ORTHODONTICS

Not so fast

Sir, it seems that N. Stanford has been using his letter published in the *BDJ*[1] as a platform to campaign and make false statements on other social media sites including GDPUK[2] against FastBraces. It is the height of hypocrisy for an officer of the British Orthodontic Society (BOS) to try and criticise any individual's website content when the BOS issued one of the most offensive and misleading dental adverts I have ever seen, in the national press (BOS advert, *Guardian*, 23 Feb 2013, p. 15), denigrating many GDPs doing patient-focussed orthodontics. Where were his advert objections to the ASA or any other body then? Where was the open BOS apology to the public and dental profession if any such 'crusade' is truly unbiased and unselfish?

Just to be crystal clear, claims made for FastBraces are based upon evidence-based medicine[3] as encouraged by the Cochrane Collaboration. Having spoken to the ASA, they confirm *only* their full Council can make any determination of fact, *not* any informal goodwill process, and in any case the ASA criteria are entirely different to evidence-based medicine criteria for clinical care and services. Thus perhaps if the ASA Council assessed Class2 div2 orthodontic cases, for example, might they narrowly conclude that *no* advertised health benefits can be made for traditional orthodontic treatments, given doing '*nothing*' produces just as good outcomes?[4]

It is notable that the public and professionals in the USA, where both legal and patient expectations generally are very high indeed, have no issues with Fastbraces' advertised claims made for the last 10 years, with many tens of thousands of FastBraces clinical results produced in just months, confirming they are extremely well established and evident in the 'real' world of frontline clinical experience and meeting patient wishes too. This is very reassuring for those whom may be new to FastBraces options in the UK.

Whilst my recent role as a UK Advisor for Fastbraces is simply pastoral for colleagues offering such options, it seems there is a significant small core of 'others' who believe GDPs should not be doing the majority of routine orthodontics in UK general practice. That is a great shame – it is not good to try and monopolise services/choices[5] or oppress/suppress/scaremonger[2] elsewhere – orthodontics is dentistry and like all other dentistry disciplines, the majority of routine cases should be done by competent GDPs and their teams, with our highly valued specialists mainly seeing the more complex cases suited to their more complex-training and expertise.[6] Increasingly, patients want braces that are fast, comfortable and with minimal side-effects too.

T. Kilcoyne, Specialist in Prosthodontics and a UK Advisor for FastBraces

1. Stanford N. Orthodontics: Fast removal of claims. *Br Dent J* 2016; **220:** 220.
2. Stanford N. GDPUK Thread (locked) Advertising standards and an Orthodontic Company. Posted at 11/3/16 12.21pm.
3. Sackett D L, Rosenberg W M, Gray J A, Haynes R B, Richardson W S. Evidence based medicine: what it is and what it isn't. *BMJ* 1996; **312:** 71-72.
4. Millet D T, Cunningham S J, O'Brien K D, Benson P, Williams A, de Oliveira C M. Orthodontic treatment for deep bite and retroclined upper front teeth in children. *Cochrane Database Syst Rev* 2006; CD005972.
5. Sultan M. Protectionism gone mad. 23 August 2013. Available at: http://www.smile-onnews.com/article/view/protectionism-gone-mad.
6. General Dental Council. *Scope of practice.* p 11. Effective from 30 September 2013. Available at: http://www.gdc-uk.org/Dentalprofessionals/Standards/Documents/Scope%20of%20Practice%20September%202013%20(3).pdf.

Nicky Stanford responds: I'd like to thank the Editor for the opportunity to respond to the comments of T Kilcoyne, following my recent letter to the BDJ.

My letter was not part of a campaign against Fastbraces or those practitioners who use them but, as I stated in my letter, an attempt to bring to the attention of BDA members the potential pitfalls of advertising claims on their practice websites that might be misleading to the public. To do so could be contrary to the GDC's Principles of Ethical Advertising.[1]

I am not an officer of the BOS as T. Kilcoyne states, although in my position within the Training Grades Group of BOS, I work with other orthodontic trainees to develop educational study days for dentists on matters relevant to orthodontic training. The BOS advert to which T Kilcoyne refers was written before I even started my specialist training. Further, it is hard to consider one advert placed over three years ago as a 'crusade'. I do not consider my position to therefore be hypocritical in pointing out misleading aspects of Fastbraces' promotional literature.

Given that 'claims made for Fastbraces are based upon evidence-based medicine', I am unsure as to why this evidence is not quoted in T. Kilcoyne's letter. When one looks at the evidence presented on the Fastbraces American website,[2] *there are 384 references of which the vast majority are presentation seminars to promote Fastbraces. None are clinical trials comparing Fastbraces one-wire treatment protocols to any other form of orthodontic treatment and none would pass scrutiny for inclusion in a Cochrane analysis. It is following a review of the available evidence that the claims made by Fastbraces can be considered to be misleading.*

One aspect of note that T. Kilcoyne neglected to mention in his letter is that he is the director of the company against which my complaint was lodged, Smile Specialist/Smilespecialist Ltd. One would have thought the Advertising Standards Association would have been suitably 'advised' on the Fastbraces evidence base having received an 'extensive response' to my complaint. Even so, the complainant then removed the following misleading claims from their advertising:

'Fastbraces are truly fast braces that can give straight teeth faster and more comfortably than traditional orthodontic braces for both adults and children'

And

'Unlike many other tooth brace systems, Fastbraces are not just quicker, but use gentler forces ... with less friction so there are less issues with pain, sensitivity and root resorption and less of the side effects one can experience with traditional brace systems that often take two or three years of treatment.'

