COMMENT

Letters to the editor

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Oral health

Treating refugees

Sir, the article titled *Personal account: A drop of dentistry in the jungle* (*BDJ* 2016; **220:** 160–163) highlighted the appalling conditions in the refugee camps set up in Calais as well as providing us an insight into the poor oral health status of many of the camp's residents. As dental students this motivated us to make the journey from Cardiff to Calais with a team of qualified medical and dental professionals with the aim of providing dental aid.

As we arrived by the camp, the mood in the car subtly shifted to a tense silence as we saw smoke masking the entrance. With many media outlets reporting that the camp was in the process of being completely demolished, all residents having been cleared, news of fires and riots spreading, there was an unspoken anxiety about what we might encounter. Entering the 'jungle' was almost dream-like: the blazed periphery gave us a view into the vast landscape which once had many thousands living in such horrid conditions. Contrary to media reports we drove past hundreds of residents until we came to a halt somewhere in the depths of the camp, where nearby, teenage boys were playing a game of volleyball.

We decided the best way to maximise patient treatment would be to set up a basic triage system equipped with three plastic chairs we spotted by a nearby tent. As students, our duties involved distributing toothbrushes and toothpastes, providing oral hygiene instructions, helping to effectively maintain the triage system and mixing GIC or Kalzinol.

The clinicians treated over 100 cases of acute dental emergencies, with many patients in pain from toothache that they had been suffering from for weeks. The majority of dental treatment involved excavating and temporising large carious lesions; however, we also came across complicated and uncomplicated crown fractures in children caused by trauma whilst playing. A young lad with acute necrotising ulcerative gingivitis also presented but we could only provide treatment with local measures by carrying out hand scaling and oral hygiene instructions. The most perplexing case we encountered all day was a lady with her buccal maxillary gingivae coloured dark blue but with no obvious signs of pathology; however, after eventually finding a translator we were reassured it was a cultural practice of tattooing the gums! The reality of the poor oral hygiene levels amongst the camp was now fully understood as almost every patient presented with carious lesions with resulting pain. It was heart-breaking knowing we could only provide a limited amount of treatment.

Besides the dentistry, it was touching to connect with the stories of struggle and sacrifice of the camp's residents, many of whom were fleeing from war and persecution. As the Calais camp has now been demolished, we hope our friends have now been reallocated to better living conditions and are provided with the very basic human needs we all require.

We would urge all dental professionals to partake in such charitable causes and offer their skills in the service of humanity.

S. M. Hussain, H. Sheikh, A. Amir, A. Al Hassan, by email

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Unsupported conclusions

Sir, we read the article entitled *Motivational interviewing in general dental practice: A review of the evidence* by E. J. Kay, D. Vascott, A. Hocking, and H. Nield (*Br Dent J* 2016; **221:** 785-791), which presents a systematised review of the evidence in relation to motivational interviewing (MI) in dental practice. This approach to changing oral health behaviours and habits is an emerging and significant theme. Considering their proposed objective, the authors concluded that the MI technique has the potential to benefit patients with poor oral hygiene and suggested that MI training for oral healthcare professionals can be added to the established set of practices. However, we observed that only two of the eight articles included are intervention studies that use the MI-based approach specifically to treat patients with periodontal disease.[1,2] Of the remaining studies, one addresses the cost-effectiveness of the intervention[3] without analysing clinical results as the main outcome. Another study[4] claimed to apply an MI-based approach, but according to the methods described it does not fall under the assumptions and techniques described by Miller and Rollnick.[5]

Three articles did not use MI-based approaches,[6-8] and one is a qualitative study[9] that only describes the approach used by dental hygienists. Lastly, one study is not cited in the references, making it impossible to determine whether the intervention involved MI or not.

