COMMENT

Letters to the editor

Send your letters to the Editor, *British Dental Journal*, 64 Wimpole Street, London, W1G 8YS. Email bdj@bda.org.
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Dental radiography

Living in a bubble

Sir, I always find it fascinating to read the views of people who live in a 'bubble', particularly one as desperately parochial as dentistry. The letter from BDA staffers in the 7 July 2017 issue entitled *Cherry picking evidence* (*BDJ* 2017; **223:** 4) is one such example. Of the many challenges that could be levelled against that letter I would confine this simply to:

1) What has this got to do with 'protecting patients and practitioners'? The individuals concerned are not patients (look it up), and those carrying out such procedures are not practitioners in the usual accepted sense, ie GDPs, but formally trained forensic odontologists

2) In what way is the use of radiation to determine age in a border security setting any different from the body scanners, which most certainly irradiate those being scanned, in use at our major airports? Answer? None. So the voices of any objectors to them were overridden, quite correctly in my view, by those with a wider view. NB in the context of those devices, just try not consenting to being irradiated at an airport in the UK and you will find that you will be prevented from boarding your flight

3) The letter refers to the academics who wrote the original offending article as 'cherry picking' the evidence, but the authors' 'considerable deliberation' seems to have extended just to three papers, depressingly parochially, from the *BDJ*, one from the *Guardian* (scientific, obviously, and of course not politically biased) and one from an institution in India which to my reading actually appears to confirm the validity of age determination by radiography albeit in a select cohort of HIV positive children so it is of course quite irrelevant to this particular issue.

4) In my many years in dentistry I have encountered numbers of noteworthy and impressive practitioners such as Professor Jack Rowe, Dr Gordon Christensen, Professor Graham Roberts and Dr Bill Magee, but I never realised they were not outstanding teachers, clinicians, and innovators but were colleagues who could be dismissed as mere 'enthusiasts'.

R. Goulden, Forensic Odontologist, by email

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Highly politicised opinions

Sir, the comments in the December 2016 edition of *BDJ In Practice* on the subject of age assessment were almost unbelievable inclusions in the *BDJ* Portfolio; they were highly-politicised opinions that simply flew in the face of reason.[1] Thank goodness, therefore, that you saw fit to include the article by Graham Roberts *et al.* that put the case for age-assessment based upon published data rather than merely opinion.[2]

If the BDA wishes to influence government opinion from a moral standpoint then it is beholden for it to do so openly, and not to hide behind unfounded evidence.

J. F. Roberts, by email

1. Husband J. Column. X-rays and X-rated. *BDJ In Practice.* December 2016; **22:** 3.
2. Roberts G, Lucas V S, McDonald F *et al.* In our opinion. *Br Dent J* 2017; **222:** 918–921.

Editor-in-Chief's note: The following summary has been brought to the attention of the BDJ. *In the matter of an application for judicial review [R (on the application of ZM and SK) v The London Borough of Croydon (Dental age assessment) [2016] UKUT 00559 (IAC)] in the Upper Tribunal (Immigration and Asylum Chamber) Heard at Field House on 7 and 17 October 2016.*

C. M. G. Ockelton, Vice President of the Upper Tribunal Immigration and Asylum Chamber, made the following observations:

'Mr Wise QC suggested, by his questions, that the sparsity of information in Professor Roberts' opinions was deliberately designed to prevent them being read critically and therefore possibly to deceive a reader. I am not persuaded of that. It does, however, seem to me that Professor Roberts has developed an attitude of omniscience, in which he is prepared to assume that what he says goes. Coupled with that, he seems to be prepared to base apparently precise assessments on material which simply cannot support those assessments. The most alarming example of this in the report under examination is obviously that of tooth wear. Croydon's assertion that they do not rely on tooth wear does not help: the point is that Professor Roberts was prepared to express this opinion in a formal age assessment report. The difficulties in relation to the other age assessment methods in the report are more subtle, but they are of the same nature.

In relation to each of the four age assessment methods, there was reliance on unreliable data, or failure to mention difficulties about use of the data, or both. In the circumstances I have, with the greatest regret, reached the conclusion that an assessment in this form (or anything like it) by Professor Roberts should be read with the greatest of caution and should be acted on only if there has been a proper explanation of the basis for the opinions expressed.'

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Oral health

Caries risk category

Sir, working for a couple of years and coming across various exam templates and attending dental legal courses I have seen the emphasis on the title 'caries risk'. I have recently come across a colleague who has been legally challenged as he incorrectly categorised a patient

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as moderate caries risk when they should have been in the high caries risk category.

Is there any official parameter for low/medium/high risk? As I am under the perception that when there are lesions of more than nine, high sugar intake and living in a low fluoridated area we should place the patient under a high caries risk with a three-month recall and the use of high fluoridated toothpaste. But what about those patients with nine or more lesions but who live in fluoridated areas and have reduced their sugar intake?

