Letters to the Editor

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.

A FULL PICTURE

Sir, I am writing regarding the paper in the *BDJ* on the introduction of the new dental contract in England – a baseline quality of assessment (*BDJ* 2008; **204:** 59-62). The authors state that the objective of the paper was to secure the views of key stakeholders about the new dental contract introduced in April 2006 prior to its introduction.

In reading the paper I noted that there was no consideration given to the fact that either patients or communities might be key stakeholders in the provision of NHS dental care and the implementation of the new contract. Do the authors consider that patients and communities should not be considered in reviewing the effectiveness of contacting for NHS dental care and have no stake in service provision?

I would suggest that it would have been useful to identify what patients and communities considered was good and bad about the old dental contract and then compare it with the position after implementation in a number of years' time, along of course with dental professionals and commissioners, to get a full picture of the impact of the contract.

D. P. Landes
Durham

Author Dr Keith Milsom responds: Our paper The introduction of the new dental contract in England – a baseline qualitative assessment *was an attempt to capture the views of those responsible for the delivery of NHS dental services at a time when the old system was drawing to a close, but before the new system was introduced. In particular we were keen to understand the beliefs, views and perceptions of those that were expected to implement the new arrangements. The new NHS dental contract was the biggest change to NHS dentistry since the introduction of the NHS in 1948, and the lead up to the introduction of this contract proved to be challenging for the dental profession. Further work by the Oral Health Unit of the National Primary Care R&D Centre, examining the incentives that influence professionals' behaviour, is expected to build upon this baseline study.*

Of course there are many stakeholders in the dental economy including recipients of care, and in undertaking this study it was not our intention to suggest that the views of patients and wider communities were not important. The authors acknowledge that in assessing the impact of any change to health care delivery systems there is a wide constituency that needs to be engaged and any further work in this area, focussing perhaps on the views of patients would be expected to complement our work.

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KISSING MOLARS

Sir, a 36-year-old female reported to the Department of Oral and Maxillofacial Surgery with a complaint of a swelling over the left lower side of the face. Her past medical history was unremarkable and she had undergone extraction of multiple carious teeth. Examination revealed a non tender diffuse swelling over the left body of the mandible which had an egg shell crackling consistency to palpation. Intraorally, an expansion of the buccal cortical plate and a soft swelling was palpable over the residual alveolar ridge in the region of the lower left second molar. A panoramic radiograph showed an impacted mandibular second and third molar with a single follicular space (Fig. 1).

Fig. 1 Impacted mandibular second and third molars with a single follicular space

Apposition of the occlusal surfaces of these molars was seen. Aspiration yielded a yellowish straw coloured fluid. Both these molars, together with the associated follicular tissue, were removed under local anaesthesia. A diagnosis of dentigerous cyst was made after histopathological examination of the follicular tissue. Post operative healing was uneventful with a gradual decrease in swelling in the follow up period.

The term 'kissing molars', first described in 1973,[1] refers to contacting occlusal surfaces of the impacted mandibular second and third molars. However, this term has also been used to describe a similar appearance with other impacted molars.[2,3] In this case, it is likely that the resorption of the bone by the expanding cyst associated with the second molar caused significant bone loss along the mesial root of the impacted third molar. This resulted in the third molar occlusal surface coming in contact with that of the second molar. Multiple 'rosetting' of the molars has been associated with mucopolysaccharoidoses[4] and the presence of such an anomaly must prompt the dental surgeon to perform further investigation. The possibility of a similar condition in

this patient was easily ruled out by the obvious clinical and histological findings of a cystic lesion.

B. Krishnan
India

1. Van Hoof R F. Four kissing molars. *Oral Surg Oral Med Oral Pathol* 1973; **35:** 284.
2. Bakaeen G, Baqain Z H. Interesting case: kissing molars. *Br J Oral Maxillofac Surg* 2005; **43:** 534.
3. Robinson A J, Gaffrey W R, Soni N N. Bilateral kissing molars. *Oral Surg Oral Med Oral Pathol* 1991; **72:** 760.
4. McIntyre G. Kissing molars: an unexpected finding. *Dent Update* 1997; **24:** 373-374.

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POOR DESCRIPTION

Sir, congratulations on your leading article *Degrees of separation* published on 26 January. I enjoyed reading it immensely.

However, my main concern in this letter is the cover image that was published in the journal on 12 January 2008 (Vol. 204, No. 1). The image has been described incorrectly in the caption/legend.

The last sentence of the legend states: 'The tooth is covered by a coat of white enamel (dark purple), the hardest tissue in the human body'.

The tissue referred to as white enamel is, in fact, cement or cementum. Outside the cement is the periodontal ligament, the latter being connected to the bone. The section shown was cut through the root of a tooth, not through the crown. There is no enamel anywhere in the picture. Enamel is found in the crown of a tooth.

I am sure you will appreciate that this is a very fundamental point. It is a shame to see such a poor description in the journal.

M. A. Bishop
Guildford

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VISUAL IMPAIRMENT

Sir, the review article *Effect of visual impairment...*[1] barely deals with the simplest and most common problems. In my case age has led to cataracts and to a reduction in visual accommodation. Following lens replacement surgery the world became bright and clear rather than the hazy yellow tint to which I had become used. The other result is that with a longer focal length I stand further from the mirror and lose detail or move closer and lose focus. Unless spectacles are worn the standard of oral hygiene can deteriorate.

During my practising career it never occurred to me to check the average patient's visual status. To achieve a high standard of oral hygiene some may have needed to wear their glasses, a few possibly to have eye surgery. High quality instruction in oral hygiene will fail to produce the hoped for results if the patient has difficulty in assessing their hygiene efforts.

