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.

IN PRACTICE

Bad posture

Sir, Shiraz Khan is a remarkable young man to have achieved so much at such a young age (*BDJ* 2015; **219:** 6), but his working life is likely to be severely compromised if he continues to work with his neck bent at right-angles as shown in the picture. Regrettably, this is a common posture. Later in his career Shiraz will quite likely be part of the millions of pounds the sickness companies pay out as claims for occupational back pain. My adage for decades has always been to adapt the patient's head position to the dentist, not the other way round. Here the mannequin head is far too low so the dentist has to severely over flex his neck to allow him to work at his close focal distance.

The solution is so simple: raise the patient's chair so the mouth is at the dentist's mid-sternal level so allowing the dentist to work with a straight back and normal neck flexion. Such appalling posture is due to the lack of teaching on correct posture to students and VDPs. I simply can't understand why they still fail to do so.

E. Paul, Edgware

DOI: 10.1038/sj.bdj.2015.675

BOOK REVIEW

Reviewing the review

Sir, it was with such considerable amazement when reading the penultimate paragraph of your *Clinical negligence expert witness* book review (*BDJ* 2015; **219:** 55) that I thought there must have a typographical error.

The paragraph ending '...should we ever become involved within a case representing a defendant or claimant it could make the journey a much less arduous one' is grossly misleading. Notwithstanding your reviewer admitting that she is relatively new to the field, I think she should be made aware of Part 35 of the Civil Procedure Rules. This states unequivocally that an expert has an overriding duty to the court over any obligation to the party from whom they have received instructions or by whom they are being paid.

A clinical negligence expert witness does not represent anybody.

E. Gordon, Finchley

DOI: 10.1038/sj.bdj.2015.676

CLINICAL GUIDANCE

Guidance on guidance

Sir, we read with interest the opinion piece on endocarditis.[1] Dentists are faced with a number of diverse medical problems that can influence the oral healthcare that they provide for their patients, but the evidence for healthcare recommendations very often does not have a reliably solid evidence base.[2] Nevertheless, clinical guidance has been developing in many areas.[3,4]

The changes in the NICE (National Institute for Health and Care Excellence) endocarditis guidelines have not been without consequences, not only in clinical outcomes,[5] but in our experience and opinion, contribute to a lack of clarity for both patients and healthcare providers. We consider that clear unambiguous guidance rather than several variants in guidance such as have appeared in the UK (eg NICE, SIGN) would be more welcome for practitioners and patients; variances between international guidelines hardly help.

Adherence to guidance, though not mandatory,[6] may well in practice be seen as such, because failure to adhere needs justification by the clinician[7] to resist challenge. Non-adherence may arise, amongst other reasons, due to guidelines being based on low-level evidence with weak recommendations and the notion that using such guidance could result in more harm to the patient.[8]

Clinical guidelines are just that, they offer guidance, which is not necessarily applicable to each and every situation and patient. In this respect, it should be stressed that fundamental to sound patient care is good clinical judgment, which involves more than simply the consideration of best current evidence, it requires consideration of patients' expectations, values and preferences to permit patients and clinicians to make informed choices.[7]

C. Scully, London
A. N. Robinson, Singapore
J. A. D. Cameron, Edinburgh

1. Thornhill M H, Lockhart P B, Prendergast B, Chambers J B, Shanson D. NICE and antibiotic prophylaxis to prevent endocarditis. *Br Dent J* 2015; **218:** 619–621.
2. Scully C. *Scully's medical problems in dentistry*, 7th ed. Churchill Livingstone, Elsevier, 2014.
3. Woolf S H, Grol R, Hutchinson A, Eccles M, Grimshaw J. Clinical guidelines: Potential benefits, limitations, and harms of clinical guidelines. *BMJ* 1999; **318:** 527–530.
4. Shekelle P G, Ortiz E, Rhodes S, Morton S C, Eccles M P, Grimshaw J M, Woolf S H. Validity of the Agency for Healthcare Research and Quality clinical practice guidelines: how quickly do guidelines become outdated? *JAMA* 2001; **286:** 1461–1467.
5. Dayer M J , Jones S , Prendergast B , Baddour L M , Lockhart P B , Thornhill M H . Incidence of infective endocarditis in England, 2000–13: a secular trend, interrupted time-series analysis. *Lancet* 2015; **385:** 1219–1228.
6. Hurwitz B. Clinical guidelines: Legal and political considerations of clinical practice guidelines. *BMJ* 1999; **318:** 661–664.
7. General Dental Council (UK). Standards for the dental team. Online information available at https://www.gdc-uk.org/Dentalprofessionals/Standards/Documents/Standards%20for%20the%20Dental%20Team.pdf(Accessed August 2015).
8. Chambers J B, Shanson D, Hall R, Pepper J, Venn G, McGurk M. Antibiotic prophylaxis of endocarditis: the rest of the world and NICE. *J R Soc Med* 2011; **104:** 138–140.

DOI: 10.1038/sj.bdj.2015.677

ORTHODONTICS

A traumatic cause of a ranula

Sir, a ranula is a mucus extravasation 'pseudocyst' that frequently occurs within the body of the sublingual salivary gland or ducts, and less frequently from minor salivary glands in the floor of the mouth.[1] We are seeing increasing numbers of ranulae which appear to be related to traumatic causes attributable to radiograph holders for bitewings or periapicals, and in the younger patient, removable orthodontic appliances. A recent clinical example of a 13-year-old female highlights this. She developed a large painful swelling in the floor of her mouth (Figs 1 and 2) after wearing a functional appliance.