The evidence found by the authors does not support the conclusions, neither regarding better oral health among patients, since the studies included did not synthesise sufficient and adequate evidence for this conclusion, nor professional training, given that none of the articles assessed this aspect for oral health teams. Moreover, we believe that MI is not centred solely on providing additional skills and techniques for clinical practice, as proposed by the authors. MI involves changing professional attitudes and conduct to establish a dialogue about change, promoting self-efficacy and helping patients change their unhealthy oral health behaviours. It is important for readers to understand that MI is a specific approach, with assumptions and techniques described by Miller and Rollnick, and should not be confused with other behavioural approaches.[10] There is more robust evidence available to understand the

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current scenario in relation to MI use and its effects on oral health.[11] As such, we reiterate the fragility of the findings of the published review and suggest that future reviews on the subject follow eligibility criteria for study inclusion in order to obtain more reliable conclusions about MI in general dental practice.

B. Carriconde Colvara, C. Stein, D. Demétrio Faustino-Silva, R. Soares Rech, Porto Alegre - RS, Brazil

1. Jönsson B, Öhrn K, Oscarson N, Lindberg P. The effectiveness of an individually tailored oral health educational programme on oral hygiene behaviour in patients with periodontal disease: A blinded randomized controlled clinical trial (one-year follow-up). *J Clin Periodontol* 2009; **36:** 1025–1034.
2. Jönsson B, Öhrn K, Lindberg P, Oscarson N. Evaluation of an individually tailored oral health educational programme on periodontal health. *J Clin Periodontol* 2010; **37:** 912–919.
3. Jönsson B, Öhrn K, Lindberg P, Oscarson N. Cost-effectiveness of an individually tailored oral health educational programme based on cognitive behavioural strategies in non-surgical periodontal treatment. *J Clin Periodontol* 2012; **39:** 659–665.
4. Kakudate N, Morita M, Sugai M, Kawanami M. Systematic cognitive behavioral approach for oral hygiene instruction: A short-term study. *Patient Educ Couns* 2009; **74:** 191–196.
5. Miller W R. Motivational interviewing with problem drinkers. *Behav Psychother* 1983; **11:** 147–172.
6. Halvari A E M, Halvari H, Bjornebekk G, Deci E L. Self-determined motivational predictors of increases in dental behaviors, decreases in dental plaque, and improvement in oral health: a randomized clinical trial. *Health Psychol* 2012; **31:** 777–788.
7. Clarkson J E, Young L, Ramsay C R, Bonner B C, Bonetti D. How to influence patient oral hygiene behavior effectively. *J Dent Res* 2009; **88:** 933–937.
8. Fjellström M, Yakob M, Söder B. A modified cognitive behavioural model as a method to improve adherence to oral hygiene instructions-a pilot study. *Int J Dent Hyg* 2010; **8:** 178–182.
9. Kasila K, Poskiparta M, Kettunen T, Pietilä I. Oral health counselling in changing schoolchildren's oral hygiene habits: A qualitative study. *Community Dent Oral Epidemiol* 2006; **34:** 419–428.
10. Miller W R, Rollnick S. Ten things that motivational interviewing is not. *Behav Cogn Psychother* 2009; **37:** 129–140.
11. Gao X, Lo E C M, Kot S C C, Chan K C W. Motivational interviewing in improving oral health: a systematic review of randomized controlled trials. *J Periodontol* 2013; **85:** 426–437.

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Health policy

Hospital cutbacks

Sir, I read with interest the letter from R. S. Randhawa *et al.*[1] which highlighted the neglect of dental care on hospital wards.

Back in the 1970s I was employed as an in-patient dental officer at Guy's Hospital where my duties were to look after the dental care of hospital in-patients. A large part of my work included pre-operative assessment and treatment of cardiothoracic patients and dealing with dental emergencies when they arose, not just at Guy's but the associated hospitals and care homes in the Guy's group. I had a standalone surgery in the main hospital and a dental nurse to assist me.

