LETTERS TO THE EDITOR

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MAGNIFICATION

Magnifying the point

Sir, we were interested to read K. F. Marshall's letter about the use of magnification in dentistry (*BDJ* 2015; **218:** 369). A study in October last year at New Zealand's only dental school showed that 23% of the 285 BDS students surveyed used magnification loupes. The percentage increased from 2% among the second year students to 48% in the final year. All final year students without loupes intended purchasing them. Over half of those wanting to buy cited expense as the limiting factor. Among the clinical teachers 72% of the 85 surveyed used loupes, most with 2.5× magnification. Exactly half of their loupes had an attached light.

Loupes are therefore not an alien concept in all dental faculties. We strongly encourage their use, not only to enhance clinical outcomes but also to improve the student's posture.

C. M. Murray, N. P. Chandler
Dunedin, New Zealand
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GOOD PRACTICE

The gloves are on

Sir, I read with interest the article 'Glove wearing: an assessment of the evidence' (*BDJ* 2015; **218:** 451–452) and find myself in full agreement with the closing sentence '...it is the responsibility of the wider medical fraternity to look ahead on the basis of science and logic rather than emotion'.

I have therefore come to the conclusion that there is more evidence in favour of the wearing of gloves while treating patients than in the practice of orthotropics.

P. Ramsay-Baggs,
N. Ireland
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SAFEGUARDING CHILDREN

Sir, the tragic death of a child in 2000 eventually led to the statutory enactment of a national database for children in 2007 called ContactPoint.[1] ContactPoint was to contain key health personnel that came into contact with children. It was scrapped by the government in 2000.

Key health personnel recorded in ContactPoint were the GP, midwife, health visitor and school nurse. Dental surgeons and opticians were omitted. The same omissions appeared to have happened with the NHS Spine. These two groups are the very clinicians that should have regular contact with all children. Not having and not regularly visiting a dentist is a safeguarding issue.

In some hospitals, an electronic discharge summary copy is sent automatically to the GP as a result of the IT system's link to the NHS Spine. For dentists, this still has to be on paper.

The first time a GP hears of a dentally-related hospital admission is sometimes via the automatic electronic discharge summary. Dentists refer patients to hospitals and a consented referral copy to the GP is courteous. This may also occasionally enable another procedure to be done simultaneously under the same general anaesthetic if one is required. This can be especially helpful and kind for patients with additional needs.

The mandatory inclusion of a dental surgeon and optician on the NHS Spine would help satisfy the 'be healthy' component of safeguarding. If a child has a mouthful of dental abscesses and cannot see the whiteboard, the 'be healthy' component of safeguarding has not been achieved, even though the child may have a reasonable BMI and can run around.

The age by which a child should have a mandatory entry on the NHS Spine of a dentist or optician associated with their care should be decided by the relevant profession. Now is the time to act and bring the two professions in from the cold. Their inclusion would make use of an existing IT infrastructure and would benefit everyone.

R. W. Mills, Bristol

1. The Children Act 2004 Information Database (England) Regulations 2007. Statutory Instrument 2007 No. 2182

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CASE REPORT

Malingering and factitious disorders

Sir, recently a 12-year-old male child, accompanied by his mother, reported with a complaint of frequent and severe pain in his maxillary left central incisor. The problem had started following trauma four months back. The previous dentist had initially treated him as a case of traumatic pulpitis. As the subsequent clinical and radiological findings did not corroborate with the persisting complaint, he was referred for specialist opinion. The dental students who took this case for work-up were also clueless about the condition.

During consultation, the history provided by the child was often incongruent with his mother's version. Further, his pain reaction to percussion of the allegedly traumatised tooth appeared exaggerated, inconsistent with the facial expressions, and erratic during repetition. Following a separate interview and a bit of gentle persuasion, the child confessed to malingering. He admitted to playing truant by frequently enacting 'tooth-ache following injury' learnt from his friend.

The incident made us realise that conditions such as malingering and factitious disorders have not received due attention in our professional education and practice, thereby leaving many dentists inept when they encounter them. It's time we include some basic training about these entities in the dental curriculum and prepare ourselves to recognise and handle them appropriately.

H. Gayathri, B. Madhan
Puducherry, India
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FLUORIDE VARNISH

Coating over FV

Sir, the recent paper by Yusuf, Wright, and Robertson[1] has stimulated me to write about our attempts to properly legitimise a fluoride varnish programme.

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In the past, when fluoride varnish (FV) trained dental nurses applied Duraphat varnish, they were doing this under the legislation provided within the prescription only medicine (POM) order (1997)[2] which permits the administration to human beings of a POM which is not for parenteral administration, without the need for a patient group direction (PGD) or prescription.

In order to improve governance we recently included the FV trained nurses in a PGD so they could more legitimately apply the Duraphat varnish (which is a prescription only medicine).

Writing the Duraphat Varnish PGD highlighted the following issues:

- Application to patients suffering from asthma is contraindicated. Many training courses substitute the phrase '...hospitalised for severe asthma' although the summary of product characteristics (SPC)[3] specifically mentions asthma as a contraindication. Some trainers advise using other varnish products to circumvent this. These products are not presently licensed for caries prevention and therefore cannot legally be substituted for Duraphat varnish
- Insofar as the Duraphat varnish tube contains latex, and there is a possibility of allergic reactions to other constituents of the varnish, our varnish teams are carrying an emergency kit. This is also required as Resuscitation Council Guidelines state that an emergency kit should be available in all clinical situations. Staff must have appropriate training in the use of the emergency kit, especially recognition and treatment of anaphyaxis. With the number of applications nationwide it may be only a matter of time before a patient suffers a reaction
- Nurses applying Duraphat varnish must be covered by indemnity as they are undertaking a clinical task
- As Duraphat varnish contains alcohol, patients and parents must be advised of this, in case they have religious qualms about the procedure. We have included this in the consent procedure.

