medial bone shelves at the level of the removed third molars (Figs 1 and 2), each measuring approximately 2 × 2 mm. The surrounding mucosa was inflamed, but without sign of infection. Radiographic examination revealed no pathology. The patient was prescribed paracetamol for pain control and chlorhexidine oral rinse for the inflamed mucosa. The necrotic and exposed bone parts exfoliated spontaneously seven weeks post-surgery. Healing was confirmed eight weeks post-surgery.

Overall, mandibular tori and the posterior aspect of the medial shelf (at the level of the mylohyoid ridge) are



Figs 1–2 Bilateral necrotic bone exposure of the medial aspect of the mandible at the mylohyoid ridge

two of the most common locations for osteonecrosis. Prior to surgery, it was noted that the patient had bilaterally prominent mandibular shelves. A standardised lateral approach was used on both sides and there was no perforation of the medial wall during the surgery. Hence, the osteonecrosis was likely secondary to bone remodelling post-surgery.

It is important for dental surgeons to be aware that osteonecrosis of the mandible is not always associated with medication or radiation but can occur in healthy patients. The local anatomy of the medial shelf needs to be examined prior to surgery in the posterior aspect of the mandible, and patients with prominent bone shelves should receive preoperative information that there is a small risk for delayed healing. As the complication described in the present case is rare, changing the surgical approach is not advised. However, a medial flap instead of a lateral could be considered in selected cases. This approach will allow the

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