

LETTERS TO THE EDITOR

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PERIODONTOLOGY

A little caution

Sir, I was interested to read the correspondence provoked by Dr Batchelor's recent opinion piece (*BDJ* 2014; 217: 405–409). There is now good evidence that proper periodontal therapy followed by assiduous supportive therapy is effective in treating and maintaining the dentitions of patients with chronic periodontitis.

If it turns out that chronic infection and inflammation affecting a substantial area of soft tissue persisting over many years does indeed contribute significantly to systemic ill-health and morbidity, would this then become a public health issue?

Many diabetic patients do not comply with health and lifestyle recommendations, but we would still regard it as appropriate to offer the best treatment we can to maintain health. Perhaps we should be a little cautious in judging the value or otherwise of periodontal therapy?

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By email

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PREVENTIVE DENTISTRY

Early childhood caries in infants

Sir, following recent publicity dealing with early childhood caries (ECC) in the press and the screening of the Channel 4 programme '*Junk food kids*', I am very concerned that, despite much research and knowledge about this problem, it is still as bad as it was 50 years ago when I first became involved in paediatric dentistry. The problem is a behavioural one involving a lack of knowledge and education among inner city parents with children at risk.

We know that very early diagnosis and the implementation of preventive care stops any early manifestations of ECC or, indeed, prevents it. The answer for many years has been that all children should be seen and under the care of a dentist by the first year of life, 'A dental visit by one'. This rubric has become established in paediatric dentistry but has not been effectively introduced in Great Britain.

ACIDIC SALIVA SUBSTITUTES

Sir, the articles by Jawad *et al.*, A review of dental treatment of head and neck cancer patients before, during and after radiotherapy: parts 1 and 2 (*BDJ* 2015; 218: 65–68 and 69–74), provide a useful overview of the management of patients receiving radiotherapy in the head and neck region. The papers highlighted how the management of these patients can be challenging and a team approach is most effective.

The authors discuss xerostomia and its management, and detail various saliva substitutes. They explain that some preparations are acidic and should be avoided in dentate patients. We feel it would be useful to further expand on this point. For patients attending our oncology support service we have identified several inappropriate prescriptions, mainly from some of our medical colleagues, and feel it would be useful to raise awareness of this issue.

A UK Medicines Information (UKMi) document¹ is a good reference and details three preparations as acidic and best avoided in dentate patients: Glandosane synthetic saliva, SST tablets

(although it is formulated with a calcium phosphate dibasic buffer to prevent demineralisation) and Biotene Oralbalance gel (although a reformulated version with a pH closer to neutral is now available). Glandosane has been shown, in many *in vitro* studies, to have detrimental demineralising effects on enamel and dentine.^{2–4} As alternatives are available it would seem appropriate to avoid these preparations in dentate patients.

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1. Henderson S. *Saliva substitutes: Choosing and prescribing the right product*. UK Medicines Information (UKMi), 2013. Available online at: www.ukmi.nhs.uk/filestore/ukmias/NWQA190.6Salivasubstitutes.doc (accessed April 2015).
2. Kielbassa A M, Shohadai S P, Schulte-Mönting J. Effect of saliva substitutes on mineral content of demineralized and sound dental enamel. *Support Care Cancer* 2001; **9**: 40–47.
3. Meyer-Lueckel H, Schulte-Mönting J, Kielbassa A M. The effect of commercially available saliva substitutes on predemineralized bovine dentin *in vitro*. *Oral Dis* 2002; **8**: 192–198.
4. Zandim-Barcelos D L, Kielbassa A M, Sampaio J E, Tschoppe P. Saliva substitutes in combination with high-fluoride gel on dentin remineralization. *Clin Oral Investig* 2015; **19**: 289–297.

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Outreach research studies, in the UK, Australia and Brazil, have all shown a substantial and significant prevention, as high as 95%, of ECC when preventive advice for mothers is started as soon as the first primary teeth erupt. When infants are under the care of dentists with repeated dental visits, if necessary at four-month intervals if there is any sign of enamel demineralisation, ECC can be eliminated.

It follows that every general dentist should now be ensuring that children born to mothers within their practice area should be seen soon after the primary incisors erupt and by the first birthday at the latest. The examination of infants is extremely easy, requiring infants to be wrapped in a favourite blanket on their mother's lap with their head cradled on a dentist's lap. Any

sign of demineralisation can be demonstrated to the infant's mother and preventive advice given. By doing so not only is ECC largely prevented but the oral health knowledge of the mothers also increases.

Mothers from high-risk, low-socio-economic backgrounds pose an additional problem of often not being registered with an NHS dentist but this can be solved by dentists working with the home visitors who follow up all births in the local community. By dentists working with the post-natal visitors a referral system should then ensure that these at-risk infants are seen before ECC becomes established. A major national campaign is needed led by the dental profession in co-operation with the NHS.

It has been long established that when children's primary dentitions are kept free