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. Readers may now comment on letters via the *BDJ* website (www.bdj.co.uk). A 'Readers' Comments' section appears at the end of the full text of each letter online.

ORAL SURGERY

Suturing in the real world

Sir, the importance of gaining suturing skills at an early stage is invaluable for turning dental students into confident and competent dentists. Commonly this involves students learning suturing on a flat suture pad, unimpeded by environmental constraints. While an effective tool, the main disadvantage is inadequate preparation for suturing when impeded by the environmental restrictions of the oral cavity. It has been shown that a hands-on experience of suturing improves student performance in basic skills assessments[1] and that simulation of a surgical procedure with formal teaching intervention enhances this.[2]

In Bristol we have devised a method to enhance this experience which we would like to share. It involves cutting an oral-cavity-sized hole out of an iced beverage lid and securing it onto a suture pad. Students are then required to suture through the hole created. The size of the hole can be changed to accommodate student ability or change the level of difficulty of the task (Fig. 1). The method is low technology and will be able to be used in any health setting regardless of resource. It can also be decorated for realism. We propose this as an adjunct to formal surgical teaching in dental school, which can be included in digital multimedia tutorials, student self-directed learning and undergraduate appraisal.

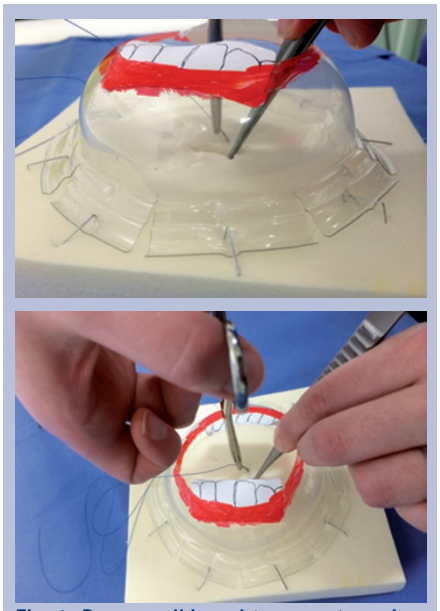

Fig. 1 Beverage lid used to recreate oral cavity space for 'real world' suturing practice

K. French, N. Sonde, R. Perry, T. W. M. Walker, Bristol

1. Liddell M J, Davidson S K, Taub H, Whitecross L E. Evaluation of procedural skills training in an undergraduate curriculum. *Med Educ* 2002, **36:** 1035–1041.
2. Lossing A, Groetzsch G. A prospective controlled trial of teaching basic surgical skills with 4th year medical students. *Med Teach* 1992; **14:** 49–52.

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BETTER SERVED IN A DENTAL PRACTICE

Sir, I read with interest the letter from J. Humphreys (*BDJ* 2015; **218:** 266) about patients presenting to the emergency department (ED) with dental complaints. As an Emergency Medicine Specialty Registrar, I have encountered numerous patients presenting to the ED with dental problems.

My experience is that patients perceive there to be limited availability of dental services, in and out of hours. There is also lack of clarity in some geographical areas about how to access these services – for both clinicians and patients. I agree that patients are also not aware of alternative emergency treatment options for dental problems. In addition, I wonder whether there is a financial aspect involved, as it is well known that EDs are free of charge at the point of care.

It should be acknowledged that there are a proportion of patients who will not seek dental care anywhere other than the ED. Could these episodes of attendance be better used as an opportunity to direct their care more appropriately?

The increased number of patients attending EDs and the shortage of beds experienced in many hospitals is well publicised in the national press. There are certainly a number of patients who have attended EDs who could have been better served in a dental practice. The patient journey is improved by collaboration between primary and secondary care, and this should include ED working with general dental practices. Are there ways to create stronger links between the two?

A. Greer, Manchester

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ORTHODONTICS

24-month braces

I was very interested to see the letter by Dr Pagonis on orthodontosis and orthodontitis in a recent edition of this Journal (*BDJ* 2015; **218:** 319–320).

I would like to share information on another dental treatment; this is called orthodontics. This is the correction of problems caused by teeth that are irregular or out of position. This is called 'malocclusion' and can be corrected by 'orthodontics'. This is a treatment in which sophisticated attachments are glued to the teeth with special adhesive. Then space-age wires are attached to the brackets using special elastics. This puts a force on the teeth and they move.

Unfortunately, the teeth do not recognise the type of brace or wire that is being used and they always move at the same rate regardless of the appliance. Most courses of orthodontic treatment take 24 months, although sometimes this can be longer or shorter depending upon the goals of treatment and wishes of the patient.

I hope that the readers of the journal are interested in this concept and consider it for their patients.

K. O'Brien, Manchester

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Unrelenting diatribe

Sir, in my opinion the recently published correspondence regarding 'orthodontosis and orthodontitis'[1] is little more than a marketing stunt of the lowest calibre.