LETTERS TO THE EDITOR

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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.

ORAL SURGERY

Comprehensive records

Sir, we refer to the letter *Oral surgery: Mandibular fracture risk* (*BDJ* 2016; **220:** 44) with respect to consenting patients for the inherent risks of procedures, in this instance the removal of mandibular third molars.

We do not disagree with the conclusion that it may be sensible to advise patients of the rare risk of mandibular fracture in the removal of lower third molar teeth. However, we would disagree that the warning should be given to all patients on the basis that it happened to one, particularly in circumstances where the likelihood of this happening was suggested to be as low as 0.005%.

It is worth spending a little time reflecting upon the judgement of Montgomery. Paragraph 89 expressly provides that the assessment of whether a risk is 'material' cannot just be reduced to percentages, but should be considered along with the nature of the risk, the effect which its occurrence would have upon the life of the patient, the importance to the patient of the benefits sought to be achieved by the treatment, the alternatives available, and the risks involved in those alternatives. The assessment is fact-sensitive, and dependent also on the characteristics of the patient.

From the letter of 22 January 2016, we do not know the idiosyncrasies of this patient, both in terms of his character and of his medical history. It may be that he was particularly susceptible to this kind of injury, which should have been appropriately assessed at the time of the initial consultation. If it was identified that he was particularly susceptible to fracture, this would have become a material risk and there would have been a duty to ensure he was aware of that risk. If there was no such susceptibility, then it was a fluke accident of a kind that the law courts in this jurisdiction will not punish.

The courts have expressly recognised that informed consent cannot include detailing every single eventuality that may arise from a procedure. This is why it has been limited to 'material risks'. We would suggest that side effects with a probability of 0.005% likelihood do not need to be included as a matter of course, but only where the circumstances make the risk material. Otherwise, practitioners will find their consent process takes an inordinate length of time, to the exclusion of all other clinical duties.

From a medico-legal perspective, the consideration of risk and consent process should be appropriately detailed in the medical records. It goes without saying that comprehensive records should be a fundamental part of the modern practitioner's clinical practice.

S. Stagnell StR Oral Surgery, B. Gil, Pupil, Old Square Chambers, London
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PHARMACOLOGY

Clarity on prescribing

Sir, in their seminal paper in the *BDJ* the authors are to be congratulated on providing GDPs with some clarity on probably the most important issue in dental prescribing.[1] Prior to 2008 antibiotic prophylaxis in cases of certain cardiac diseases was considered the sheet anchor of dental therapeutics; suddenly, overnight, what had been repeatedly instilled was dismissed as wrong and a thinly veiled inference put abroad that if the GDP prescribed, as it was his or her signature on the script, and not the cardiologist who had advocated it, then in the event of any untoward reaction the buck stopped with the GDP. Medical colleagues continued to be adamant that prophylaxis was necessary.

It was not made clear that the guidelines were advisory and most colleagues saw them as prescriptive. This made for some awkward conversations with medical colleagues who, as patients, had been advised by their doctor to take prophylaxis before certain dental procedures. Most patients who had previously been prescribed prophylactic antibiotics requested that it was continued. One must question how many patients have suffered unnecessary and chronically debilitating disease and even death because of a guideline in which the main driver seems to have been a small financial saving.

D. McIntosh, London

1. Thornhill M H, Dayer M, Lockhart P B *et al.* Guidelines on prophylaxis to prevent infective endocarditis. *Br Dent J* 2016; **220:** 51–56.

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ADVERTISING

TV dentists

Sir, my TV viewing is limited. Tonight an ad particularly irritated me, bringing my previously subliminal thoughts about TV dental product advertising to the surface.

If companies wish to advertise their products – fine. If the format of the advertisement is such that a dental professional appears to be fronting it, I am far from sure that it reflects well on the profession. Evidence basis and financial bias are among the many issues involved. I have not noticed similar TV ads involving our medical colleagues.

J. K. A. Parker, Hereford
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ORAL HEALTH

Praying for preventive care

Sir, in India, caries is predicted to increase significantly and oral cancer is a growing problem.[1] Meanwhile, the oral health workforce is showing a dramatic rise: the number of dental schools has increased from 95 to 290 within the last 20 years and more than 25,000 dentists are graduating each year in India.[2] Most schools are in urban regions and partly as consequence the dentist-population ratio is as high as 1:4,000 in urban India while in rural areas can be as low as 1:30,000.[2] Challenges include the fact that the disease burden is highest amongst the disadvantaged; oral health is not considered integral to general health; the inaccessibility of oral health services to people in rural regions; and much of modern dental practice is highly interventionist.

Whilst the small business model of dental

care will be with us for the foreseeable future, we submit that countries need to refocus their health workforce to tackle disease burden. Policies should strive to curb the dental-medical divide and to reduce social and service inequalities. The focus needs to be shifted from interventionist to preventive approaches. Preventive care should be customised for communities and carried out by teams drawn from the whole spectrum of health and social welfare professions. For such a paradigm shift, barriers from the entrenched profession will be a major challenge. Practical suggestions for a start on such reorientation would be to ban new dental schools in over-served countries and to train all members of putative oral healthcare teams together. 'The family that prays together stays together.'

S. Kumar, N. W. Johnson, Australia

1. Mathur M R, Singh A, Watt R. Addressing inequalities in oral health in India: need for skill mix in the dental workforce. *J Family Med Prim Care* 2015; **4:** 200–202.
2. Jaiswal A K, Srinivas P, Suresh S. Dental manpower in India: changing trends since 1920. *Int Dent J* 2014; **64:** 213–218.

