

Letters to the editor

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Multidisciplinary teamwork Collaborating on diabetes

Sir, diabetes mellitus afflicts 3.3 million people in the UK with perhaps a further one million as yet undiagnosed.¹ As HbA1c rises, the risk of periodontal disease increases dramatically.² The combination of increased inflammatory mediators, advanced glycation end products and impaired immunity in diabetes may all play a role.³ But this is by no means a one-way street. Indeed, the bidirectional relationship between poor glycaemic control and periodontal disease is long established.³ One would assume therefore that, between dentists and physicians, information regarding these diseases is both easily accessible and eagerly sought...

As doctors, we are fortunate to know several practising dentists from whom we can seek insight into current practices. 'We just ask how well controlled it is... and some do a BM' was the first response we garnered after asking a dental colleague. Another explained, 'dentists don't really talk to GPs or diabetic specialists. We just tell patients with periodontal disease to make sure they get their glucose tested and make sure it's well controlled with [medications] and diet'. A third colleague reported, 'it's usually a case of taking the patient's word for it'. Indeed, more often than not we can trust that our patients will give us a truthful insight into the control of their condition. However, both denial and lack of insight are certainly not devoid in such patient groups.^{4,5} Needless to say, as doctors we are guilty of much of the same. I cannot recall a single instance where I, or one of my peers, had thought to consult a patient's dental records!

We would like to invite our dental colleagues to work more closely with us to increase awareness and curb the incidence of diabetic periodontal disease. Awareness of poor oral health amongst doctors may prompt early investigation for diabetes, whilst awareness of

poor glycaemic control amongst dentists may encourage targeted dental assessment and aid diagnosis. Just as the once estranged medical specialties have irrevocably come to realise, multidisciplinary teamwork may well be the key in breaking such vicious cycles.

S. Dhesi, J. Ellenbogen, by email

1. Diabetes UK. Diabetes prevalence 2014 (June 2015). Available at <https://www.diabetes.org.uk/Professionals/Position-statements-reports/Statistics/Diabetes-prevalence-2014/> (accessed 9 February 2017).
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3. Mealey B L. Periodontal disease and diabetes. A two-way street. *J Am Dent Assoc* 2006; **137**: 26–31.
4. Broom D, Whittaker A. Controlling diabetes, controlling diabetics: moral language in the management of diabetes type 2. *Soc Sci Med* 2004; **58**: 2371–2382.
5. Garay-Sevilla M E, Malacara J M, Gutiérrez-Roa A, González E. Denial of disease in type 2 diabetes mellitus: its influence on metabolic control and associated factors. *Diabet Med* 1999; **16**: 238–244.

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Oral health

Welcome progress

Sir, for oral health to be included as a key indicator in the Royal College of Paediatrics and Child Health report¹ published in February is welcome progress. At last the mouth is considered to be integral to well-being. A number of factors seem to have brought us to this point including a Chief Dental Officer whose rallying cry is that the mouth needs to be put back into the body. Other factors are the growing awareness that the state of children's oral health is unacceptable in a first world country and an acceptance that children's teeth are not simply the responsibility of parents or dentists. As a society, we all have a part to play whether it's a willingness to embrace a sugar tax, to support tooth-brushing in nurseries or to adopt fluoridation where it's warranted.

BSPD welcomes the movement towards greater collaboration among all those working with children. This was one of the key aims

from the stakeholders meeting we held last year. We are grateful that the Child Oral Health Improvement Programme Board is driving that collaboration.

It's now understood that in these straitened times we are spending millions of pounds carrying out extractions under general anaesthetic in hospital. By working together we can dramatically reduce the burden on the public purse and the impact on children and their families, suffering from a disease which, let's remember, is almost always preventable.

C. Stevens, Vice-President of the British Society of Paediatric Dentistry

1. Royal College of Paediatrics and Child Health. State of Child Health Report 2017. Available at: <http://www.rcpch.ac.uk/state-of-child-health> (accessed March 2017).

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Child dental health

Forty year overview

Sir, in our overview of 40 years of surveys of Children's Dental Health,¹ we reported that 33% of 15-year-old children had permanent teeth extracted because of decay in 1973, reducing to 24% in 1983, and then to 7% in 1993. It has remained near to that figure for the last 20 years.

The proportion of 15-year-olds undergoing extractions as part of orthodontic treatment ranged from 21–26% between 1973 and 2003.^{2,3} We examined the raw data, recently made available, of 2,415 15-year-old children from the 2013 survey of England, Wales and Northern Ireland.⁴ Fifteen percent of 15-year-olds in England had had at least one tooth extracted as part of orthodontic treatment, compared with 16% in Wales and 21% in Northern Ireland. The teeth most commonly extracted were: upper first premolars (8.9%), lower first premolars (4.1%), and upper and lower second premolars (3.8%). Less than 1% of first permanent molars were extracted for orthodontic reasons. In