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.

Prosthetic dentistry

Seal gut and walrus ivory

Sir, further to your correspondents Shirsat *et al.* in *BDJ* 227 issue 6 p. 436 (*Self-repaired dentistry*), I spent much of the 1980s working as a peripatetic dentist in several areas of the Canadian arctic and sub-arctic.

In a part of what then was the North West Territories (and since 1999 is called Nunavut – the Eastern Arctic), I recall two particular patients with prosthetic problems. Many of the Inuit patients could speak little or no English so I always engaged a local resident to act as interpreter during my visits.

One elderly gentleman presented with a slightly loose full upper acrylic denture, the looseness brought on by the denture's age and his resorbing palatal bone ridge.

What made it interesting was that the denture had obviously sustained a previous midline fracture and had been repaired.

The repair had been undertaken by drilling about two dozen tiny holes along each side of the fracture and both halves were then held together with what the interpreter told me was seal gut. The very fine thread 'stitching' was both across opposite holes and diagonally to adjacent ones, right along the length of the fracture. It transpired that the repair had been done some 20 years previously.

The denture itself was solid but on inspecting his palate, there was a concomitant set of thread impression indentations which to a degree appeared to have assisted the denture's lateral stability. They showed no sign of local inflammation and both denture fit surface and palatal tissues were clean and healthy. I was told that he cleaned both when possible with snow...

I effected a chairside relining for him over the reduced ridge but avoided covering the manageable midline repair, at his request.

The second patient was an elderly lady who presented with a full upper acrylic denture. The fit was fine but her complaint when

interpreted was that one of the upper front teeth was discoloured. It had been getting steadily darker in shade.

On inspection, indeed it was: the tooth was perfect in anatomy: shape and surface polish, but darker than all the other teeth. I was at a loss to explain how or why until the interpreter told me that 15 years previously, this front tooth had been lost and that this lady had then repaired it herself. It transpired that the dark tooth was made of walrus ivory and I was assured that initially, it was a perfect colour match.

Given the distance from her summer and winter hunting grounds to any dental care, this was a truly ingenious accomplishment.

To my eternal chagrin, I didn't at that time (pre-digital) take any clinical photographs. Bulky film was then for people, wildlife and the truly stunning landscapes for which and in which I was privileged to work.

R. D. B. Dickson, Morpeth, UK

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Dental education

A few corrections

Sir, I would like to respond to the letter in the *BDJ* in August¹ as the recently appointed Chair of the Advisory Board for Foundation Training in Dentistry (ABFTD).

Firstly I would like to thank Dr Ismail for his comments; I am in agreement that evaluation tools have an important role in education and specifically in relation to DFT. I must, however, make one or two corrections to his statements which are probably due to him being unaware of the full process.

As well as completion of the DFT National Survey there is also a separate survey of the trainers which is carried out by the General Dental Council (GDC). The former report is available to area Deaneries and the Joint Committee for Postgraduate Training in Dentistry (JCPTD) and provides

the necessary checks and balances for the trainers in each area programme.

I apologise for the delay in the publishing of the reports since 2016 – these are collated on behalf of the ABFTD and we understood these had been updated – I have been informed that the surveys for both 2017 and 2018 are now available on the website. It should be noted, however, that the results of the surveys and the national summary report were forwarded to the Deaneries and available to inform the management of the schemes prior to this. The 2019 report will be published after it has gone through the appropriate committees.

I welcome the comments on how the process could be improved and this will form part of the discussion at the next meeting which will be my first as Chair of ABFTD. I can assure all taking part in DFT that the Committee constantly look to improve on previous years and the feedback received is viewed with high importance as a means of evaluation and user experience. We recognise that trainers and trainees may need personal development and the survey is just one tool available to help this process.

M. A. Horton, London, UK

Reference

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Dental history

A remarkable story

Sir, I have read with great interest the two excellent papers by Paul Hellyer on the rise of general dental practice in Bexhill-on-Sea.^{1,2} It is not possible to imagine how many (hopefully happy) hours of research have gone into investigating all the aspects of the lives of the practitioners concerned, not just in dentistry.

It is interesting to see how the Editor has taken this remarkable story as a context to

consider dentistry today.³ For example, what types of people now become dentists, what problems face them, what outside interests help to keep them sane. I will continue to read the pages of the *BDJ* carefully in the hope of seeing some answers.

