COMMENT

Letters to the editor

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Dental radiography

Heroin case questions

Sir, a recent case report regarding heroin and methadone unfortunately contained the word 'user' which implies that the patient is not prescribed the drugs but uses them illegally.[1] Clearly this patient was prescribed methadone which is a drug used for: pain management, especially for terminal patients; as part of opiate drug withdrawal management; and as a long-term substitute for opioids - methadone maintenance therapy (MMT) 80-120 mg daily. Central to MMT is the provision of counselling, case management and other medical and psychosocial services. Here the patient was reported as receiving 105 mg of methadone daily; a dose consistent with MMT. The paper made no mention of either MMT or as to how the drug was administered - which has a great importance in the progression of dental decay.

The clinical examination did not include a report regarding the periodontal status of the patient. The pre-treatment photographs were captioned with the statement that the photographs showed 'chronic gingivitis', but the radiographic report stated there was 'generalised horizontal bone loss consistent with chronic periodontitis'. No mention was made of the vertical bone loss visible in the lower labial segment periapical radiograph (Fig. 2).

Modern radiological practice is to keep the radiographic exposure 'As low as reasonably practicable'. The concept being to keep radiographic exposures to a minimum to keep the dosage to a minimum. Why therefore were an orthopantomogram (OPT) and full mouth radiographs both taken? Surely not merely to examine the lower left eight, which could have been assessed using a sectional OPT.

In the radiographic report the upper lateral incisors were judged to be un-restorable and non-vital. But the post-treatment photographs show the upper lateral incisors to have been restored within the treatment period with gold crowns. One wonders whether they were also root-filled and posts placed?

Figure 4 shows that the two gold crowns were then extracted and added to the upper partial denture. A radiograph of the denture depicted in Figure 4 shows that the crowns were added to the denture post-construction. This would indicate that as the full gold crowns are shown in the post-treatment photographs, these images are not post-treatment, but rather mid-treatment.

The disease control phase of the treatment included a smoking cessation programme but the success of this for patients with abuse disorders is very poor. The psychological trauma of drug rehabilitation is high and I doubt if smoking cessation would be considered important relative to ceasing drug rehabilitation. Patients have frequently informed me that it easier to give up drugs than cigarettes. Managing patients in rehabilitation has shown me that the priority is to manage substance abuse and to leave cigarettes to one side until the patient's life has settled.

R. A. Baker, Cardiff, UK

The authors, Hassan Abed and Yazan Hassona, respond: Thank you for your interest regarding our published paper; here are some clarifications. Dental treatment should be included when managing patients with drug abuse.[2] In our case report, dental treatment was aimed at improving the patient's eating, as he was losing some weight because of his difficult eating pattern, and to improve his psychological wellbeing and his social interaction. Methadone was prescribed and controlled as a part of methadone maintenance therapy (MMT), so the patient himself did not illegally use it. The patient has been seen recently with a smaller dose of methadone. Treatment of a patient who is addicted to heroin should include all the patient's aspects that might help to improve his general wellbeing, not only focusing on one aspect such as drug withdrawal.[2] Regarding the radiographs and periodontal status, we believe that the quality of radiographs provided in our case is not clear enough in the printed version to give enough details and there is a possibility of image distortion during transfer of images. Our radiograph systems in the hospital can help with advanced tools to check if there are bone defects. Furthermore, after the discussion with the endodontic team, periapical and bitewings were taken to help assess teeth restorability and to decide either to extract some teeth or to consider conservative treatment with fillings and/or root canal treatment. An orthopantomogram cannot give enough details to help have a definitive treatment plan, especially when massive dental extraction is required. Neither can it be used to assess teeth restorability.[3,4] Moreover, it is true that the post-treatment photographs show the upper lateral incisors to have been restored within the treatment period with gold crowns. However, the treatment with gold crowns was made using ready-made crowns and cemented outside our hospital. It was cemented improperly with no root canal treatment and no post. However, after discussion with the patient about the improper treatment and the need for dental extraction for both non-restorable teeth and the presence of periapical infection, the patient understood and was happy to proceed with the extraction, but he was keen to add the gold crown to the existing denture and that is what we made. Thereby, the gold crowns were added to the denture at the patient's request. In regard to the smoking cessation programme, dentists can help patients to stop smoking through a smoking cessation programme. The MMT team can manage disorders; dentists also can help in this management by encouraging patients and providing a better

