LETTERS TO THE EDITOR

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GUIDELINES

Sound principles

Sir, I thank Mr Greene for his letter (*BDJ* 2014; **217:** 388–389). If all patients behaved in the same way, ie like compliant robots, I would agree with him.

I also agree that using the BPE to monitor periodontal disease, from the dentist's perspective, is like telling the time with a calendar. However, from the patient's perspective the micro view may be counter-productive in the early stage of the pathway to periodontal health. What is needed initially to assess an individual is an overview and not the specifics.

A behavioural approach to treating patients requires skilled application of principles to have the best outcomes in terms of patient compliance. I think we'd all agree that responsible biofilm control is key to periodontal health and that can only reasonably be achieved by the individual patient. Dentists and particularly GDPs have the responsibility to interact with patients in a way that demonstrates the application of sound principles.

W. Richards, by email
DOI: 10.1038/sj.bdj.2015.2

Inform and clarify

Sir, I write to further the current discussion regarding the use of clinical guidelines in assessing negligence. I was delighted to see that Dr Greene had responded to my previous correspondence (initially in response to Professor Richard's letter outlining a case he had come across) as I believe that often there is a great deal of uncertainty and confusion over how legal claims are assessed for merit. I hope that our letters and the resultant dialogue inform and clarify rather than muddy the waters.

The difference in opinion between Dr Greene and myself is a public example of often what happens behind closed doors in a dental negligence case. Like Dr Greene, I act as an expert in legal cases, but do so in my capacity as a dentist rather than as a specialist. Quite often experts will disagree and they are required to come together and discuss the issues at hand. Whilst I have every respect for Dr Greene, I come at this case from the slightly different viewpoint of a non-specialist GDP. As GDPs we have to balance the pressures of NHS general practice with the desire to provide efficacious and appropriate treatment. This is in line with the spirit of the Bolam test.

In this case of the pertinence of 6 point pocket charting for the assessment of periodontitis, I have no particular issue (although I do not class this to be so myself) with Dr Greene's opinion that failure to carry these out strictly speaking could be classed as a breach of duty. However, as many will be aware, a breach of duty does not automatically lead to a finding of negligence if causation cannot be established. In the case Professor Richards previously described whereby the only deficiency is purported to be a lack of 6 point charting, I still fail to see how, even if this is defined as a breach of duty, this may be responsible for causing a patient's periodontitis to worsen if treated appropriately in every other way.

Dr Greene's approach is of course appropriate, desirable and probably what many would term the 'Gold Standard' with regards to treating periodontitis. However, when faced with the multi-faceted pressures of general practice, one can perhaps be excused for not expecting dentists to always provide 'Gold Standard' treatment that rigidly follows idealised guidelines; after all, patients are not entitled to expect perfect treatment. Providing that any treatment given is found to be acceptable by a reasonable body of professional opinion which has logical basis, no legal claim should succeed.

A. C. L. Holden, by email
DOI: 10.1038/sj.bdj.2015.3

FOREIGN OBJECTS

Rubber damn!

Sir, a 24-year-old man presented to the Oral and Maxillofacial Radiology Clinic with a trauma from a rubber bullet which had occurred two weeks previously.

The patient had paraesthesia of the mucosa and the cheek in the left molar region. The teeth in the area were vital to electric pulp tests. Intraoral and extraoral examination revealed lumps detected in the vestibular sulcus area and a panoramic radiograph revealed a radioopaque mass in the region of teeth 33–36 (Fig. 1).

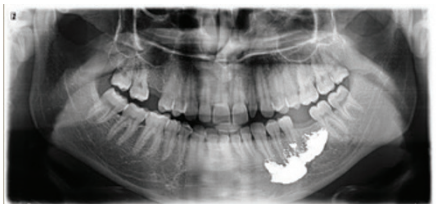

Fig. 1 Panoramic radiograph of the patient

It was understood that the rubber bullet fragmented in the tissues because of the impact on the mandibular bone. The plastic & reconstructive surgery department performed an operation to remove as many particles as possible from the tissues but some of them remain. The patient has a paraesthesia in the related region and will be called for routine follow-up.

T. Emre Köse, A. Burak Cankaya, Istanbul
DOI: 10.1038/sj.bdj.2015.4

PROSTHODONTICS

Enigmatic dental appliance

Sir, I was about to undertake a routine examination of a new patient and as the patient sat in the chair they removed this device from their mouth (Fig. 1). The device appeared to be made of cobalt-chromium, fitting onto the maxillary dentition, covering the occlusal and also palatal surfaces of the maxillary teeth (Fig. 2). I had not seen anything like it before and on further questioning, the patient reported that she had this device fitted in her teens, on the advice of her treating dentist at the time '*to help correct her bite*' and she had worn the device ever since! The patient presented with a moderate/severe Class II skeletal relationship and once the device was fitted, it appeared to cause a very mild anterior open bite which helped to decrease the otherwise traumatic anterior overbite. I have not encountered such an appliance before and discussions with my colleagues left us all wondering about the origins of this dental appliance.