P. Erridge
East Grinstead

1. Mahoney E K, Kumar N, Porter S R. Effect of visual impairment upon oral health care: a review. *Br Dent J* 2008; **204:** 63-67.

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SURGICAL ENDODONTICS REFERRALS

Sir, we investigated the suitability of referrals for surgical endodontics (apicectomy) from general dental practitioners (GDPs) to two oral and maxillofacial surgery (OMFS) units. Referrals were measured against a benchmark of criteria specified by the Royal College of Surgeons England (RCS Eng) guidelines;[1] 150 consecutive letters from one hospital and 35 from the other hospital were analysed. Only 48% and 53% of letters respectively met the referral criteria.

Economic factors may play a role in a GDP referring a patient to hospital rather than a specialist endodontist. A single canal re-root treatment in an anterior tooth costs at least £200 when done by a specialist endodontist. In comparison the total cost of an apicectomy performed in hospital (including the cost of an outpatient appointment, local anaesthetic surgery and review) is in the region of £700. The patient, however, pays nothing for this hospital treatment. This represents a significant barrier to the patient seeking specialist endodontic treatment and a considerable expense to the National Health Service.

Our study suggests some OMFS units may be receiving a significant number of inappropriate referrals for surgical endodontics. We therefore advise that all GDPs at least follow the RCS Eng guidelines and oral and maxillofacial surgical units are mindful of these recommendations when accepting referrals.

J. Breeze
A. J. Gibbons
By email

1. Guidelines for Surgical Endodontics by the Faculty of Dental Surgery, Royal College of Surgeons of England 2001.

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AN ECSTATIC CASE

Sir, reading the recent article on *Ecstasy (MDMA) and oral health* (*BDJ* 2008; **204:** 77-81) reminded me of a case during my vocational training.

A 20-year-old female attended the dental practice complaining of 'flattened teeth' and a 'dry feeling in the mouth'. She also reported pain and stiffness of the jaw. Medically she was fit and well. She was a medical student and worked in a nightclub. She drank ten units of alcohol a week, smoked five cigarettes a day, and stated she did not use any recreational drugs.

Extra-oral examination revealed tenderness of the jaw joint and the muscles of mastication. Intra-orally, she had signs of a dry mouth, with frothy and airy saliva present. Clear saliva was expressible on palpation of her parotid glands. The patient had a class 1 molar and incisor relationship with canine guidance on lateral excursion. She had minimal restorations with fair oral hygiene. The premolars and molars showed signs of pathological toothwear. Radiographic examination revealed no abnormalities.

It was felt this patient suffered with TMJ pain dysfunction syndrome and xerostomia. The patient stated she was extremely stressed as exams were looming and she had relationship problems. I reassured her and gave conservative advice, and referred her to the local oral and maxillofacial unit for further assessment.

Following frequent consultations at the unit the patient eventually acknowledged a four year history of ecstasy, speed and cocaine use on a regular basis. The patient was diagnosed with xerostomia, toothwear and TMJ pain secondary to drug abuse. She was referred to the drugs and alcohol dependence unit for a rehabilitation programme.

This case illustrates that although an accurate and non-confrontational

medical history was taken by several clinicians, the patient could only be managed fully when she was ready to reveal her drug use. Unfortunately, it took one year for the patient to acknowledge her habits therefore delaying diagnosis and treatment. However like most drug or alcohol dependents, she was able to reveal all when she felt comfortable within herself and the environment she was in, suggesting that along with a non-confrontational approach, frequent visits may be necessary to build trust and establish a good rapport with the patient.

A. Patel
London
DOI: 10.1038/bdj.2008.220

MYSTERIOUS CONDITIONS

Sir, is evidence-based dentistry only applicable in certain situations when evidence, of sufficient quality, supports its implementation?

NICE are considering recommending an end to antimicrobial prophylaxis because there is insufficient evidence of its effectiveness, so how long would it take for NICE to analyse the evidence on vCJD transmission in dental settings and provide recommendations based on this scientific approach rather than 'plausibility', 'prudence' and 'possibility' as mentioned in the CDO's letter of 19 April 2007, referring to SEAC's statement in 2006?

Early prophylactic principles appeared entirely plausible too, when first introduced, but since then evidence-based dentistry has become *de rigeur*. However, it does seem that EBD only applies when a mysterious set of conditions compel its application – politics, time etc. How else can you explain changes in clinical practice, as in the case of vCJD, being advised on early evidence from mice experiments? The research concerned makes no allowances for whether the mice were NHS or private, their individual practice infection control policies or even how many hours CPD on cross infection control they had undertaken in their current five year cycle.

It only needs to come to the attention of the general media and then it wouldn't be long until we'd have a situation similar to the MMR/autism fiasco.

J. Cooper
By email
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GREEN ANTIBIOTICS

Sir, at last it seems that common sense has prevailed. The recent guidelines by the National Institute for Clinical Excellence (NICE) reported by M. V. Martin (*BDJ* 2008; **204:** 107) to provide antibiotic cover only for a highly restricted group of patients who are theoretically 'at risk' for infective endocarditis are a bold, brave step to minimise global antibiotic abuse.

If we believe in evidence-based medicine/dentistry, which we must, then there should be no compunction to pay heed to these new directives and also educate our patients appropriately. Everyone needs to understand that we are running out of antibiotics and the sooner we recognise and stop the abuse the better for all. In the UK, for example, most community antimicrobial prescribing is by general medical practitioners, but dentists account for about 7%. Some 20-50% of human prescriptions are thought to be unnecessary or questionable while 40-80% of the agricultural use of antibiotics appear to be highly questionable.[1]

Let's go green on antibiotics too!

L. Samaranayake
Hong Kong

1. Samaranayake L P, Johnson N. Guidelines for the use of antimicrobial agents to minimise the development of resistance. *Int Dent J* 1999; **49:** 189-195.

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