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smile that improves a patient's psychological wellbeing so that they will be keen to have a better general quality of life.[5,6] *This was noticeable with our patient, as the MMT team reduced the amount of the methadone dose. Moreover, smoking cessation was advised to help improve periodontal and gingival health, which has been proven in this case and also during the review clinic. This impacts oral and dental healthcare, and thus general health and psychological and social aspects of patients. We always offer our patients who smoke a smoking cessation programme as a part of dental treatment. The main role of dentists is to improve oral and dental healthcare, which will help to improve other aspects of life.*[5] *Regarding your experience with your patients who informed you that it is easier to give up drugs than cigarettes; this depends on the type of drug they use, dosage and number of years, and also the frequency and number of cigarettes they use.*

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GDC regulation

Tying a knot using water

Sir, a recent article[1] in the *BDJ* reported on proposed research into the meaning of 'seriousness' in the assessment of fitness to practise (FtP) cases at the General Dental Council (GDC). The subject arose from the GDC's *Moving upstream* document[2] in which the GDC acknowledged a need to learn how to improve their ability to assess whether a case is serious enough to warrant a full fitness to practise investigation. The article included quotations from the GDC's head of policy and research programme. Apparently, the research will not define seriousness and will not make a list of serious issues in possible FtP cases. Yet it is stated that a 'framework' for guidance and clearer policy for fitness to practise panels will be devised. It said further that this will provide more information that goes beyond the current provision to decision makers in FtP cases.

However, with the refusal to define seriousness and to list possible issues, how will the GDC and the rest of us know what we are talking about? We will not know and I think it follows that the proposed framework will be empty. If, as reported, this really is the basis of the research the 'results' will be meaningless, like trying to tie a knot using water.[1]

If the people at the GDC who make judgements about seriousness lack knowledge of dentistry, the present poor situation is not surprising. As human beings we make judgements on the basis of analogues or comparisons with that which we have seen or experienced before. If you ask an untrained person to make judgements about things that happen between a patient and a dentist, that person will struggle because they have few comparisons to make. Conversely, a dentist will have had training in dentistry and years of clinical experience to provide a host of relevant situations and comparisons. Judgements made by a dentist would thus be informed and probably more useful and just than those made by an untrained person. Is it not time to employ the obvious resource, ie dentists, to make these judgements?

In a recent unpublished review of the document *Moving upstream*[2] (now submitted to the members of the council of the GDC), I have noted in addition to the above that the problems of the unworkable NHS and the atmosphere of fear dentists endure have been ignored. The GDC offers a continuing state of uncertainty, disquiet and uneasiness for both patients and the dental profession. This prolonged experiment with governance by the unqualified must be terminated soon. Surely it is time to end the torture and install a new governing body?

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Oral surgery

Poor antibiotic guardianship

Sir, I read with interest and sympathy the paper by Mackie and colleagues detailing their experiences with referrals for third molar management.[1] It mirrors that of my own department, and that of many others, I am sure.

Osler is credited with the phrase 'listen to the patient, he is telling you the diagnosis'.[2] Whilst he was teaching in the early 1900s, the advice is no less pertinent today. Good history taking will clearly delineate the potential different diagnoses for odontogenic and non-odontogenic pain in most cases, and the characteristic symptoms are detailed by the authors. Such attention to the most basic yet important of skills in medicine and dentistry is constantly overlooked, leading to misdiagnoses that may have tragic effects.[3]

However, I would urge practitioners not to be put off from referring their patients for management of third molar issues. Third molar disease carries a significant quality of life impact, and whilst NICE guidance has become increasingly controversial, the need to refer for treatment should not be delayed, and the reasons for treatment are well defined. I see many patients who have suffered third molar symptoms for years, having been prescribed antibiotics on multiple occasions, without definitive referral for management. To use antibiotics in such a way is poor antibiotic guardianship, as the gold standard for management of third molar disease remains extraction and will continue to be so for the foreseeable future. Needless to say, the prescription of antibiotics for symptoms of TMD simply promotes a deep sigh.

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