Send your letters to the Editor, British Dental Journal, 64 Wimpole Street, London W1G 8YS E-mail 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.

Altered sensation

Sir, we would like to report the case of a 58-year-old female who was referred to a maxillofacial unit by her dentist, with persistent numbness and altered hearing, following a buccal infiltration (1 ml 2% lignocaine with 1:80,000 adrenaline) for periodontal treatment in the upper right seven region. She had a medical history of myocardial infarction, unstable angina, hypertension, asthma, hypercholesterolaemia, diet controlled diabetes mellitus and osteoarthritis and was taking several medications, none of which interact with local anaesthetic.

Clinical examination revealed diminished sharp and blunt discrimination of the first and second divisions of the right trigeminal nerve. No other abnormality was found. Intraorally there was tenderness of the buccal gingivae adjacent to the upper right second molar tooth, which was also tender to percussion but vital. An ENT opinion was sought in relation to the auditory acuity, but no abnormalities were diagnosed and no further investigations were required. Diagnoses of right first and second division trigeminal neuropathy, reduced auditory acuity and tinnitus were made. At two week review the upper right seven was extracted. After ten months there was limited recovery of the trigeminal nerve, but the reduced auditory acuity and tinnitus were still present. An audiogram and MR imaging arranged at this stage were reported as normal. Interestingly, at this review bilateral temporomandibular joint dysfunction was found.

The exact mechanism causing these symptoms is unknown; the following theories have been proposed:

- Retrograde anaesthetic vasoconstrictor access to the middle ear via venous system resulting in vasospasm of the cochlear division of the internal auditory artery, leading to vestibulocochlear nerve dysfunction[1]
- Nerve damage following direct needle penetration[2] or upon withdrawal of a barbed needle.[2,3] Such barbs rupture the perineurium, herniate the endoneurium and cause transection of nerve fibres[2]
- Tinnitus due to temporomandibular joint dysfunction[4]
- Neuropraxia from intraneural haematoma due to intraneural blood vessel trauma, leading to constrictive epineuritis.[2] An initial phase of neurotoxicity is followed by reactive fibrosis which inhibits nerve healing[2]
- Neurotoxicity produced by LA solution deposited intraneuerally.[2] Chemical trauma also causes demyelination, axonal degeneration, oedema and inflammation, of the nerve fibres.[2] The endoneurial oedema causes ischaemia, followed by a period of reperfusion, during which reactive free radicals produce cytotoxic nerve injury.[2] If the LA solution is highly concentrated there is an increased chance of neurotoxicity.[2]

Spontaneous complete recovery from the altered sensation occurs within eight weeks in up to 95% of cases.[2] However, patients with paraesthesia of longer duration after injury, have less chance of a full recovery despite attempts at microneurosurgical decompression.[2]

This case highlights that unusual events can occur following a common procedure in dental practice.

D. Jariwala, R. M. Graham, J. C. Lowry
Blackburn

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Time is scarce

Sir, as per Mike Grace's invitation (*BDJ* 2007; **202:** 641) to make one's views known regarding BDA matters, here are mine on *BDJ* CPD from a consumer (ie BDA member perspective).

For me, halving the journal's CPD content, together with now offering CPD papers on dental technicians' professional development (*BDJ* 2007; **202:** 685-689) equates to a reduction in value for money. This topic may make interesting 'casual reading' to some. However, as a BDA member what I desire from *BDJ* CPD is simple: resumption of both CPD papers in print form, with content that is applicable to clinical dentistry.

I would like to request that the BDA canvass its members on the current content and delivery of CPD. If members overwhelmingly support its current format/content, then fine. If not, then change it.

The internet is amazing, but wasting time and money by printing out CPD articles is not. Running a group practice and raising a family means that 'surplus' time is scarce – I prefer to use it as wisely as possible.

F. Dean
New Zealand

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Unexpected quinsy

Sir, we would like to report the case of an 11-year-old male, who presented to an emergency dental service with a three day history of pain from the lower right quadrant and difficulty in swallowing. Coincidentally, antibiotics had been prescribed by his general medical practitioner, three days prior to this, for an unrelated ear infection. The patient had an unremarkable medical history. At the EDS, upon clinical examination, the patient appeared systemically unwell and bilateral lymphadenopathy of the submandibular and submental triangles was palpated. Intraoral examination did not reveal any obvious or related dental pathology, however, a right soft palate and fauceal swelling, with uvular displacement, was noted. A provisional diagnosis of a quinsy was made; therefore, the patient was referred to the local paediatric ENT service and the diagnosis was confirmed. He was admitted, rehydrated, given intravenous antibiotics and the abscess was drained successfully.