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Refugees in Jordan

Sir, refugees in Jordan enjoy free access to schools, universities, clinics, hospitals, health and social care facilities, on par with their Jordanian brethren, stretching infrastructural capabilities to their absolute, maximum limits, and endangering oral and general health. There is risk of shortages in essential medical kits, medicines and vaccines. Oral health should always be viewed within the lens of general health. Oral diseases cause pain, lower quality of life, reduce productivity in terms of missing school, work and can cause systemic diseases (infective endocarditis, renal impairment).[1] Moreover, they become obsolete especially in times of adversity. But what affects oral and general health is the social context that people live in. Health is produced not just by individual biology and medical interventions, but by conditions in the wider natural, social, economic, and political environments.[2] And as 90% of refugees live across urban centres, it is vital to envisage a holistic paradigm of action that focuses on sustainable development and supports capacity building in host communities (national health systems, schools, community centres, etc), and tackles social injustices and inequities. By integrating oral health into strategies of promoting general health and by incorporating refugees' health into the healthcare systems of host communities, strategists can help Jordan remain resolute and unwavering in its humanitarian and peacekeeping missions, lifting huge burdens from the global community at large.

M. F. Al Qutob, London

1. Sheiham A. Oral health, general health and quality of life. *Bull World Health Organ* 2005; **83:** 644.
2. Fustukian S, Zwi A. Balancing imbalances: facilitating community perspectives in times of adversity. *In* Williams H A (ed). Special issue on Caring for those in crisis: integrating anthropology and public health in complex humanitarian emergencies. *NAPA (National Association of Practising Anthropologists) Bulletin* 2001; **21:** 17-35. Available at: http://onlinelibrary.wiley.com/doi/10.1525/napa.2001.21.1.17/epdf (accessed March 2016).

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MOUTH CANCER

Acute necrotising sialometaplasia

Sir, I read with interest the letter from Gogna *et al.* (*BDJ* 2015; **219:** 560) regarding palatal mucosal necrosis after administration of a local anaesthetic palatal infiltration, and would like to highlight a similar case.

In August 2015 a 43-year-old Caucasian female with an unremarkable medical history was urgently referred to our oral and maxillofacial department by her dentist with suspected oral cancer. The patient reported an eight-day history of a painful ulcer on the hard palate, and on examination there was a 1.0 × 1.5 cm diameter 'punched out' ulcer on the left posterior hard palate which extended down to bone. The defect contained loose, yellow sloughing tissue and the adjacent tissues were erythematous with raised, rolled margins (Fig. 1). An urgent incisional biopsy was performed which confirmed a diagnosis of acute necrotising sialometaplasia and excluded dysplasia. The patient was reassured of the diagnosis, advised to maintain good oral hygiene, and subsequently reviewed to assess for healing. The patient was discharged eight weeks later following complete resolution of the lesion.

Acute necrotising sialometaplasia is a rare, benign and self-limiting inflammatory condition of salivary gland tissue which occurs as a result of trauma causing the tissues to become ischaemic and necrotic.[1] It typically presents as a unilateral necrotic ulcer on the hard palate but is often preceded by a firm, fluctuant and often painful swelling which can mimic a dental abscess.[1] This condition has been associated with trauma, heavy smoking, excessive alcohol consumption and violent vomiting, such as in patients with bulimia, but can also occur following palatal infiltrations.[2] As Dr Gogna's patient did not receive a biopsy to confirm a diagnosis, I wonder if acute necrotising sialometaplasia could have been a differential diagnosis to consider? The most significant issue to highlight is that it can mimic malignancy, both clinically and histologically, which could result in an incorrect diagnosis and unnecessary intervention. The condition is self-limiting and does not require treatment besides supportive measures, often healing spontaneously within 4-10 weeks without complication.[1]

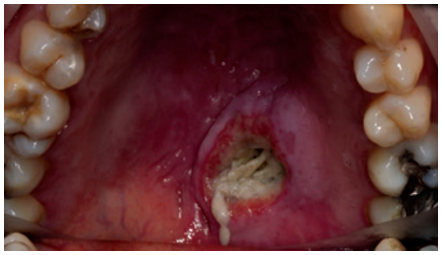

Fig. 1 The 'punched out' ulcer on the left posterior hard palate which extended down to bone

Should this condition present in general dental practice, then an urgent referral to the oral and maxillofacial or oral medicine team for a second opinion is advisable, as an incisional biopsy will often be undertaken to confirm a diagnosis and exclude malignancy.

A. Davies-House, Liverpool

1. Randhawa T, Varghese I, Shameena P M, Sudha S, Nair R G. Necrotizing sialometaplasia of tongue. *J Oral Maxillofac Pathol* 2009; **13:** 35–37.
2. Carlson D L. Necrotizing sialometaplasia: a practical approach to the diagnosis. *Arch Pathol Lab Med* 2009; **133:** 692–698.

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DENTAL STUDENTS

Humanitarian endeavours

Sir, what an impact! And what a riveting piece of journalism: the personal account in the *BDJ* of dental students going to Northern France to assist voluntarily in the dental well-being of migrants: no pay and looking after people in atrocious conditions for whom they had no legal responsibility but felt the call of common humanity to do what they could to help.[1]

Was it foolhardy? Possibly. Was it brave? Undoubtedly – we read about the violence and the protection rackets with horror. A big thank you from all of us with an interest in dentistry for such a humanitarian endeavour.

Now may we look forward please to an equally revealing article, illustrated, of the experiences of the junior hospital dentists while on their strike days, refusing to treat patients who they were contracted to look after and helping the junior doctors in postponing thousands upon thousands of appointments, each of which will have meant a great deal to the victims?