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

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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

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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

Advice following surgery is to 'eat slowly, chew carefully and only eat a small amount at a time', while also avoiding foods that could block the stomach, as this could result in vomiting.² Malnutrition and a blocked gut are recognised risks listed by the NHS, but what are the consequences dentally?

With the potential for a rapid decline in dental health following these procedures, I feel as a profession we need to regard these patients as high risk for both dental caries and tooth surface loss, especially if they are 'grazing' throughout the day, suffer from GORD or they are frequently vomiting.

For patients who are about to undergo or who have undergone gastric surgery there should be consideration of reducing recall, prescription of uraphat toothpaste as well as patient education on dietary choices and oral hygiene to help reduce their risk of dental disease.

A. Davies, Newcastle, UK, by email

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Alcohol consumption

Craft beer and trendy wine glasses: the hidden high-risk patient groups?

Sir, there seems to be an ever-expanding market for craft beers in the UK. In a local pub, I couldn't help but notice the vast array of high alcohol by volume (ABV) brews available, with some as high as 15%. It seems that the average ABV on offer has been creeping up alongside the numbers of craft-ale enthusiasts.

Keen craft beer drinkers may not be the only group for whom alcohol consumption could be rising. The average wine glass sold in England has almost doubled in volume since the 1980s.¹

This combined increase in ABV, and ever-growing wine glass size complicates the alcohol unit calculation. Could it be that for some patients their actual alcohol consumption is much greater than first thought?

The increased risk of oral cancers in those consuming high levels of alcohol is well reported. Perhaps as a profession we are missing individuals at higher risk of oral cancer from their self-reported consumption of beer and wine?

As dentists we are well-placed to advise patients about alcohol consumption, yet I wonder if we have some catching up to do. Dentists ought to ask routinely the details about the strength of a patient's regular tippie, as well as how generously sized their wine glass!

I. Rogers, Newcastle-upon-Tyne, UK, by email

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CPD

Hard and soft skills

Sir, I read with interest your thought provoking and interesting, editorial entitled 'The practical mode of teaching'¹ where you astutely state that 'CPD activity is also enhanced by reflective practice, but the literature confirms that these skills are not inherent, and professionals need to be trained in how to reflect well'.

Reflective learning is a soft skill that should be imparted during the formative period of the dental career in dental teaching institutions.

Clearly, the traditional pedagogy with teacher-centred lectures, and tutorials will not necessarily impart such soft skills in the future generation of our dentists. Academics both in Britain and elsewhere ought to seriously consider obligatory introduction of learner-centered, hybrid curricula with problem-based learning, flipped class rooms, and personalised, mixed mode learning in all dental schools to nurture such soft skills.

Only then will we have a generation of dentists armed with both hard as well as soft skills 'fit for the future' and well trained in reflective clinical practice.

Whilst many institutions have adopted such hybrid curricula, there are still a significant number of schools that are laggards in embracing such newer and necessary learning modes. The sooner we do so, the better for patients and the profession.

L. Samaranayake, University of Hong Kong, Hong Kong, by email

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SPRINGERNATURE