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.

The following two letters are in response to the article 'The ultimate guide to restoration longevity in England and Wales. Part 5: crowns: time to next intervention and to extraction of the restored tooth' published in the BDJ *on 6 July 2018.*

Restoration longevity

New treatment plan

Sir, after reading 'The ultimate guide to restoration longevity in England and Wales. Part 5: crowns: time to next intervention and to extraction of the restored tooth'[1] in the July issue of the *BDJ*, I changed a treatment plan in the hope of a better and more minimalist approach.

As shown in Figure 1 15, 16 and 17 all had MOD carious, leaking and fractured amalgams; I had replaced the amalgams with composite cores under rubber dam (Fig. 2) with the intention of crowning or onlays if stable – that is, until I read the latest research indicating the reduced lifespan of teeth restored with crowns.

Fig. 1 15, 16 and 17: long standing and failing amalgams secondary to caries and fracture

I looked again at the pictures after amalgam removal and at the composite cores (incidentally highlighting the benefit of photographing one's work to allow for reflection and discussion with peers). I then concluded that, rather than cutting away tooth out of habit, with the favourable occlusion and guidance, I would polish the composites up instead as permanent restorations (Fig. 3).

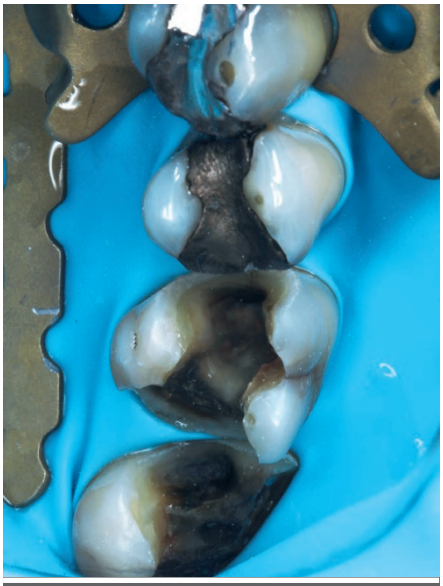

Fig. 2 Rubber dam placement & removal of amalgam 16, 17; disto-buccal cusp 16 fractured & to be removed

Fig. 3 Finished restorations in 15, 16 and 17

The patient seemed keen on this change of treatment plan in avoiding further work and potentially having more tooth left to play with in the future. In keeping with the findings of the article, as a young dentist (BDS 2015) I hope my direct restorations will perform well! My only regret is not placing an opaquer to hide the amalgam stained dentine.

A Parr, by email

1. Burke F J T, Lucarotti P S K. The ultimate guide to restoration longevity in England and Wales. Part 5: crowns: time to next intervention and to extraction of the restored tooth. *Br Dent J* 2018; **225:** 33–48.

DOI: 10.1038/sj.bdj.2018.762

Patient and dentists' interests matter

Sir, with all this information on longevity and further interventions[1], what should we answer when a patient asks 'how long will this last?

We can, of course, quote the published papers but shouldn't the real answer be 'I don't know how long my restorations last' unless the practitioner has undertaken a proper audit of this type of treatment. I also wonder how reliable and useful is the information given over in the above[1] and preceding articles.

While recognising that the figures are drawn from actual treatments carried out – ie what practitioners did – we do not know why they did what they did and what their decision making process was. Secondly, how is this information to be used when there is a patient in the dental chair?

A look at Cochrane reviews will reveal that most relevant papers published in relation to the above or related topics are excluded because of bias or inadequate protocols.

With restoration failure, there is no universally applied standard. There are, then, two

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possibilities; if the restoration is replaced, it is considered to have failed or the restoration has failed when the decision to replace it was based on clearly defined guidelines.

The lack of controlled clinical trials shows the difficulties of carrying out these trials in practice and therefore, throws into question the motivation in the decisions made by the practitioners who carried out the treatments reported on in this paper.

There are several factors that contribute to prescribing patterns:

- Undergraduate or postgraduate training
- Time available for treatments
- Financial pressures
- Gender
- Age
- The environment the practitioner is working in be it general practice, hospital or academic.

All of these will influence, more or less, the choice or preference for treatment.

Daniel Kahneman, in his book *Thinking, fast and slow*[2] writes: 'The extent of consistency is often a matter of concern' and mentions how experienced radiologists who evaluate chest x-rays as 'normal' or 'abnormal' contradict themselves some of the time when they see the picture on different occasions.

