

LETTERS TO THE EDITOR

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DENTAL RADIOGRAPHY

CBCT scrutiny

Sir, we wish to highlight a recent case of an intimate relationship between the roots of a lower second molar and the inferior dental canal (IDC) seen incidentally on a cone beam CT (CBCT) scan acquired to assess the relation of the lower third molar to the IDC prior to its surgical removal (Fig. 1). There are two lessons to be learnt: firstly the importance of reviewing the entire CBCT volume, not just the area of interest, for any incidental findings that might have a clinical relevance. The basic principles in the most recent guidelines of radiation protection clearly state that CBCT images must undergo a thorough clinical evaluation (radiological report) of the entire image dataset.¹ They also state that all those involved with CBCT must have received adequate training. This ensures that relevant important information is gleaned. In this case, the area of interest was the third molar; however, the lower second molar exhibited a significant intimate relation to the IDC not only in distance, but so that the apical foramen opened directly onto the canal itself with loss of canal cortication clearly seen on CBCT.

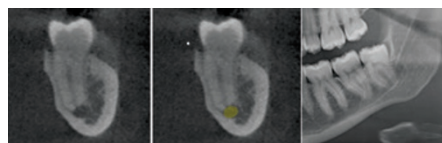


Fig. 1 Intimate relationship seen between the roots of a lower second molar and the inferior dental canal

Secondly, this potential intimate relationship would be an important consideration when an intervention is required such as endodontic treatment or surgical removal. Chong *et al.* described 55% of mandibular second molar apices having a distance to the IDC of ≤ 3 mm.² In this case, as the foramen opened directly onto the canal, this would pose a significant risk to nerve injury from overzealous instrumentation and hypochlorite use. We encourage practitioners to consider the position of the IDC

ANTIBIOTIC PRESCRIBING

Embrace antimicrobial stewardship

Sir, the latest data published on NHS antibiotic prescribing by primary care dentists in England appears to show a 7% decrease on the previous year, with the number of items prescribed down to 1996 levels.¹ This is good news from the perspective of antimicrobial resistance, with NHS dentists now responsible for 8.7% of all antibiotic prescribing in primary care.

Antibiotic resistance is a major threat to health² and it is recognised that antibiotic consumption drives the development of antimicrobial resistance.³ It would appear from this latest data that NHS dentists are doing their bit in tackling the problems of antimicrobial resistance.

However, this should not lead to complacency in antibiotic prescribing. Dentists should continue to embrace antimicrobial stewardship and prescribe appropriately in line with the guidance available by providing definitive clinical treatment for infections and where

possible avoiding prescribing clindamycin, co-amoxiclav and cephalosporins.⁴⁻⁶

N. Palmer, Liverpool

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prior to root treating a lower second molar, and in some cases the use of CBCT prior to endodontic therapy may be justified.

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ORAL CANCER

Another challenge for the dental team?

Sir, by 2030 half of all head and neck cancers will be related to HPV. This major new risk factor has the potential to influence

all aspects of diagnosis and management of oral cancer; not restricted to secondary care.

General dental practitioners must ensure they are providing accurate information in regards to a rapidly advancing field of research which can be gained via continuing professional development that is specific to the challenges and advances of this disease. Accurate patient information leaflets specific to the topic may further be of benefit to practices.

Reassuringly, thorough clinical examinations may vastly remain unchanged as the presentation of these cancers are clinically indistinguishable. However, a change in demographic and patients' needs will be evident. Previously, patients with head and neck cancer have, for the most part, been male, over 60 years old and have a history of high alcohol intake and smoking. Instead, those affected by HPV positive oro-pharyngeal squamous cell carcinomas

(OPSCC) are often younger middle-aged men who may lack the previously significant risk factors.¹

