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.

Cone beam CT

Governance concerns in CBCT interpretation and reporting

Sir, we read with interest your recent publication on the current practice in the use of cone beam CT in UK dental practices.[1]

Although it is difficult to generalise based on the limited sample of respondents in this study, we share the concerns of the authors regarding the interpretation and reporting of CBCT scans. We would like to share our experience of referrals and associated imaging received in secondary care.

As a regional oral and maxillofacial unit, we often receive referrals from colleagues in primary care sending patient referrals in with radiographs (OPT) with incidental findings. We do in these cases provide a second opinion to the patient and the practitioner regarding further management and, where appropriate, provide the necessary care.

Our response to CBCT imaging received for the same reason with incidental findings and normal anatomical structures is different. The practitioners are advised to have the images reported by an appropriate radiologist. This is purely because we should all work within our scope of practice and competence and we do not have access to CBCT scans within the hospital trust yet.

In these situations, there is clearly a need for practitioners to be aware of their responsibilities and to keep up to date with skills in radiographic interpretation. In addition, they should have a robust clinical governance process in place for this sophisticated imaging modality.

We have also in recent months received referrals from colleagues in primary care accompanied by a CBCT including a report from an imaging centre.

However, the report was from a radiologist with no GDC/GMC registration credentials. Teleradiology and outsourcing of reporting is increasingly common, but all who report on patients in the UK, wherever in the world, should be registered with a UK healthcare regulator.

The Royal College of Radiologists has published a comprehensive document[2] in its *Standards for interpretation and reporting of imaging investigations* which defines the standards and best practice which our patients should expect and is aimed at radiologists and other reporters.

We would strongly recommend this guidance to clinicians and imaging centres with cone beam CT scans, to allow them to provide high quality, safe care for our patients.

A. Mahmood, J. Shah and A. Majumdar, Bed Herts and Bucks Maxillofacial Network, UK, by email

References

1. Yalda F A, Holroyd J, Islam M, Theodorakou C, Horner K. Current practice in the use of cone beam computed tomography: a survey of UK dental practices. *Br Dent J* 226: **2;** 115-124.
2. Royal College of Radiologists. *Standards for interpretation and reporting of imaging investigations, Second Edition*. 2018.

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Dermal fillers

Dermal filler dangers

Sir, in a time of austerity and increasing surgical waiting lists, the time taken for completion of combined orthognathic and orthodontic treatment is inevitably prolonged.

In addition, there is an increase in the use of dermal fillers from both medical and dental practitioners, as well as beauticians. Perhaps unsurprisingly in this context, it has been observed that several of our patients have used dermal fillers whilst awaiting their initial assessment, or during the primary orthodontic treatment to disguise any perceived aesthetic defect.

This is troublesome for both planning any potential orthognathic movements, due to the altered soft tissue contour, and may possibly adversely affect the surgical outcome.

We would stress the importance of the general dental practitioner in advising patients to avoid such treatments before or during any orthognathic treatment.

A. Power, Y. Safdar and B. Solanki, Bradford, UK, by email

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Coronectomy

Coronectomy consent

Sir, the coronectomy procedure has become widely used in the treatment of vital teeth which are deemed at 'high risk 'of causing inferior alveolar nerve injury (IANI).

Once the root of the tooth is deemed to be involved with the inferior alveolar nerve (IAN) canal radiographically, there is a 20% risk of the patient developing temporary IANI and a 1–4% risk of developing permanent IANI with surgical removal.[1]

With the push by managing bodies to find cost effective alternatives to providing high quality care, there have been oral surgery contracts commissioned to provide services in primary care settings, which are usually delivered by secondary care providers, through specialist dentists or dentists with specialist interests.

Although the duty of gaining consent from the patient lies mainly with the operating surgeon, there is an onus on the referring practitioner to be able to provide the various treatment options to allow the patient to make an informed decision and prevent inappropriate referrals.

Although indicated in the National Institute for Health and Care Excellence (NICE) as an alternate treatment for third molar extractions, coronectomy is often