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.

CASE REPORT

Getting it taped

Sir, a 16-year-old female, who was originally from East Timor, presented at the Oral Surgery Department of the Royal Victoria Hospital in Belfast, having moved to Northern Ireland when she was 7 years old. She had been referred by her general medical practitioner regarding a lump in her lower lip. This was painless, and had been present for approximately 9 years with no fluctuation in size noticed by the patient. She had no relevant past medical history.

Examination revealed a well circumscribed submucosal swelling at the inner aspect of the left side of her lower lip, which was approximately 1 cm in diameter. The lump was firm in texture with normal overlying mucosa, and appeared blue in colour when pressed towards the mucosal surface of the lip. No other abnormalities were noted.

The lesion was excised under local anaesthetic. Histopathological examination revealed a cysticercus cyst consistent with a cestode (tapeworm) parasitic infection, following the ingestion of tapeworm eggs (Fig. 1). The patient was referred to the infectious diseases department of the hospital, whereupon in light of the fact that she displayed no other manifestations of tapeworm infection she was discharged without further intervention but advised to recontact if further symptoms arose. Her lip healed well, and she was also discharged from the Oral Surgery Department.

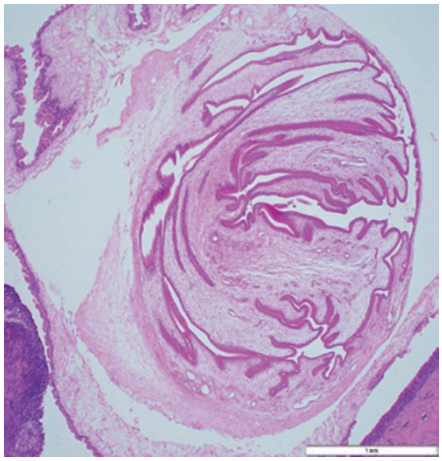

Fig. 1 Histopathological appearance of lesion

Cysticercosis is particularly prevalent in Latin America, sub-Saharan Africa, and Southeast Asia but the incidence in western countries is rising in line with increased international travel and immigration.[1,2] The likelihood is that this patient contracted the condition before she moved to Northern Ireland. We can find no previous reports of cysticercosis affecting the oral cavity being diagnosed in this country.

We would like to highlight the possibility of cysticercosis as a differential diagnosis when considering oral submucosal swellings, particularly in patients who have lived in areas of the world where the condition is prevalent.

J. Smyth, V. Adams and S. Napier, Belfast

1. Maurice J. Of pigs and people – WHO prepares to battle cysticercosis. *The Lancet* 2014; **384:** 571–572.
2. Jay A, Dhanda J, Chiodini P L, Woodrow C J, Farthing P M, Evans J, Jager H R. Oral cysticercosis. *Br J Oral Maxillofac Surg* 2007; **45:** 331–334.

DOI: 10.1038/sj.bdj.2015.639

PRISON DENTISTRY

Irish prisoners' oral health

Sir, since February 2015, the Inspector of Prisons in Ireland has been undertaking a Review of the Irish Prison Services (IPS).[1] One area that requires urgent attention is that of prisoner health but the oral health of Irish prisoners is conspicuously absent from the debate. Very little is known about the oral health of Irish prisoners but given the high prevalence of smoking, alcohol and substance abuse among inmates when compared with the rest of the Irish population,[2] we can infer that the oral health needs of prisoners is high. However, no oral epidemiological survey of the Irish prison population has been conducted. In addition, it is not clear if, and how, the oral health needs of Irish prisoners are being meet by the current prison dental policy which only permits routine dental treatment to those who are sentenced to 16 months or more in prison. There is also no onsite access to dentists; prisoners are referred to a dentist in the nearby community based on the clinical judgement of a prison medical officer or prison nurse.

It is clear that the Irish Prison Service needs to recognise the importance of oral health to the health of prisoners and offer a more comprehensive dental healthcare service for its prisoners.[3] The recent article series of Heidari *et al.* (*BDJ* 2014; **217:** 69–71; *BDJ* 2014; **217:** 117–121) confirms

A TRIBUTE TO THE KING

Sir, Re: 'Cecil, King of Lions'. I was horrified to read about the slaughter of Cecil, King of Lions in Zimbabwe by the American dentist, Walter Palmer, who had paid $35,000 for the 'privilege'. He has also paid vast sums of money to kill endangered species, including a leopard and a white rhino. Thankfully, the dentist was not British. Even so, I fear that he has brought shame and disgrace upon our profession, as not being a caring person. His leering face beams over his dead trophies, which likewise, were obviously lured to their death and easy targets for his bow and arrow.

It is even more poignant for me, as I visited my cousin who lived in Zimbabwe about 16 years ago. We stayed a couple of nights at Hwange National Park and were taken by transport at night and sunrise to the watering holes to view the wildlife. It was sheer magic. During the day we looked through binoculars, and each day there was a posting of the animals seen.

It is a matter for his conscience, but in view of the harm he has done, he should repay every penny, and more, to the wildlife conservation for the preservation of these animals, otherwise they will become extinct. Recently, His Royal Highness the Duke of Cambridge has spoken about this in London and New York.

A. Stockel, London

DOI: 10.1038/sj.bdj.2015.640

this as does the 'common risk factors'[4] approach to understanding health. The recognition of the interconnectedness of physical, oral and psychological health should be reflected in IPS health policy and inform any future investment and development of its prison health service. It is only by acknowledging the equal importance of general, psychological and oral health will the IPS be able to deliver a prison health service that fully caters for the health needs of its inmates.

