this relates to the time pressures of NHS dentistry - the practice I work in has 15 minute appointments for an 'Emergency Pain' which appears to be the norm in the area. Is this really enough time to take a full and detailed history as well as examining the patient, performing any investigations and then treatment?

Despite time pressures, this patient reinforced in me the importance of ensuring patients are asked regarding doses of painkillers taken; and when advising painkillers, ensure patients are made aware of the dosage and if needs be the consequences of an overdose.

In order to act holistically, these two quick and easy points should be followed as a matter of routine. After all, taking it to an extreme, the seconds needed to address these simple points have the potential to save someone's life.

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Restorative dentistry

Prostheses in Parkinson's disease

Sir, I enjoyed reading the *BDJ*'s recent paper on the restorative options available to partially dentate/edentulous patients with Parkinson's disease (PD).¹

Implant-retained mandibular overdentures are argued as the minimum standard of care in improving denture retention and stability in edentulous adults.² However, Kaka *et al.* acknowledged high costs, the risks of aspiration (during implant placement) and the potential poor long-term survival of these restorations in patients with dyskinetic parafunction habits.³ It is also important to consider the often overlooked decline of a patient's oral, physical and mental health before offering advanced restorative treatment.

Parkinson's disease is a progressive disorder, where cognition and control over movement continue to decline with age. This creates barriers to good oral health that include dementia, dysphagia and a reluctance to cooperate with carer-assisted oral hygiene, eventually leading to a deterioration in oral health and the need for domiciliary dental care; complicating the long-term maintenance of implants and the supporting periodontium.

Alternatively, although providing a 'wearable' tissue-borne denture can be difficult even in cooperative patients, a good knowledge of a) impression materials (well-tolerated fast-setting alginates and silicones), b) the denture-making process (using acrylic base plates when assessing retention and stability at the occlusal registration/try-in stages) and c) the denture-bearing area (engaging the retromylohyoid space in improving the stability of a lower denture), is invaluable which, when the need for adjustment or repair arise, is better managed when in the domiciliary setting.

From the viewpoint of a dental student, it is important to be pragmatic in your long-term approach to restorative dentistry when treating elderly patients with complex needs as a more simple option, though arguably not the 'minimum standard', may be in the patient's best interest.²

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Global policy

Beyond the dental silo

Sir, we read with interest and a degree of amusement the recent editorial from our worthy *BDJ* editor-in-chief who, in his customary style, raises some interesting points which we would like to address.¹

First, we would like to thank him and the senior BDA staff for attending and participating in the recent UCL-*Lancet* launch event to mark the publication of the Oral Health Series.^{2,3} They joined an international audience who enjoyed presentations delivered by the co-authors and a lively discussion from an invited panel of leading policy advocates.

We feel it is important to explain the background to *The Lancet* series which was commissioned by the editorial team recognising their neglect of oral health. Such series are intended to provide an overview and introduction of a topic, and while not new to a dental readership the subject will certainly be so to *The Lancet*'s global medical and policy audience.

Dr Hancocks rightly acknowledges the high esteem of *The Lancet*, its influence and its global policy reach. It is surprising therefore that he bemoans their interest in setting forth a future agenda to address the global neglect of oral health. Sometimes outsiders are best able to see the way ahead rather than those of us who are too narrow and fixated with the minutiae of oral health.

It is incorrect of Dr Hancocks to state that the overriding message of the series was that 'individual treatment was no longer the way forward'. We call for radical reform of oral health care systems to enable clinicians to deliver high quality and appropriate care to their patients, combined with policy changes to promote population oral health and reduce inequalities. It is also important to acknowledge that the issues raised equally apply to high- middle and low-income countries. In the UK many positive developments have occurred in oral health and dentistry in recent years. However, many challenges remain. Our population still suffers from a significant burden of oral diseases; we have persistent inequalities in oral health across our populations; and many in the dental profession are dissatisfied with their NHS contract. Oral health systems across the UK require urgent reform to enhance prevention, promote greater equity and access, deliver high quality care, be better integrated with the wider NHS, and improve staff morale and wellbeing.

Following publication of the series the authors are now in discussion with *The Lancet* to discuss options for a Lancet Commission on Oral Health which would bring together dental, medical, members of the public and policy experts to further develop a detailed action plan for oral health. A video of the launch event is available at: www.ucl.ac.uk/dph.

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