K. Rai, by email

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NHS dentistry

Slow the troubling trend

Sir, as a doubly qualified maxillofacial trainee who qualified as a dentist in 2005, then a doctor in 2011, I have had the misfortune to see contracts imposed on both of my professions by successive governments. The 2006 dental contract came under much criticism due to its rushed implementation, cost cutting measures and little emphasis on prevention, and the new contract due to be implemented in 2018/19 is currently being piloted in practices across the country.[1]

Having first looked at trends in cervicofacial infections requiring surgical treatment in 2006,[2] we completed a prospective survey of all those presenting in Leeds, Mid Yorkshire, York and Hull across a one month period completed in April 2016, ten years following imposition of the new contract.

The number of patients presenting with cervicofacial infections requiring surgical treatment in this 30-day period was 66, over a 4 × increase in the same period ten years ago. Fifty-six percent presented directly to accident and emergency without primary care input compared to 48% previously, and overall, 44% had no registered dentist compared to 56% ten years ago.

These results are alarming, and although the reasons are presumably multifactorial, it does lead to concerns about further pressures on an already troubled system. Death from dental sepsis is rare in the United Kingdom,[3] but every dental abscess must be considered potentially life threatening if left untreated. The increased workload on accident and emergency, in addition to the unplanned activity in emergency theatres, can only be assumed to negatively impact care elsewhere. We must ensure as a profession that any new dental contract addresses the issues of access and preventative dental care to hopefully slow this troubling trend, and ease the burden on an already stretched system.

A. Power, E. Bowden, A. Adams, L. Carter, Leeds

1. Dental contract reform: prototypes. Available at: https://www.gov.uk/government/publications/dental-prototype-agreements-directions-and-patient-information (accessed 14 July 2017).
2. Carter L M, Layton S. Cervicofacial infection of dental origin presenting to maxillofacial surgery units in the United Kingdom: a national audit. *Br Dent J* 2009; **206:** 73–78.
3. Green A W, Flower E A, New N E. Mortality associated with odontogenic infection! *Br Dent J* 2001; **190:** 529–530.

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Paediatric dentistry

Let's support each other

Sir, it was with great delight that I opened the pages of the *BDJ* to see a three-page spread dedicated to BSPD's Dental Check by One (DCby1). Thank you to you and your editorial team for picking up on this important campaign so promptly. It was additionally rewarding to note the positive responses from all your interviewees who not only supported the campaign but reported on inspired and committed approaches to managing young children in the dental chair.

One of your interviewees dissented in one aspect only and this was in relation to access. Currently, in his or her practice (the interviewee chose to remain anonymous) there was no capacity to treat additional children. However, I understand that a commissioning concept has been proposed to all NHSE regional leads. If agreed, this would include a mechanism for allowing the 25% of practices who have met their UDA target to receive additional UDAs in order to see young children.

For Dental Check by One to become a reality, the support of dental practices – both private practices and practices with NHS contracts – is essential. BSPD looks forward to a strengthening collaboration with primary care. Through you, can I invite your readers in general dental practices to use our DCby1 logo and we will support each other as we work together to bring down the number of children requiring GAs for dental extractions.

For more information about the campaign and to download the logo, please visit http://bspd.co.uk/Resources/Dental-Check-by-One.

C. Stevens, Vice President BSPD, Manchester

1. Quinlan K. Perspectives: 'Step by step we build up a rapport'. *Br Dent J* 2017; **223:** 6–8.

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Dental education

Missing something vital?

Sir, this letter highlights some of the advantages of incorporating vital signs in the initial assessment of patients. Notwithstanding an increased workload for dental students and their supervisors, teaching it may provide valuable information about patients' general health and wellbeing. Assessment of vital signs is certainly crucial in the prevention and management of medical emergencies. Given an increase in ageing population in the UK, it is apparent that dentists in primary care are seeing a higher number of patients with medical problems, diagnosed and undiagnosed. Assessment of vital signs as part of initial examination may help in identifying signs of previously undiagnosed medical conditions such as cardiorespiratory diseases, hypertension etc. This may prompt referral to medical colleagues for further investigations.

Another related example is the assessment of body temperature to rule out fever in patients presenting with oral infections and make informed decisions including antibiotic prescriptions and the need for referral to the hospital for treatment as inpatients. However, it is not unusual in dental practice environments to rely on patients' perceptions regarding the presence and severity of fever. It would be helpful to ensure that thermometers are routinely available in general practice dental settings. Incorporating this element in the initial medical assessment of patients will not only help students to consolidate their skills but also contribute further to improved clinical care without any significant financial implications.

K. Ali, Plymouth

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