S. Gelbier, London, UK

References

1. Hellyer P. The growth of general dental practice in a developing Sussex seaside resort: 1885-1916 - Part 1: the early settlers. *Br Dent J* 2019; **227**: 419-425.
2. Hellyer P. The development of general practice in a new seaside resort: 1885-1916 - Part 2: the next generation. *Br Dent J* 2019; **227**: 519-539.
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<https://doi.org/10.1038/s41415-019-0952-9>

Conservative dentistry

Long term attachment

Sir, I was interested to read Damian Panchal's case report on crown fracture.¹ I carried out a very similar re-attachment of the incisal half of an upper central incisor for a 19-year-old male on a Sunday morning in October 2006 following trauma on the previous evening.

I used no preparation and merely attached the fragment with acid etch, bond and low viscosity composite (Fig. 1). Rubber dam was not used and other treatment options were not considered. A very limited prognosis was suggested.

Although we were all very satisfied with the immediate result, I went away thinking that it was not likely to last long-term. Having given it some further thought, I then

Fig. 1 The tooth fragment was attached with acid etch, bond and low viscosity composite

Fig. 2 The tooth seven years later

took an impression for a non-precious metal backing which was cemented in place with Panavia Ex two weeks later. In 2013 he came back to see me. The tooth was still looking good. There was no discolouration, no apical pathology and a vital pulp test (Fig. 2). I recently contacted him (now almost 13 years since the reattachment) to gain consent for this letter and he tells me that all is still good.

These days, if the incisal edge were more translucent, an alternative backing material could be considered. If space is needed for the backing, I would suggest temporarily adding a little pimple of composite labially to the lower incisors that oppose the upper incisors adjacent to the traumatised tooth. The backing can then be cemented and impressions taken for an upper vacuum formed retainer to be used only at night to maintain the position of the upper teeth. The occlusion will then settle 'Dahl style' and the composite can be removed from the lower incisors. If appropriate, the continued use of the retainer could be considered on an occasional basis. I did not provide a retainer.

D. A. Rhoden, Worthing, UK

Reference

1. Panchal D. A case report of uncomplicated crown fracture: tooth fragment reattachment. *Br Dent J* 2019; **227**: 259-263.

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Aesthetic dentistry

Cant in the interpupillary line

Sir, establishing the occlusal plane is a fundamental step for occlusal balance. The anterior occlusal plane plays a significant role in developing aesthetics, symmetry and harmony while rehabilitating a patient. In complete denture prosthodontics, the interpupillary line is almost always used as a reference plane to establish the anterior occlusal plane.¹ The maxillary anterior occlusal plane is established parallel to the interpupillary line with the Fox occlusal plane indicator and a ruler. An anterior occlusal cant of 4° results in a slanted smile which can be observed even by laypeople.² This can influence the aesthetic and psychological outcome of the treatment. Furthermore, anterior occlusal cant may not be perceptible in the mounted casts or photographs but can be observed only in the patient's mouth in relation to the facial features.³ In our practice, in many patients the interpupillary line is not straight and cannot be relied upon as a reference plane such as in cases of vertical orbital dystopia.

Various causes of vertical orbital dystopia have been identified which include congenital (craniofaciocervical scoliosis complex, coronal craniosynostosis and facial clefting syndromes), trauma, torticollis, tumours, iatrogenic and idiopathic factors.⁴ Among these the congenital factor plays a crucial role. Certain cases of strabismus, unilateral proptosis and ptosis can also add to the difficulty in establishing the parallelism. Studies are needed to identify and classify these conditions in cohorts. A study report supports the fact that only in 13% do subjects' incisal plane coincide with the interpupillary line.⁵ Establishing the anterior plane perpendicular to the facial midline and choosing a reference plane closer to the oral cavity would be more acceptable. A simple and reliable method or an instrument needs to be designed to establish the anterior plane without relying on the interpupillary line.

M. Kavitha, Coimbatore, India

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4. Tan S T, Ashworth G, Czipionka S, Poole M D, Briggs M. Vertical orbital dystopia. *Plast Reconstr Surg* 1996; **97**: 1349-1361.
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Communication

Anonymous referrals

Sir, as a hospital-based dentist I am regularly in receipt of communications from other dentists regarding patients. The majority of these include the referring dentist contact details so that we can correspond with them as required. There is one group, however, who rarely give any such details. These are level 2 surgeons providing MOS services outside the hospital who have seen a patient and decided that an onward referral to secondary care is necessary. I am sure they would never consider sending a professional letter anonymously under normal circumstances, so why make an exception for these onward referrals? May I use the letters page of the Journal to implore all level 2 surgeons to submit their contact details when making such a referral?

J. Fraser, Cambridge, UK

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