I find it difficult to reconcile T. Kilcoyne's attempts to 'reassure' UK dentists that the claims made by Fastbraces' American advertising are proven, whilst at the same time he is the director of a company that removed similar claims from their own advertising after investigation by the Advertising Standards Authority.

In summary, my concern is not about GDPs carrying out orthodontic treatment. I have no issues with any dentist with relevant training and experience providing orthodontic treatment with or without Fastbraces. It is that practitioners should be cautious when repeating claims made by any company in any UK advertising or promotional material.

1. General Dental Council. Ethical advertising guidance. Effective from 1 March 2012. Available at: https://www.gdc-uk.org/Dentalprofessionals/Standards/Pages/Ethical-advertising.aspx.
2. Fastbraces Technology. Fastbraces Technologies... Research and Development. 30 years in the making. Available at: https://fastbraces.com/research_and_technology.

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ORAL CANCER

A reasonable postulation

Sir, I read with interest the letter by S. S. Shetty and P. Shetty presenting a case of oral squamous cell carcinoma (OSCC) linked with early coitus and dormant human papilloma virus (HPV) in a 22-year-old mother.[1] I would like to mention certain

additions to this letter regarding the role of early coitus and dormant HPV in OSCC. In a study conducted by Schwartz *et al.* about oral cancer risk in relation to sexual history and evidence of HPV infection, it was found that HPV type 16 infection may contribute to the development of OSCC and factors such as early coitus, multiple sexual partners and history of genital warts were associated with oral cancer risk in men.[2] There is a lack of convincing information about studies of OSCC linked with early coitus and dormant HPV in women in the literature. It seems reasonable to postulate that high-risk HPVs have evolved to maintain their infected host cell in a stem cell-like state in order to establish a persistent infection as pericoronitis or tonsillitis which later transforms into OSCC.[3] An exfoliated oral cytology test for high-risk HPV is also feasible in this case.[4]

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1. Shetty S S, Shetty P. Oral cancer: Link with early coitus. *Br Dent J* 2016; **220:** 279–280.
2. Schwartz S M, Daling J R, Doody D R *et al.* Oral cancer risk in relation to sexual history and evidence of human papillomavirus infection. *J Natl Cancer Inst* 1998; **90:** 1626–1636.
3. Münger K, Baldwin A, Edwards K M *et al.* Mechanisms of human papillomavirus-induced oncogenesis. *J Virol* 2004; **78:** 11451-11460.
4. Smith E M, Ritchie J M, Summersgill K F *et al.* Age, sexual behavior and human papillomavirus infection in oral cavity and oropharyngeal cancers. *Int J Cancer* 2004; **108:** 766–772.

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SUGAR

A latte on my mind

Sir, it is with interest that we followed the news regarding the quantity of sugar contained in hot beverages served in some of the UK's most popular cafes.[1] A red label warning of excessive sugar levels would be required for 98% of the 131 hot beverages surveyed should they be labelled, and 35% containing the same, or even more sugar than a can of Coca Cola.

The worst offender was the 'Hot Mulled Fruit' beverage from Starbucks which contained 99 g of sugar per serving, the equivalent of 25 teaspoons of sugar, closely followed by Costa Coffee's Chai latte containing 79.7 g of sugar per serving.[2] With the popular trend of adding high sugar syrups into coffee this seems to be an easy way to help surpass the latest World Health Organisation recommendation of free sugar intake to be less than 5%.[3] High free sugar intake can contribute not only to dental caries, but to myriad other health problems including increased body weight and diabetes.

Obviously as dentists we are aware of the dangers of unlabelled food and hidden sugars and in light of this and of the frequency of consumption of these hot beverages (claimed to be one in five visiting a coffee shop daily[4]) perhaps it would be prudent to highlight this information to our patients on a more regular basis?

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1. Brignall M. The cafes serving drinks with 25 teaspoons of sugar per cup. *The Guardian* 17 February 2016. Available at: http://www.theguardian.com/business/2016/feb/17/cafe-chains-selling-drinks-25-teaspoons-sugar-starbucks-costa-coffee.
2. Action on Sugar. Shocking amount of sugar found in many hot flavoured drinks. Available at: http://www.actiononsugar.org/News%20Centre/Surveys%20/2016/170865.html.
3. World Health Organisation. Sugars intake for adults and children guideline. 2015. Available at: http://www.who.int/nutrition/publications/guidelines/sugars_intake/en/.
4. Shubber K. Everyone wants a taste of booming UK coffee market. *Financial Times* 24 March 2015. Available at: http://www.ft.com/cms/s/0/860d06cc-d13c-11e4-98a4-00144feab7de.html#axzz3nPPAMG3Qe (subscription required).

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