The risks of fixed and removable orthodontic appliances to the hard and soft tissues of the oral cavity are well documented.

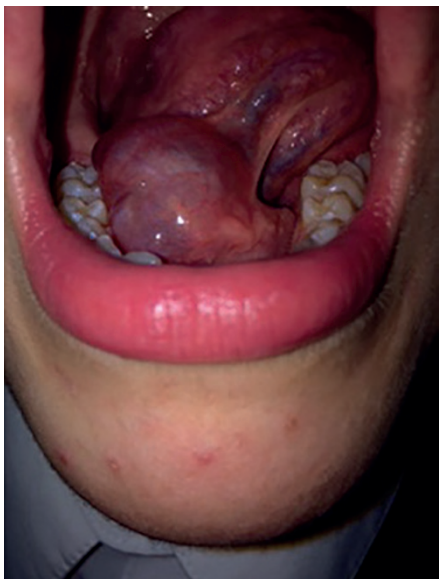

Fig. 1 The sizeable floor of mouth swelling

Fig. 2 The offending appliance

However, a risk that is frequently omitted in the literature is the potential for trauma and obstruction to the major and minor salivary glands of the floor of the mouth. It is possible for a functional orthodontic appliance to damage or impinge on the sublingual salivary gland and mucosa, resulting in the spillage of mucin into the surrounding soft tissues. The result can cause serious morbidity to the patient. On this occasion the patient required surgical management requiring general anesthesia.

We suggest that due care and consideration be given to using any instrumentation or appliances that could be traumatic to the delicate structures of the soft tissues of the mucosa, especially the floor of the mouth.

D. J Owens, C. J Mannion, Leeds

1. CM Flaitz *et al.* Mucocele and ranula clinical presentation. 19 May 2015 (update). Available online at http://emedicine.medscape.com/article/1076717-overview (accessed August 2015).

DOI: 10.1038/sj.bdj.2015.678

CLINICAL

An opening

Sir, we would like to share with your readers an interesting case we recently encountered. A 38-year-old male patient presented complaining of reduced mouth opening and swelling in his right cheek. The patient was medically fit and well with no known drug allergies. Approximately 18 years previously, the patient stated that he had undergone the surgical removal of his 48, but the patient reported that he had had repeated swelling of his lower right side multiple times during the last 15 years. His general medical and dental practitioners had previously prescribed antibiotics and on each occasion, the symptoms had resolved within a few days. On presentation, he was apyrexic with pain limiting his maximal mouth opening to 1 cm. There was a non-fluctuant swelling adjacent to the 47.

Clinical examination was difficult due to the trismus. There was no obvious hard tissue pathology in the lower right quadrant, however a buccal sinus adjacent to the 47 was noted.

A sectional orthopantogram (Fig. 3) demonstrated an ill-defined radiolucent area distal to the 47. A size 20 gutta percha (GP) point was placed into the sinus tract and a further sectional orthopantogram was taken (Fig. 4). The GP point appeared to be localising to the radiolucent area.

The patient underwent cone beam computed tomography of the region prior to surgical exploration and debridement of the area. At the time of surgery, specimens were taken for histological examination and these were consistent with the clinical suspicion of an infected residual cyst.

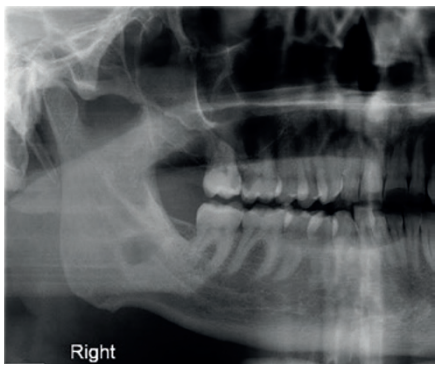

Fig. 3 A sectional orthopantogram

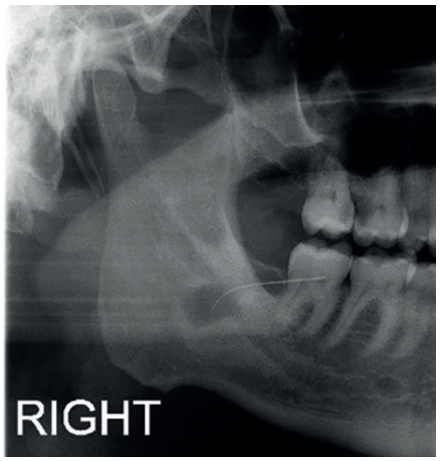

Fig. 4 A follow up after a gutta percha was placed

This case was unusual due to the time lapse between surgery and presentation. The patient had been prescribed antimicrobials on a number of occasions but the cause of the infection had not been identified. This illustrates the importance of taking a full dental history and the benefit of using a GP point to aid diagnosis and management.

S. L McKernon, M. C Balmer, K. H Taylor, S. Reid, Liverpool

DOI: 10.1038/sj.bdj.2015.679