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This case highlights that there can be unexpected findings in a patient who attends with what appears to be a dental related problem. It also emphasises the need for a high index of suspicion for other types of pathology when carrying out a dental examination.

M. A. Bussell, J. Heady
Oldham
DOI: 10.1038/bdj.2007.797

Cutting edge skills

Sir, I would like to congratulate the BDA on introducing the CPD business skills in the June issue of *BDA News*. This latest initiative complements the popular clinical CPD available in its sister publication, the *BDJ*.

In today's rapidly changing dental industry, dentists require strong business skills to achieve professional and personal success. To run a successful dental practice requires many business skills in addition to the essential technical skills of a capable dentist. Very few dentists possess the necessary skills to succeed in business, yet they are expected to run a business successfully.

Gone are the days of the corner shop mentality. Today's dentists must be armed with cutting edge business skills, SMART business plans, advanced financial acumen, motivational managerial thinking etc. before they even start thinking about the latest endo gadget! No wonder dentistry is one of the most stressful professions!

C. A. Yeung
Manchester
DOI: 10.1038/bdj.2007.798

Call for support

Sir, we the undersigned are very concerned that a dentist who was employed by a PCT had serious allegations of professional misconduct made against her and yet the PCT refused to investigate.

This dentist had been employed for 25 years and treated only vulnerable groups of patients: young children and severely handicapped or acutely ill elderly patients. She was highly appreciated by all her patients and colleagues and had never had a complaint or criticism from anyone during that time.

Then suddenly out of the blue, she had the following accusations made about her.

A dental nurse stated that she felt '*intimidated*' by this dentist because she '*has a very impatient manner towards patients who may be difficult when being treated. This is very unprofessional and a rude attitude and it is sometimes frightening to witness and* the dental nurse *finds it intimidating in that she dare not approach the dentist for fear of reprisal*'.

The quotation shown above is the written complaint in its entirety; no details of any kind were provided.

Your readers must agree that these are dreadful allegations to be made against any dentist and extremely distressing for the dentist involved, who loved her work. The dentist understandably wanted a full and proper investigation. However, the Trust refused to investigate.

The dentist felt she was owed an investigation or she would never be able to clear her name, for the allegations were on her employment record. She therefore brought a case in the High Court. Unbelievably, the High Court stated that the Trust had acted correctly and no investigation was necessary.

Surely any dentist has a right to a full and proper investigation?

From the public's point of view the implications of not investigating allegations of this nature are unthinkable. If PCTs are allowed by the courts to simply sweep such serious allegations under the carpet, the Trusts are putting patients at great risk of injury. If these allegations were true, the most vulnerable members of our society were at great risk of serious injury and unable to defend themselves or complain. If the allegations were false, patients are at an even greater risk, for if staff are prepared to lie about a dental professional's work they will lie about anything and the most gross misconduct could be covered up. Refusing to investigate we consider was not an option.

This dentist needs extra evidence to apply to the Court of Appeal to overturn the High Court's finding that the allegations did not need to be investigated and needs the support of her profession. We are asking for your support. Would your readers agree:

- these are serious allegations which refer to the dentist's professional practice
- the allegations should have been fully and properly investigated by the PCT?

Please support her not only for her sake, but also for the sake of patients and the reputation of the profession.

B. Gatoff, C. Harper, R. Joyson, M. Moselhi, S. Stanton
London
DOI: 10.1038/bdj.2007.799

Looking-glass world

Sir, colleagues working under the new contract may be interested in this year's Edexcel GCSE Business Studies exam paper in which students were required to answer questions based on a mythical dental practice, 'a National Health Service practice with some private patients', owned by a practitioner who wants to go into partnership with her dentist brother and open a branch NHS dental practice in another town.

Candidates were required to answer questions on the advantages of forming a partnership and of opening a second practice.

It is very strange to read about a long ago dental Eden when it was possible to form partnerships without being offered a nil value contract.

Colleagues should note that the much derided GCSE assumes that dentistry exists in a normal business environment while the truth is that our profession has been cast adrift into a looking-glass world alien to financial reality and normal practice management.

I am willing to bet that the minister's advisers never sat GCSE Business Studies.