P. Neville, Bristol

1. Office of the Inspector of Prisons. Available online at http://www.inspectorofprisons.gov.ie/ (accessed August 2015).
2. Drummond A, Codd M, Donnelly N *et al. Study on the prevalence of drug use including intravenous drug use and blood-borne viruses among the Irish prisoner population.* Dublin: National Advisory Committee on Drugs and Alcohol, 2014.
3. Bose A, Jenner T. Dental health in prisons. *In* Moller L, Stover H, Jurgens R, Gatherer A, Nikogosian H (ed) *Health in prisons. A WHO Guide to the essentials in prison health.* pp 147–156. Copenhagen: WHO Regional Office for Europe, 2007.
4. Watt R, Sheiham A. Integrating the common risk factor approach into a social determinants framework. *Community Dent Oral* 2012; **40:** 289–296.

DOI: 10.1038/sj.bdj.2015.641

IN SURGERY

An observation on an observation

Sir, the paper by M. Syrimi and N. Ali (*BDJ* 2015, **218:** 597–598) was an interesting review of stereopsis in clinical practice as was the observation that it was not deemed essential in operative dentistry. I was surprised the authors did not comment on the fact that if one uses a mirror to view the operative site then one is using monocular vision of the operative area. Most dentists master the art of working in a monocular view with a mirror during their undergraduate days. So whilst stereopsis has a significant role in developing hand eye co-ordination a major part of operative dentistry is practised with monocular vision without problems for perhaps 50% of clinical activity.

A. Miller, Bristol

DOI: 10.1038/sj.bdj.2015.642

PUBLISHING

Predatory publishing

Sir, the term predatory publishers was first used by Ball in 2010 for journals following an exploitative open access publishing business model that involves charging authors a publication fee without providing the editorial and peer review services associated with legitimate journals.[1]

Because of promotion, academic reputation and pay rise issues many dental academicians are forced to publish their work. Young scholars in developing countries, such as India, are more vulnerable to become a victim of such a practice.[2] These journals reach authors by different ways; mostly they send an email and offer fast publication, some journals claim that well known academicians are on their editorial board although the person has no relation with the journal.[3] The journals often have a name that does not adequately reflect their region (eg Canadian, American, European or Swiss but has no relationship to these places) and falsely claim to have a high impact factor. Some predatory journals do not initially inform authors that they charge for publication until the article has already been accepted for publication.[4]

One should remember that these journals not only take one's money but also one's academic reputation.

M. Bajpai
Jaipur, India

1. Beall J. Predatory publishers are corrupting open access. *Nature* 2012; **489:** 179.
2. Beall J. Avoiding the peril of publishing qualitative scholarship in predatory journals. *J Ethnogr Qual Res* 2013; **8:** 1–12.
3. Castillo M. Predators and Cranks. *Am J Neuroradiol* 2013; **34:** 2051–2052.
4. Jalalian M, Mahboobi H. Hijacked journals and predatory publishers: Is there a need to re-think how to assess the quality of academic research? *Sci Tech* 2014; **11:** 389–394.

DOI: 10.1038/sj.bdj.2015.643

ORAL CANCER

Cancer referral guidelines

Sir, I would like to draw your readers' attention to the updated National Institute for Health and Care Excellence (NICE) guideline on '*Suspected cancer: recognition and referral*'.[1] In a change to its 2005 predecessor, the 2015 guideline uses a new approach which focuses on the symptoms that a patient may experience.

For each cancer site (eg oral), the following two clinical questions were asked:[2]

- What is the risk of (oral) cancer in patients presenting in primary care with symptom(s)?
- Which investigations of symptoms of suspected (oral) cancer should be done with clinical responsibility retained by primary care?

The recommendations for oral cancer are:

1. Consider a suspected cancer pathway referral (for an appointment within two weeks) for oral cancer in people with either:
   - Unexplained ulceration in the oral cavity lasting for more than three weeks or
   - A persistent and unexplained lump in the neck [new 2015].
2. Consider an urgent referral (for an appointment within two weeks) for assessment for possible oral cancer by a dentist in people who have either:
   - A lump on the lip or in the oral cavity or
   - A red or red and white patch in the oral cavity consistent with erythroplakia or erythroleukoplakia [new 2015].
3. Consider a suspected cancer pathway referral by the dentist (for an appointment within two weeks) for oral cancer in people when assessed by a dentist as having either:
   - A lump on the lip or in the oral cavity consistent with oral cancer or
   - A red or red and white patch in the oral cavity consistent with erythroplakia or erythroleukoplakia [new 2015].

The Guideline Development Group estimated that the recommendations would result in an increase in costs within the community dental service, and a decrease in the number, and therefore cost, of suspected cancer pathway referrals, but were uncertain over net effect.[2]

Although the authors state that they are making 'recommendations not requirements, and [they] are not intended to override clinical judgement', their advice often reads like requirements, and courts might interpret their advice this way.

This updated NICE guideline will have major implications for general practitioners in England, and most likely in Wales and Northern Ireland. In Scotland, similar referral guidelines for suspected cancer were updated by Healthcare Improvement Scotland in August 2014.[3]

C. A. Yeung, Lanarkshire

1. National Institute for Health and Care Excellence. *Suspected cancer: recognition and referral.* 22 June 2015. Online information available at http://www.nice.org.uk/guidance/ng12 (accessed August 2015).
2. National Collaborating Centre for Cancer. *Suspected cancer: recognition and referral.* Full NICE guideline. June 2015. Online information available at http://www.nice.org.uk/guidance/ng12/evidence/full-guidance-65700685 (accessed August 2015).
3. Healthcare Improvement Scotland. *Scottish referral guidelines for suspected cancer.* August 2014. Online information available at http://www.healthcareimprovementscotland.org/our_work/cancer_care_improvement/programme_resources/scottish_referral_guidelines.aspx (accessed August 2015).

DOI: 10.1038/sj.bdj.2015.644