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## Address the real cause

Sir, it is worrying that the article by Liedholm *et al.*: *Third molar treatment outcome: a comparison of patients' preferences in Sweden and Wales* (BDJ 2005; 199: 287-291) includes, amongst its criteria for wisdom tooth removal, worsening incisor imbrication.

Wisdom teeth DO NOT cause this crowding, as evidenced by a previous Bristol study where on one side the wisdom teeth were present, but on the other side were either congenitally absent or had been removed. There was no difference between crowding on the two sides!

We have all seen a tiny upper nine preventing eruption of the maxillary wisdom tooth above it. How illogical therefore to assume that a wisdom tooth could 'push' the seven teeth in front forwards! Worsening incisor imbrication is a significant finding but NOT an indication for wisdom teeth removal. It may reflect late orthodontic relapse, or uprighting of incisors caused by tongue retroposition, when Spheno-occipital synchondrosis activity elongates the skull base (continuing between the ages of 18-25 years). However, the commonest cause today is exaggerated mesial drift resulting from a tooth clenching habit. This is the forerunner of temporomandibular joint pain dysfunction problems.

Failure to recognise this connection wastes the opportunity of early corrective treatment, while removal of the wisdom teeth diverts the patient's attention away from addressing the real cause. As of course also happens with later temporomandibular joint surgical intervention! With all signs and symptoms, we much correctly interpret, such that it is possible to treat the cause; not merely the symptoms.

**B. Littler**  
Essex

**Rolf Liedholm, the author of the article, responds:** *I will emphasise that worsening incisor imbrication was NOT presented as a criterion for wisdom tooth removal. It was intended for patients to imagine experiencing the outcome described in a vignette. The reason for including it was to allow patients to assess the weight of an often discussed*

*issue and as a matter of fact still considered of interest by some clinicians. The results showed, both in Sweden and Wales, that the vignette comprising the information 'lower front teeth which had been more squashed together' had a very low impact on patients' life. This can be interpreted as patients will not suggest wisdom tooth removal for this reason which is well in accordance with my opinion.*

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## Sugar and cancer

We recently reported in this section of the BDJ<sup>1</sup> growing evidence which suggests a link between sugar-sweetened drinks consumption and wider health issues such as obesity and type II diabetes.

It was suggested that when giving dietary advice, dentists should also warn patients about the potential association with these medical conditions, as well as dental disease.

We would like to bring to the attention of the readers two recent studies published which suggest a link between sugar consumption and breast and pancreatic carcinoma.

Tavani *et al.*<sup>2</sup> reported a case-control study conducted between 1991 and 1994 in Italy involving 2,569 women with breast cancer and 2,588 female controls. Women in the highest tertile dessert intake (including biscuits, cakes and ice cream) and sugars (including sugar, honey, jam and chocolate) had multivariate odds ratios of 1.19 (95% confidence interval 1.02-1.39) and 1.19 (95% confidence interval 1.02-1.38), respectively. These results were similar in strata of age, body mass index, total energy intake and other covariates.

Schernhammer *et al.*<sup>3</sup> examined the relationship between sugar-sweetened soft drink consumption and the development of pancreatic cancer in an Austrian cohort. Among 88,794 women and 49,364 men without cancer at baseline, 379 cases of pancreatic cancer were documented during a 20 year follow-up. Only women in the highest category of sugar-sweetened drink intake (>3 drinks weekly) experienced a significant increase in risk (relative risk 1.57; 95% confidence interval 1.02-2.41;  $p = 0.05$ ) and the risk was limited to those

with low physical activity and elevated body mass index.

It is helpful for dentists to appreciate the wider implications of sugar consumption when discussing preventive advice with patients. The two reported studies help to provide further evidence for the wider health implications of sugar consumption.

**S. K. Gill**

**D. S. Gill**

1. Gill S K, Gill D S. Sugar sweetened drinks. *Br Dent J* 2004; **197**: 520.
2. Tavani A, Giordano L, Gallus S *et al.* Consumption of sweet foods and breast cancer risk in Italy. *Ann Oncol* 2005.
3. Schernhammer E S, Hu F B, Giovannucci (Ed). Sugar-sweetened soft drink consumption and risk of pancreatic cancer in two prospective cohorts. *Cancer Epidemiol Biomark Prevent* 2005; **14**: 2098-2105.

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## No to chlorhexidine

Sir, we read with interest the commentary on our article entitled *A study of visual and blood contamination on reprocessed endodontic files from general dental practice* (BDJ 2005; 199: 522-525) and noted that '...a decontamination programme reported by Paraschos *et al.* appears to be satisfactory...'<sup>1</sup> – a close inspection of this method reveals that it involved pre-treating soiled instruments with chlorhexidine. The use of chlorhexidine to clean instruments is a poor choice of cleaning agent, since this chemical tends to stick to proteins and various surfaces rather than exert a detergent action. The use of chlorhexidine for example, in surgical hand scrubs, for cleaning instruments has been highlighted as poor practice and is not recommended in Scotland.<sup>2</sup> Advice on alternative agents for use as detergents can be found online at [www.show.scot.nhs.uk/scieh/](http://www.show.scot.nhs.uk/scieh/).

We recommend that practitioners do not use chlorhexidine containing agents for cleaning dental instruments.

**A. Smith**

**J. Bagg**

**S. McHugh**

**By email**

1. Paraschos P, Linsuwanont P, Messer H H. A cleaning protocol for rotary nickel-titanium endodontic instruments. *Aust Dent J* 2004; **49**: 20-27.
2. Scottish Executive Health Department Letter (HDL) 2005 (01) Decontamination Compliance in Primary Care

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