Informal seminars were also given to nurses about the importance of the oral health of patients in their care.[2]

Unfortunately, the job eventually fell victim to one of the early cutbacks in NHS funding in the 1980s. This was a short-sighted expediency and resulted in a lost opportunity to improve patient care at a relatively low cost.

Perhaps it is time to revisit this aspect of holistic care so aptly raised by your correspondent.

G. Feaver, London

1. Randhawa R S, Chandan J S, Thomas T. Oral health: Dental neglect on wards. *Br Dent J* 2017; **223:** 238.
2. Feaver G P. The dental care of cardiothoracic and radiotherapy patients. *Nursing Mirror* 1977.

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Oral surgery

The drug holiday

Sir, we read with interest *Aggressive denosumab-related jaw necrosis – a case series.*[1] It highlighted the contentious role of the drug holiday in the treatment of MRONJ in patients taking denosumab.

It is a clinical challenge to determine the risks *versus* benefits of stopping denosumab for dental treatment in patients with metastatic disease.

Denosumab-related osteonecrosis of jaw is rare. In some cases it can cause significant morbidity.[1] According to the literature, skeletal related events (SREs) such as pathologic fractures and spinal cord compression in patients with metastatic disease are common and reduce quality of life.[2] In our clinical experience some patients have been placed on a pre-emptive denosumab drug holiday by their oncologists to presumably reduce the risk of MRONJ if they require dental extraction. The evidence for the efficacy of drug holidays is poor and it is not supported by published guidance.[3]

However, performing dental treatment before denosumab therapy has started is a recognised preventive approach.[4] The skeletal complications of bone metastases are responsible for a range of complications and costs and decreased quality of life.[2] The role of denosumab in delaying SREs and thus maintaining quality of life is clear.

Therefore, by stopping denosumab temporarily we may be increasing the risk of SREs in these patients and ultimately reducing their longevity.

Therefore, is it prudent to stop this therapy at all? Are we at risk of losing focus holistically speaking? Further research and evidence-based guidance is needed to aid oncologists and dentists on the effects of drug holidays in patients with metastatic disease.

D. Shiels, A. Goodall, by email

1. Badr M, Kyriakidou E, Atkins A, Harrison S. Aggressive denosumab-related jaw necrosis – a case series. *Br Dent J* 2017; **223:** 13–16.
2. Clemons M, Gelmon K A, Pritchard K I, Paterson A H. Bone-targeted agents and skeletal-related events in breast cancer patients with bone metastases: the state of the art. *Curr Oncol* 2012; **19:** 259–268.
3. Ruggiero S L, Dodson T B, Fantasia J *et al.* American Association of Oral and Maxillofacial Surgeons position paper on medication-related osteonecrosis of the jaw – 2014 update. *J Oral Maxillofac Surg* 2014; **72:** 1938–1956.
4. Scottish Dental Clinical Effectiveness Programme. *Oral health management of patients at risk of medication related osteonecrosis of the jaw*. March 2017.

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Dental radiography

Short roots

Sir, this radiograph (Fig. 1) was taken of a fit young man and we were both surprised to discover that all his teeth have such short roots. Trawling through books and Internet searches has provided no explanation and so I hope that one of your readers will be able to provide an explanation.

There are concerns that this could be an expression of some genetic problem as he has just got married and intends to have a family in a few years.

C. Marks, by email

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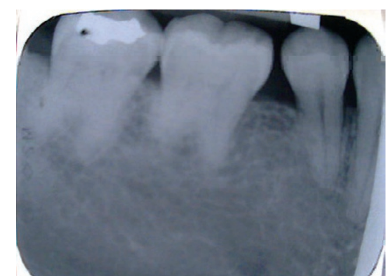

Fig. 1 Radiograph of a young adult male showing short roots

Erratum

Quick release mechanism

In the original version of the above letter (*Br Dent J* 2017; **223:** 237), only one author was given, N. Uppal.

The correct author listing should have been: M. Kumar, N. Uppal.

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