COMMENT

Letters to the editor

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NHS dentistry

UDA disaster

Sir, my native country is Italy, where I have 23 years of experience as a dentist. I recently visited a family friend who is working as a GDP in a deprived part of north west UK. I was horrified to learn and witness the UDA system imposed on dentists in the UK. Any qualified dentist with a few years of experience would have foreseen the catastrophic consequences of this system.

There are pockets of deep deprivation in my friend's town where the majority of people have poor oral status and are in need of extensive treatment. On the contrary, other parts of the same town benefit from an affluent population who will barely need any treatment. It is absolute madness when dentists are required to do almost identical numbers of UDAs in such a system.

The dentist in question, using her dental software, has documented that on average each of her patients requires five fillings. I would expect the probability of periodontal and endodontic complications in the majority of these patients to be very high. Personally I would need approximately 20 minutes for restoring an average cavity. Five fillings including the cross infection procedures would require about two hours of my clinical time. I discussed the same issue with a periodontist who considers 2-3 hours of periodontal treatment/instructions as a minimum. His patients are expected to pay for his time, his staff's time and all other costs on an hourly basis.

Now replicating the same principles in an NHS practice, we could assume that a typical patient in my friend's practice is in need of estimated three hours of treatment. Each typical band 2 patient has been allocated 3 UDAs for all his/her treatment, therefore every UDA will require on average one hour of clinical work. An appropriate UDA allocation for each dentist in such a practice should be about 1,760 UDAs annually (1 UDA x 8 hours x 20 days x 11 months). However, the dentist in question is required by her NHS contract to deliver 6,000 UDAs annually.

The second issue in UK dentistry is the high regulatory regime which has been brutally policed by the GDC. The GDC is by far the most demanding and pedantic regulator in Europe and possibly in the world. Failing to perform an academic periodontal treatment and a periodontal six pocket examination (including all bleeding sites) based on a 6,000-UDA-environment will devastate a dentist's career. I have advised my friend to resign from her post as soon as possible and will question the sanity of any other dentist who has agreed to such conditions.

M. Rossi, Rome

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Pharmaceuticals

MRONJ and prostheses

Sir, MRONJ, a rare but well recognised condition, was previously referred to as bisphosphonate-related osteonecrosis of the jaw (BRONJ). This updated nomenclature was the result of an increasing number of cases of osteonecrosis associated with other antiresorptive and antiangiogenic therapies, such as denosumab and tyrosine-kinase inhibitors.[1]

Bisphosphonates are still one of the commonest antiresorptive agents associated with MRONJ and their formulations can be administered via oral or intravenous (IV) routes. It is well recognised that the IV form carries a higher risk for MRONJ when compared to the oral formulation and the overall risk increases in patients with additional co-morbidities. Nevertheless there is great scientific debate regarding the aetiology of MRONJ but the leading theory on its pathophysiology suggests that inhibition of osteoclastic bone resorption and angiogenesis play a role and lead to bone necrosis.[1]

These pathological processes are thought to have occurred in an 84-year-old lady who presented complaining of pain in her upper left jaw. She reported no history of radiotherapy or recent dental treatment but wore an unstable upper partial denture. Nine months previously she had been diagnosed with temporal arteritis and was started on prednisolone; simultaneously she also stated taking risedronate to prevent steroid-induced osteoporosis. On examination there was evidence of a mucosal defect and bony sequestration on the buccal aspect of the alveolus in the area of the upper left lateral incisor (Fig. 1). The clinical presentation was characteristic of MRONJ and chronic irritation from the denture flange appeared to be the cause. The disease progression was categorised as stage 2 and required adjustment of her denture, multiple courses of antibiotics, debridement and long-term follow up. Fortunately she responded well to this treatment, however, the evidence that shows preventative regimes are successful in reducing the incidence of MRONJ in susceptible individuals must not be overlooked.[1]

This case emphasises that osteonecrosis can occur early during the drug regime and simply from minor mucosal trauma.

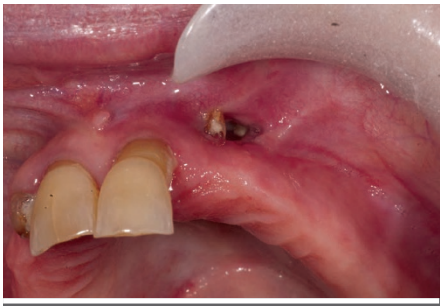

Fig. 1 Mucosal defect and bony sequestration on the buccal aspect of the alveolus in the upper left lateral incisor