B. D. Skinner
London
DOI: 10.1038/bdj.2007.800

Downsides of implants

Sir, a few weeks ago a patient commented to me regarding his new set of partial 'falsies' that he could not feel himself chewing his food as he used to with his own teeth. It's true of course that when people unfortunately have lost their teeth we need to offer some form of replacement to aim to mimic as closely as possible the original function and appearance. Naturally, at the moment, we cannot obtain a true copy of the true form and nature of real teeth with their associated ligamentary connection to the alveolar bone of the jaws. Nonetheless, my patient's comments to me made me think of what do implants 'feel' like? I know they are profitable for the profession but are they respectful of biology? In this era, I see that implants are becoming more frequent and more extensive for mouth reconstructions, but I wonder if osseointegration is truly a good thing in reality from a biological point of view? Let us recall from our dental histology and oral physiology (yes, the dreary preclinical years!) that the periodontal ligament not only supports and nourishes teeth but also contains proprioceptive (sensory feedback nerve fibres) protective mechanisms – such as the jaw opening reflex. These mechanisms protect the jaws and TMJ from the pretty harsh occlusal forces going on around in the mouth! Thus I think osseointegration is a poor substitute for the actual periodontal ligament – could we be causing for future years

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a sharp rise in TMJ cases? Time will tell but I think the profession should be cautioning patients over some of the potential downsides of implants more – to consider biology over one's profit margins! I am writing as a dental scientist as well as a practising clinician.

J. A. Loudon
Sydney

P. S. I do not do implants in my practice of dentistry!

P. P. S. I also add that I am rather worried over the extensive adverts I see in the *BDJ* for cosmetic facial care that can be given by dentists over there – this is illegal in New South Wales for dentists to do!

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Misleading values

Sir, I am writing to report what appears to be inaccurate or misleading values within the article *Special Care Dentistry...* (*BDJ* 2007; **202**: 619-629).

With part of my work in dentistry over the past few years involving both children and adults with special needs I do not dispute the value of such service provision, however some of the statistics within this article appear either to be false or misleading. I hope it is an error produced in the editing and modifying of this document and not inaccurate data that have either been overlooked by the authors or reviewers of the article prior to acceptance for publication.

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'1. THE SIZE OF THE CHALLENGE

...In England and Wales, recent data indicate that almost 9.5 million people (18.2% of the population) self-report a long-term illness, health problem, or disability which limits their daily activities or work.[18] Whilst self-reported morbidity must be viewed with some caution,[20] the impact on society cannot be ignored as more than one in eight of these people (4.3 million) are of working age (16-64 for men and 16-59 for women).[18]'

The figures in this piece of text do not appear to add up. 'self reported morbidity' = 9.5 million; 'one in eight of these people' = 12.5%; 12.5% of 9.5 million = 1,187,500 people – whereas they then say 4.3 million.

Page 623

'CURRENT SERVICE PROVISION

a) Current workforce

...and only four of the 120 people (0.33%) attending the British Society of Gerodontology meeting in December 2004 were general dental practitioners.'

Four out of 120 x 100 = 3.33%, not 0.33% as reported in the article.

I appreciate that the production of statistics in reports is a difficult and time consuming task, but hope that these figures are purely a result of numerical accident rather than intentional over-estimation of the problem that the provision of special care dentistry services creates.

It also highlights the need for dental healthcare professionals to work closely with statisticians in the production of such reports.

D. J. Baldwin
London

Drs Jenny Gallagher and Janice Fiske respond: Our thanks to Dr Baldwin for his/her detailed reading of our paper and for drawing attention to the two points above which we shall address in turn.

First, in relation to the size of the challenge, we accept that the phrasing of one sentence in the published paper did not convey the intended meaning and apologise for any confusion. 'These people' refers to working age people, one in eight of whom self-reports morbidity. This relates to 4.3 million people and highlights the level of impact on society. To assist with clarity, we have revised the second sentence in the text below:

'In England and Wales, recent data indicate that almost 9.5 million people (18.2% of the population self-report a long term illness, health problem, or disability which limits their daily activities or work.[18] Whilst self reported morbidity must be viewed with some caution,[20] the impact on society cannot be ignored as more than one in eight people of working age (16-64 for men and 16-59 for women) have a self-reported morbidity; this amounts to 4.3 million people.[18]'

Second, regarding current service provision, you are correct that the decimal point was in the wrong place.

Thank you for enabling us to clarify and correct these points which in no way affect the size of the challenge outlined in the paper. We welcome your support in addressing the professional challenge of ensuring appropriate dental care for people with a wide range of disabilities. Building on existing models of good practice, Special Care Dentistry, working closely with GDPs, will play an important role in this process.

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