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.

Animal care

Fun incident

Sir, the recent *BDJ* cover with the diver cleaning the shark's teeth reminded me of a fun incident I had at our local zoo, Marwell Zoo, a few years ago.

I spent the day as a keeper, working in many different zones of the park, finishing with supper time for the big cats.

One of their male Amur tigers was due to be sedated with a dart as it had cracked off the tips of its lower canines. The keepers still had no idea of my normal work as a dentist and then the accompanying picture happened.

I had just served the tiger his supper and he very kindly opened really wide for me to examine all his teeth – it is more likely that he was unhappy to have me next to him and so thank goodness for the strong bars between us.

I was then able to notice that the enamel was intact and the teeth mirrored each other, indicating that the tips had simply not

formed properly rather than having broken off. This was a great relief for the keepers but it did mean that I had spoiled that young male tiger's fun as he was now out of any breeding programme.

C. Marks, Southampton, UK, by email

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Christmas

Christmas chuckles

Sir, to say I enjoyed your Editorial in the pre-Christmas issue is an understatement, but my enjoyment of your spoof letters page and other copy which followed brought tears (of laughter) to my eyes. Superb writing.

Many congratulations are due in bringing a bit of levity to our often difficult job and sour current world. I am sure that your readership will agree.

I did have two concerns – the first is that my paper (with Steve Lucarotti) which followed only a few pages after your entertainment

section might also be taken by readers as a joke – which it was not intended to be, and the second is that you did not incorporate into the ode to the carious tooth a couple of lines something like: 'If we didn't have caries, all we would be doing is cleaning teeth.'

Keep up the good work!

F. J. Trevor Burke, Birmingham, UK, by email

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Indemnity

Indemnity cover for dentists and staff

Sir, I was surprised to read in the January 11 edition of the *BDJ* that both the BDA¹ and Dental Protection Ltd.² appear to be supportive of the government's proposal to legislate for insurance-based indemnity cover for primary care dentists and others.

With such warm noises emanating from these bodies it isn't hard to see why the Department of Health & Social Care's consultation document³ is less about whether or not to introduce insurance-based indemnity (the preferred option in the consultation), and more about seeking respondents' opinions on how this change – apparently almost a foregone conclusion – will be brought about.

Both the BDA and the government acknowledge that there is little, if any, evidence that patients are being poorly served by the existing indemnity system though much is being made of the fact that currently indemnifiers can refuse to settle claims on behalf of clients.

On the rare occasions when this has happened in the past, there is usually evidence of criminal activity by the client and, as anyone who has ever owned a car, house, or pedigree pet knows, criminal activity is a get-out clause in all types of insurance policies. So no change there.

Apart from increased premiums and the opportunity to pay more Insurance Premium Tax there seems to be little to recommend

C. Marks at Marwell Zoo

the government's preferred option to the membership of the BDA and DPL and the wider primary care dental community.

With our normally vocal medical GP colleagues placated by the promise of a state-backed indemnity system, it falls to the dentists to respond vigorously to this consultation in an effort to head off an unnecessary and undesirable increase in expenses.

Anyone looking for a suitable form of words might consider echoing the sentiments expressed by the Chief Executive of MDDUS²

which certainly reflect my view of insurance-backed indemnity.

C. J. McGrady, Belfast, UK, by email

References

1. Ward P. Indemnity in the spotlight. *Br Dent J* 2019; **226**: 1.
2. O'Dowd A. Consultation on indemnity cover for dentists and staff. *Br Dent J* 2019; **226**: 12.
3. Department of Health & Social Care. Appropriate clinical negligence cover. 2018 Available at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/762296/clinical-negligence-cover-consultation.pdf (accessed March 2019).

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Surgery

Gastric surgery: the dental implications

Sir, an increasing number of patients are having gastric surgery each year in order to aid in weight loss¹ and reduce the risk of obesity-related conditions such as hypertension or type 2 diabetes. Often this results in a smaller appetite with frequent snacking throughout the day, often on highly cariogenic foods due to 'low fat' items having a high-sugar content.

CASE REPORT

Fractures

Idiopathic fractured mandible

Sir, I wish to report the unusual presentation of an idiopathically fractured mandible.

A 67-year-old female presented for an urgent dental appointment complaining of pain over the right-hand side of her face, which was swollen over the mid-body of mandible. The swelling was allegedly present for the past four days with increasing size and severity. At the time of presentation, it was approximately the size of half a ping pong ball. She attended on the advice of her GP who believed this swelling could have been of dental origin.

Following a stroke six months ago, she was diagnosed with lung cancer, three weeks of radiotherapy ensued and then no other treatment. She was a well-controlled type 2 diabetic and suffered from fibromyalgia. Her current medications included

metformin, inhalers, and tramadol, with no history of bone-modifying medication.

She described having been completely edentulous for a number of years. On clinical examination, there was no cervical lymphadenopathy but mild unilateral tracking of the swelling down the neck. Upper and lower comfortable, stable, and retentive complete acrylic dentures were present, and had never caused any concerns. Intra-oral landmarks were unremarkable. Over the Attwood Class V alveolar ridge of the lower right premolar region, there was acute tenderness to palpation, especially buccally directly adjacent to the extra-oral swelling. Here, the swelling was firm, fixed, and contained within well-circumscribed boundaries. No intra-oral fluid-filled swelling, fistula/sinus, bruising or cut was identified.

The patient recalled no history of trauma to the region, nor recent over-zealous eating, and the dentures were intact. Initial discussion included further investigation using a

periapical radiograph in order to ascertain the possibility of a potentially unerupted tooth, retained root, other bone pathology or any infectious process. A second opinion was sought from a senior colleague, who could only confirm the original findings and acquiesced with the plan.

We decided to explore further using panoramic radiography to better gauge a larger area for identifying a cause for this idiopathic swelling (Fig. 1).

The OPG revealed the presence of a horizontally ectopic lower left premolar and a complete, undisplaced mid-body mandibular fracture.

The patient was informed and extremely surprised. The local SHO in oral and maxillofacial surgery was called and the patient was advised to transfer across to A&E immediately. An initial management plan of intra-venous antibiotics followed by fixation was devised.

Idiopathic fractures of the mandible, most commonly categorised in pathological fractures, are rare and account for 2% of all mandibular fractures.¹

There are many risk factors associated with pathological mandibular fractures such as age, gender, existing infection, or bone lesions.¹ Identification of such fractures can be beneficial for patient care and should be recognised as a potential differential diagnosis when assessing high risk patients.

A. Ali, Rochdale, UK, by email

References

1. Boffano P, Rocca F, Gallesio C, Berrone S. Pathological mandibular fractures: a review of the literature of the last two decades. *Dent Traumatol* 2013; **29**: 185-196.

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Fig. 1 A full panoramic radiograph identifying the horizontally ectopic lower left premolar and a complete, undisplaced mid-body mandibular fracture on the right-hand side