As human beings we are not as consistent or reliable as we would like to think. And how useful is this information?

With the patient sitting in the dental chair, the question that confronts the dentist is 'what do I do here?' The practitioner has to make a decision within the context of the patient. If the tooth were out of the mouth and held in the hand the 'best' way to bring it to form and function may be one type of treatment.

But, in the context of the mouth, modifying factors have to be taken into account and the option for 'best' treatment may be quite different.

The real challenge is for practitioners to be aware of all the treatment options and how and why they arrive at the option of choice and to be conscious of the question as to whose interests are being served in the provision of treatment. Is it the patient's or the dentist's? Hopefully, both!

R. Caplin, by email

1. Burke F J T, Lucarotti P S K. The ultimate guide to restoration longevity in England and Wales. Part 5: crowns: time to next intervention and to extraction of the restored tooth. *Br Dent J* 2018; **225:** 33–48.
2. Kahneman D. Thinking, fast and slow. p 225. Penguin Books, 2012.

DOI: 10.1038/sj.bdj.2018.763

Dental research

International research collaboration

Sir, the office of the International Association for Dental Research Caribbean Section [IADR-CS] is pleased to share the official launch of its Newsletter.

The overall objectives are strengthening the mission and vision of IADR among Caribbean members, providing an opportunity for collaboration and the promotion and dissemination of research activities from dentists and specialist dentists within the region.

The launch of the first issue took place on 15 June 2018 at the IADR-CS meeting: the 3rd Caribbean Oral Health Initiative Summit in Puerto Rico, USA.

The contents of the newsletter include a message from the IADR President, key events, and research at Trinidad and Tobago. The full text is available at https://goo.gl/XgPUQh. We continue to look forward to research collaboration across global dental researchers.

A. B. R. Santosh, J. Collins, L. Feliz and N. Abreu, by email

DOI: 10.1038/sj.bdj.2018.764

Dental trauma

Trauma protocol for schools

Sir, a recent case in practice has led me to carry out a service evaluation in the local community – assessing the knowledge of the management of dental trauma amongst school teachers in the North East.

A nine-year-old girl attended with a complicated enamel-dentine fracture 11 and an uncomplicated enamel-denture fracture on the 21, which occurred during lunch time. She attended one hour after the incident with her teacher, who was also her mother.

On review of the incident with the child's mother, it was reported that there was no dental emergency protocol at the school.

A brief 'trial' survey distributed to the schools near the practice showed that on review of 45 responses from the teachers and staff within these schools, there was an overall unsatisfactory knowledge of the appropriate management procedures and protocol a school could have in place to prevent, manage and treat the various dental injuries which may occur during school hours.

The Department for Education has confirmed that its current health and safety requirements for schools lie in the hands of the school's owner/employer (usually the local council), and they should ensure there are appropriate measures in place so that the safety of staff and pupils are adequate. When it comes to dental trauma and its management, it seems there is no such appropriate measure in place yet.

I have distributed a region-wide voluntary questionnaire to all the schools in the North East, for assessment of their knowledge and desire to seek an appropriate method of training and advice.

Post evaluation of this data, I aim to provide a dental trauma protocol for schools and a 'training package' for teachers, which I am currently constructing.

I also plan to submit a similar letter to an education journal in the North East to increase awareness of my project and enthuse schools to take part.

G. O'Neill, by email

DOI: 10.1038/sj.bdj.2018.765

Occlusion

Time to debate malocclusion

Sir, I believe dentistry could be at the centre of a health revolution. There is the very real possibility that simple public health measures could minimise and even eliminate malocclusion, TMJ and sleep apnoea, thereby improving the lives of countless individuals and saving the NHS huge sums of money. I don't have all the answers, but I am asking the right questions. I want the truth, backed by scientific evidence, so our patients can benefit.

For a decade, I have raised concerns that our profession treats a modern disease, malocclusion, as a genetic inevitability. The evidence for an environmental origin is unambiguous. Less than 1,000 years ago, the vast majority of people gained and maintained all of their teeth in reasonable occlusions and alignment from birth to death.

Today, more than a third of 12-year-old children in the UK have an index of treatment need score of 3.8 or above and permanent retention is routine.

We should work together to change this by finding definitive answers to questions such as:

- Why has there been such a rapid rise in malocclusion?
- Why do teeth become crooked in the first place?
- How is TMD related to malocclusion?
- Will root resorption affect root canal therapy?

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