Digging deeper into the legality of extended duties undertaken by dental care professionals and the use of PGDs raises quite a few similar issues. Whilst therapists working in NHS Trusts are covered by properly written and audited PGDs, what is the situation with open access? Also, perusal of the SPCs for common drugs raises some interesting issues. For example, articaine with adrenaline is contraindicated in diabetics,[4] whereas lidocaine with adrenaline is not,[5] and this has to be reflected in their PGDs.

Nowadays it is not acceptable to run programmes or promulgate extended duties without due diligence in their design. Our recent experience with Duraphat varnish shows the potential pitfalls even in apparently simple programmes, or am I being too fussy?

D. Howarth
London

1. Yusuf H, Wright K, Robertson C. Evaluation of a pilot oral health promotion programme 'Keep Smiling': perspectives from GDPs, health champions and school staff. *Br Dent J* 2015; **218:** 455–459.
2. The Prescription Only Medicines (Human Use) Order 1997. Available online at http://www.legislation.gov.uk/uksi/1997/1830/made (accessed June 2015).
3. Product details for Duraphat 50 mg/ml Dental Suspension. Available online at http://www.mhra.gov.uk/home/groups/spcpil/documents/spcpil/con1416548968142.pdf (accessed June 2015).
4. Product details for articaine. Available online at http://www.mhra.gov.uk/home/groups/spcpil/documents/spcpil/con1418105030968.pdf (accessed June 2015).
5. Product details for lidocaine with adrenaline. Available online at http://www.mhra.gov.uk/home/groups/spcpil/documents/spcpil/con1404110297100.pdf (accessed June 2015).

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ERRATUM

Letter (*BDJ* 2015; 218: 556–557)

'Oral cancer: A new therapeutic agent'

In the above letter authored by A.N. Robinson and C. Scully, this heading was incorrect and should have read 'Behcet disease: A new therapeutic agent'.

We apologise for any inconvenience caused.

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ORTHODONTICS

Getting straight to orthodontic relapses

Sir, the recent paper by Johnston and Littlewood (*BDJ* 2015; **218:** 119–122) admirably summarises contemporary orthodontic retention regimes, but in doing so reveals that in the past 30 years there has been little progress in our understanding of why almost all cases relapse to some degree, even after prolonged retention.

While the common reappearance of lower incisor crowding is not always noticed by the patient, it is frequently accompanied by less acceptable reflected changes in the upper arch. As the authors point out it seems very likely that the reappearance of lower arch crowding is due to growth-related forward migration of the buccal segments.[1] How odd then that it is now regarded as unacceptable for orthodontists to leave even small residual premolar extraction spaces at the end of fixed appliance treatment, when the evidence is that to do so will preserve labiolingual incisor alignment in the lower arch for many years until these spaces finally close?[2]

Less is understood about the cause of relapse of corrected rotations. As Johnston and Littlewood state this is thought to be due to the stretching of transseptal and supracrestal periodontal fibres which then try to return the tooth to its original rotated position. But why, in this area of very high cellular and collagen turnover, does the rapid replacement of these fibres not retain the tooth in its new position rather than cause its relapse? If these obdurate fibres are indeed the cause, why is it that the once popular surgical procedure of 'pericision' (circumferential supracrestal fiberotomy), be it undertaken by scalpel or YAG laser only reduces, rather than eliminates the relapse? Nevertheless, it seems this support mechanism must be implicated since, given adequate space, emerging rotated lower incisors correct spontaneously until they are half erupted and the gingival attachment becomes established.[3]

Francis Bacon observed that 'nature is often hidden, sometimes overcome, seldom extinguished',[4] and that 'where the cause is not known the effect cannot be produced'.[5] I submit that the adoption of semi-permanent retention should be regarded only as a pragmatic temporary solution to this intractable problem, for when a lingual bonded retainer fails it is often at a single tooth which the patient fails to notice until significant relapse has occurred. Surely it is incumbent on our speciality to continue to research this area to clarify the underlying causes of relapse in its various forms and devise more satisfactory solutions?

C. D. Stephens OBE
Bristol

1. Stephens C D, Houston W J B. Facial Growth and lower pre-molar extraction space closure. *Europ J Orthod* 1985; **7:** 157–162.
2. Swessi D, Stephens C D. The spontaneous effects of lower first premolar extraction on the mesiodistal angulation of adjacent teeth and the relationship of this to extraction space closure in the long term. *Europ J Orthod* 1993; **15:** 503–511.
3. Killingback N, Stephens C D. A study of the effect of removal of deciduous canines on the alignment of mandibular incisors. *J Dent Res* 1989; **68:** 571 (abst).
4. Bacon F. *In* Scott M A (ed) *The essays of Francis Bacon, XXXVIII Of nature in men.* p 178. New York: Charles Scribener's sons, 1908.
5. Bacon F. The new organon or True directions in the interpretation of nature. Book 1, III. 1620.

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