Fig. 1 The device as it appeared on the bracket table

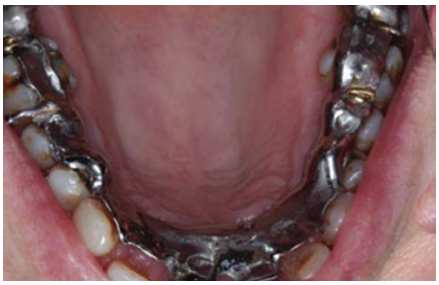

Fig. 2 The device *in situ*

Could any members of the dental community help shed further light on the use and indications for such a device?

G. Shoker, West Midlands

DOI: 10.1038/sj.bdj.2015.5

DENTAL PATIENTS

Transgender issues

Sir, recently, a case in which a hospital dentist needing to make an admission was unsure of the patient's gender raised issues of awareness. The patient identified herself as female and this was respected throughout her uneventful stay in hospital and treatment but the case highlighted a number of pending issues related to the dental care of intersex, transgender and trans-sexual individuals:

1. Have we given due consideration to these patients in our routine practice?
2. Is our curriculum adept in sensitising us to the issues of this community?
3. Are hospital policies explicit in the way such individuals must be handled?
4. Are the medical, psychosocial and legal aspects of dental care for these patients clearly understood?
5. Is it feasible and recommended to have special wards earmarked for them?
6. How do we ensure a non-discriminatory healthcare environment for these patients?
7. How can they be mainstreamed in the medical milieu?

Two years back the Honourable Supreme Court of India made an important observation that 'Many hospitals and other institutions do not admit [transgender individuals] in women's wards because women do not feel comfortable or free in their presence and in men's wards they face sexual abuse. Provision of separate wards in all hospitals and other institutions is necessary'.[1] Nothing substantial appears to have happened since then. We believe that many of our worldwide colleagues have faced a similar situation and request the *BDJ* to bring these issues to the attention of the worldwide dental fraternity, steer the process of finding effective solutions and help in achieving a truly equitable dental healthcare system for all.

Balasubramanian Madhan, Balasubramanian Krishnan, Gnanasekaran Arunprasad, India

1. The Hindu. Court notice to Centre, States on transgender issue. 2 October 2012. Available at: http://www.thehindu.com/news/national/court-notice-to-centre-states-on-transgender-issue/article3956185.ece (accessed November 2014).

DOI: 10.1038/sj.bdj.2015.6

INFECTION CONTROL

Oral–systemic relationships

Sir, Laurence *et al.* identified an association between the presence of a dental infection and an increased likelihood of hospital admission among adult patients with a sickle cell crisis event. The study was a cross-sectional analysis of data from the Nationwide Emergency Department Sample which is the largest all-payer emergency department (ED) database currently available in the US.[1] Using the same analysis we have demonstrated an association between the presence of either a dental infection or dental caries and an increased likelihood of hospital admission among adult patients with pneumonia.[2] We concluded that the presence of a dental infection may worsen the overall clinical symptomatology in ED patients with pneumonia thereby increasing their likelihood for hospital admission. Given the lack of data demonstrating a plausible biological pathway between the presence of dental caries and an increased likelihood for the development of pneumonia, we suggested that dental caries may be a marker for poor oral hygiene and increased dental plaque rather than serve directly as a source of respiratory pathogens.

It is likely that infections are more concerning than dental caries to an ED physician and therefore have a greater likelihood of being diagnosed and coded appropriately, thereby presenting a limitation of our analysis. Despite such limitations, our studies suggest that dental infections can result in worsening overall health as evidenced by an increased likelihood of hospital admission and that this deserves further study as a valid and reliable outcome when studying oral-systemic relationships.

B. Laurence, N-K. Mould-Millman, USA

1. Laurence B, Haywood Jr C, Lanzkron S. Dental infections increase the likelihood of hospital admission among adult patients with sickle cell disease. *Community Dent Health* 2013; **30:** 168–172.
2. Laurence B, Mould-Millman N, Scannapieco F, Abron A. Hospital admissions for patients with pneumonia more likely with concomitant dental infections. *Clin Oral Investig* 2014; [Epub ahead of print].

DOI: 10.1038/sj.bdj.2015.7