At the time of diagnosis or after the completion of treatment, patients may have questions and concerns regarding how and why they have become infected with HPV² as well as needing advice relating to vaccination. In addition, these patients will possibly have partners and young families under care of the same practitioner. These relatives may have anxieties and questions of their own relating to HPV transmission. The treating team will often be the first point of contact for the provision of information. As the number of those treated increases it is likely that the dental practitioner or members of their team will be asked questions that were previously considered taboo and potentially cause embarrassment. The possible psychosocial impact of diagnosis of HPV positive OPSCC should not be overlooked either. Receiving a diagnosis can initiate new feelings of anguish in addition to those coupled with a cancer diagnosis. In cervical cancer, research has shown emotional distress is common amongst women diagnosed with HPV. These feelings include decreased self-esteem, guilt and depression and can generate transmission concerns and intimacy issues.³ Investment in advanced communication skills courses for dental teams may aid the practitioner in addressing these topics. Early signposting to medical practitioners and support systems could also be of benefit.

M. Dillon, D. J. Smith, A. Kanatas, Leeds

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Misleading association

Sir, the title of the letter *Oral cancer: Link with early coitus* (*BDJ* 2016; **220**: 279–280) suggests a link which is misleading since it is oral sex that is associated with human papilloma virus (HPV), not early coitus.¹

HPV is associated with between 12–63% of all oropharyngeal cancers and prognoses of HPV associated non-cervical cancers are better than HPV-negative noncervical cancers.² Engaging in orogenital sex with multiple sex partners is associated with HPV-associated oropharyngeal cancer.³ Oral HPV

is found three times more commonly in men than women; 8–40% of HPV-positive oropharyngeal squamous cell cancer patients report never having had oral sex⁴ and oral sex and open-mouthed kissing are a risk factor for HPV-associated oral cancer.⁵

Dentists should take a history of oral sex from all patients, particularly young patients who present with lymphadenopathy and sore throat, and educate them about HPV-associated oral cancers as early detection provides better prognosis. Dentists should discuss and educate patients about HPV vaccination and prevention of HPV transmission.

Vagish Kumar L S, Mangalore, India

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CAREERS

The absence of restorative dentistry

Sir, I was somewhat perplexed by the absence of restorative dentistry as a potential career pathway in a recent promotional piece in the *BDJ In Practice* (*Which career is right for you?* *BDJ In Practice* No. 11, November 2015). Rather curiously, 'implant dentistry' (which is not recognised by the GDC as one of their 13 specialist areas) was featured amongst oral and maxillofacial surgery, oral surgery, paediatric dentistry and orthodontics as 'one of the fastest growing branches of dentistry'. Granted, this piece appeared to be more about quietly advertising a sponsored careers day and the promotion of certain postgraduate programmes to appeal to the next generation of dentists. 'Promotions' such as these, however, add to the increasingly worrying trend of some young dentists believing that they can practise 'implant dentistry' in isolation and apparently become 'specialists' in this area. This is despite the increasing body of evidence on the biological complications and the associated challenges involved with this treatment modality.^{1–3}

Dentists considering a career in secondary

care might wish to explore the option of restorative dentistry, which is recognised as a GDC specialty, as a possible career. It integrates implant dentistry as part of prosthodontic treatment, as well as providing wider training in prosthodontics, endodontics and periodontics to help manage patients who require complex multidisciplinary care. These patients include, but are not limited to, those with oral cancer, hypodontia, cleft lip and palate, those who have suffered dental trauma, and managing the complex oral healthcare needs of the increasingly ageing population. Consultants in restorative dentistry support general dental practitioners in helping to solve complex problems of various kinds and offer leadership in the delivery of appropriate restorative care. It is a varied and interesting option for those seeking to follow an established GDC recognised career pathway rather than highlighting just one facet of it such as 'implant dentistry'.

R. Chauhan, London

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Bridging to medicine

Sir, the Dental Council of India (DCI) has offered a solution to the acute shortage of medical doctors and specialists in India. It has proposed to start a bridge course for dental graduates so that they can become an MBBS doctor. There is already a bridge course for MBBS doctors who would like to become a dentist. The DCI president Dr D. Majumder has suggested a bridge course to help dental graduates to become MBBS doctors.

In India over 85% of positions for physicians are vacant at community health centres, yet more than 15,000 dental graduates are jobless. The bridge course would be a good solution to both problems.¹

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