COMMENT

Letters to the editor

Send your letters to the Editor, *British Dental Journal,* 64 Wimpole Street, London, W1G 8YS. Email bdj@bda.org.
Priority will be given to letters less than 500 words long. Authors must sign the letter, which may be edited for reasons of space.

OMFS

Instant relief

Sir, may I congratulate Jaspreet Virdee at such an early stage in her career on delivering such a thought-provoking Opinion article[1] and review of current management issues in TMD stimulated by, and following, her personal poor experience when visiting her local 'teeth focussed' GDP. I would like to make gentle comment on two areas of this paper.

The section 'Management in primary care' focuses on the administration of paracetamol, NSAIDs (such as ibuprofen) and sometimes the addition of benzodiazepines (diazepam) to alleviate the acute and iatrogenic trauma to the TMJ structures that often ensues following prolonged sessions of dental treatment. This therapy regime is quoted in the paper, and from other sources, to be likely to take sometimes as long as three weeks to take maximum effect.

TMDs must be the most common musculoskeletal disorder in the causology of facial pain. In my practice following a long session of multiple quadrant preparations, in spite of the patient being seemingly relaxed, with 'rest periods' given, often with mouth prop and rubber dam in place – and even sometimes having fallen asleep – it was certainly the sort of situation that accounted for easily the majority of patients that often experienced this complicating acute TMJ discomfort and significant pain postoperatively.

The most effective and reliable method I found of treating this scenario when correctly diagnosed and with a dramatic effect in dealing with the acute pain, hypo-mobility, associated inflammation, and of course the inevitable distraught patient, was the administration of oral dexamethasone, a glucocorticoid, in a tapering dose orally over five days beginning at a total of 6 mg on the first day.[2] The almost instant relief experienced by affected patients is best illustrated by the effusive early morning calls received following the day of prescription expressing thanks for the pain relief and 'the best night's sleep for some time'.

Jaspreet Virdee references the advice of NICE and also the Special Interest Group in TMD but not the potential of the above regime in producing the effective removal of the patient distress and discomfort associated with the traumatised TMJ apparatus in such circumstances which is evidence based.

One other comment if I may, in regard to the statement that 'botulinum toxin (BT) injections may be considered as an alternative for masticatory myofascial pain if conservative methods have failed'. This is not offered here as a guaranteed solution in resolving such pain but in that it may improve the severity of symptoms, in that significant reductions in pain scores were achieved. The pathway for this seems to be that BT administration has a proven effect on depression[3] and the associated mood lift effect may well serve to diminish the perceived pain.

Hopefully this paper will encourage other younger colleagues to publish in the *BDJ*!

K. F. Marshall, Llanybri

1. Virdee J. The headache of temporomandibular disorders. *Br Dent J* 2018; **224:** 132–135.
2. Zandi M. The role of corticosteroids in today's oral and maxillofacial surgery. *In Glucocorticoids - new recognition of our familiar friend.* InTech Publications, 2012.
3. Chung S, Chhabria A, Jung S, Kruger T H C, Wollmer M A. Botulinim toxin as a treatment for depression in a real world setting. *J Psychiatr Pract* 2018; **24**: 15–20.

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Maxillary position

Sir, I would like the opportunity of commenting on Dr Jaspreet Virdee's interesting opinion on TMD.[1] Currently there seems to be little consensus on either the cause or cure for TMD, or the most appropriate treatment. One constant feature is a retruded maxilla, but this is rarely mentioned and to my surprise many dentists are not aware of it and even specialists often seem unable to assess it.

These days dentistry is considered to be an evidence-based subject but evidence faces a problem when there are a large number of variables. It gets progressively more difficult to design studies that can consider more than five or six factors simultaneously. Each study tends to consider a number of relationships in specific situations, but many fail to establish whether the factors are causative, associated or resultant, meaning that in this situation we may be left with no more than a long list of possible factors.

In a sense the research has blighted TMD treatment rather than provide us with a set of answers. Here I believe that logic may do better than research. The condyle is a very small part of the body and yet it is blamed for many aspects of dysfunction and pain. Mammals have been around for more than 60,000,000 years and evolution has ensured that we now function quite well. In this case reason would suggest it is unlikely that more than one or maybe two things have gone wrong rather than 20 or 30 often suggested.

I am sure that many clinicians have suggestions to make, but my money is on maxillary position.

J. Mew, Heathfield

1. Virdee J. The headache of temporomandibular disorders. *Br Dent J* 2018; **224:** 132–135.

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Healthcare provision

Registration and retention of dentists

Sir, Professor Batchelor's paper, *Registration and retention of dentists on the General Dental Council register between 2006 and 2016* (*BDJ* 2018; **224:** 105–109) highlights important issues to be considered by those tasked with the challenge of dental workforce planning. This challenge is confounded by, amongst other factors, lack of information on the number of General Dental Council (GDC)

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registrants contributing to oral healthcare provision in the UK, and the extent of registrant's engagement in clinical practice.

How many GDC registrants based in Europe, or further afield internationally, retain their GDC registration for purposes other than the practice of dentistry in the UK? And, what is the average commitment of GDC registrants working in the UK to the clinical care of patients? It is suggested that answers to these questions would greatly increase the value of future dental workforce planning exercises.

How could such data be collected? One solution could be findings from questions posed at the time of making the required annual statement of continuing professional development (CPD) completed to the GDC. For example: Do you anticipate providing (or contributing to) the clinical care to patients in the UK during the next 12 months? If so, how many hours a week on average do you anticipate being engaged in the care of patients? It is acknowledged that the findings from such simple questions would suffer certain limitations; however, the impact on workforce planning could be profound.

Answers to questions of the type proposed would help to protect the public and should, therefore, be seen to be an appropriate responsibility of the GDC. Assuming answers provided from individual registrants online could be collated electronically, there would be little additional burden on the Council.

N. Wilson, by email

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Special care dentistry

Advanced care planning

Sir, it is greatly encouraging to see the findings arising from dental teams working with memory clinics as discussed by Emanuel and Sorensen.[1] Aligned with applicable publications and guidelines,[2,3] the article rightly concludes that we should be encouraging prevention of dental diseases in those with early signs of cognitive decline, especially when the potential future complexity of treating these patients is considered.

Despite the importance of disease prevention, multiple studies have shown that oral diseases persist in this patient cohort[4,5] which often results in the need for active intervention from dental teams. As dementia progresses, there is the potential for patients to lose the ability to express their preferences regarding treatment and to lose the capacity to consent for their treatment. Related to those processes, best-interests decisions and treatment planning can become increasingly complex and treatment provision can be associated with a greater degree of risk.

The memory clinic is likely a useful setting in which to investigate patients' experiences of dental attendance and to plan prevention approaches. For those who don't attend dental settings, I wonder if this or similar services would also be suitable forums to gather patients' preferences for their future dental treatment needs? A similar approach could be taken by dental teams for those who do attend for routine care. Though these preferences would not be fully binding without an advanced directive, an awareness of patients' past preferences could significantly assist in determination of individual patients' best interests if dental intervention becomes necessary when dementia has progressed and patients are assessed to lack the capacity to consent for treatment.

A. Geddis-Regan, by email

1. Emanuel R, Sorensen A. A study of oral health prevention behaviours for patients with early stage dementia. *Br Dent J* 2018; **224:** 38–42.
2. Faculty of General Dental Practitioners. *Dementia-friendly dentistry.* London: Faculty of General Dental Practitioners, 2017.
3. Pretty I A, Ellwood R P, Lo E C M *et al.* The Seattle Care Pathway for securing oral health in older patients. *Gerodontology* 2014; **31 Suppl 1:** 77–87.
4. Gil-Montoya J A, Sánchez-Lara I, Carnero-Pardo C *et al.* Oral hygiene in the elderly with different degrees of cognitive impairment and dementia. *J Am Geriatr Soc* 2016; **65:** 642–647.
5. Zenthöfer A, Schröder J, Cabrera T, Rammelsberg P, Hassel A J. Comparison of oral health among older people with and without dementia. *Community Dent Health* 2014; **31:** 27–31.

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Environmental issues

Dental sustainability

Sir, the recent 'Blue Earth' programme highlighted dangers from the increasing use of plastics in disposable items. The future of marine life, the plant, and humanity appears to be at some risk.

As dentists our contribution of non-biodegradable plastics is not being addressed. The European Union Directive; Health and Safety (Sharps Instruments in Healthcare) Regulations 2013 and equivalent UK Regulations 2013 move dental practitioners away from reusable syringes towards disposable syringe-needle combinations, the rationale being to reduce the number of needle-stick injuries and hence a burden of disease, injury, and permanent or temporary impairment or handicap. Assuming hypothetical figures of 10,000 dentists administering five local anaesthetics a day over a working year of 200 days, this amounts to 1,000,000 plastic syringes added to the plastic waste for disposal.

HTM 01-05 and other legislation introduced sealable pouches for most dental instruments. Although the need to pouch has since been reduced, again assuming 10,000 dentists using, say, 20 pouches a day, there will be in excess of 4,000,000 plastic sleeves, headrest covers and instrument pouches (most have plastic windows) to be disposed of annually, probably a conservative estimate.

Building healthy public policy, one of the five areas for action determined by The Ottawa Charter for Health Promotion, recommended the use of Health Impact Assessments (HIA) as 'means of assessing the health impacts of policies, plans and projects in diverse economic sectors'. One of the principles of this approach is 'sustainability', defined as 'a process that aims to meet the needs of the present generation without harming the ability of future generations to meet their needs'.

HIAs may be an overlooked governmental concern, but in dentistry we are not only statutorily required to carry out risk assessments and show evidence-based benefits for all procedures, but are ethically obliged and professionally responsible for doing so. Should we or could we carry out risk analyses as part of an HIA? The policy to introduce disposable syringe-needle combinations, and the demands of HTM 01-05, have been criticised for the impossibility of a true evaluation of outcomes without a valid starting database to show how many needle-stick injuries there were before the change, or the incidence of proven dental surgery induced infections prior to 2007. Without these data it may not be possible to carry out any objective based or economic evaluation, or a valid risk-assessment to see how any reduced risk of personal injury might balance against the gradual destruction of marine environment.

But we do need to seriously consider our responsibility to our planet, to future generations, and whether our actions are responsible. Perhaps the BDA could set up a commission to investigate the sustainability of policy developments, to assess the true health impacts, and to inform policy makers of the wider consequences of their decisions?

J. Aukett, by email

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