unclear. Additionally, this process is reported to involve any part of the root of a tooth, with the cervical region being least affected and is, therefore, commonly referred to as external surface resorption (based on the classification of resorption by Andreason in 1970). This process is distinct from dental caries. In contrast to the aetiology of resorption (described above), dental caries results from the detrimental effect of the acidic by-products of bacterial metabolism and enzymatic action, causing the chemical dissolution of tooth tissue and removal of organic tissue (ie this process does not involve osteoclastic resorption).

The distinction between these two clinical presentations is important in relation to the management of dental caries and resorption with the former benefitting from changes in patient behaviours and the provision of a cleansable restored tooth surface, and the latter benefitting from the removal of the tissues that drive resorption.

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International dentistry

Collecting smiles

Sir, I vividly remember that moment in the student union when I realised that I first noticed a person's teeth before their eyes! Since then, I have collected smiles across the globe (Fig. 1). My elective project at university was on the Mayan civilisation in Mexico, researching how they adorned their teeth with jewels to depict their wealth, drilling perfect holes to mechanically retain precious stones such as jade and turquoise. Today, Central American countries and the Caribbean still value gold teeth over the Western white smile, with one blind and edentulous patient I treated in Trinidad asking for gold canines on her full upper denture.

Japan, however, has moved away from the traditional practice of *ohaguro*, where teeth would be permanently blackened as a sign of beauty. This black lacquering process was also thought to prevent caries. The Uros tribe who live on Lake Titicaca, which borders Peru and Bolivia, also had a novel method in preventing tooth decay. Not only do they use the totora reeds to build their floating islands and homes, but also chew them to release the natural fluoride. Their smiles gleam from ear to ear in the high altitude sunshine.

Whether you've visited eight or 80 countries, you only need to look around you to see the thousands of smiles dentists

Fig. 1 Some of the photographs Victoria Mellish has taken of smiles on her travels around the world

facilitate. It's the pride and joy I see when I photograph a stranger's smile that feels so warming and satisfying. What a great role we play as dentists in society: creating and enabling happy and healthy smiles.

V. Mellish, London, UK

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Paediatric dentistry

No surprise

Sir, the British Society of Paediatric Dentistry (BSPD) welcomes the paper *Is access to paediatric dental general anaesthesia by need or by postcode?*¹ Sadly, the findings of the survey – chiefly that patients may struggle to access specialist services in parts of the UK – come as no surprise to BSPD. We are aware of the shortage of both specialists and consultants in paediatric dentistry and continue to try and highlight the issue, most recently in our evidence to the Health and Social Care Committee inquiry into dentistry services.²

We are grateful to the cohort of dentists who are stepping into the breach in order to provide extractions under GA. We recommend that non-specialists undertaking extractions under dental general anaesthesia (DGA) both link up with their local Managed Clinical Network in paediatric dentistry and join the ranks of BSPD so we can provide support.

There are early signs that the number of hospital admissions for DGA may be going down for the first time in many years. But this should not lead to complacency. As the survey lead Helen Sanders rightly points out, to receive the best treatment it's essential that children have access to comprehensive care and this is provided by consultant or specialist-led services. This is the model advocated in our Commissioning Standard for Paediatric Dentistry³ and which we would like to see widely adopted. We also support the introduction of a national database of paediatric GAs for audit and service evaluations.

C. Stevens CBE, Manchester, UK

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Oral surgery

Fainters, pull up your socks!

Sir, I have always been a fainter. I was that child in the school choir, and I was that student in dental school. When I was 16, I shadowed my general dentist for work experience. Standing there, peering into the patient's mouth, I watched the procedure eagerly. Then I felt it creep up on me. An uncomfortable warmth, followed by a dry mouth, tingles in my legs, blurred vision, and ringing in my ears. The next thing I knew, the dental nurse was

kneeling next to me, with the patient horrified that her procedure caused me to faint.

Ten years on, not much has changed. Any period of extended standing for procedures is likely to bring about a fainting episode. This had not been a major challenge, as dentistry mostly involves seated work. Cue September 2019, however, and this was to change as I embarked on 12 months of oral and maxillofacial surgery as a dental core trainee. The prospect of full days spent in theatre caused me to seek advice from friends in the medical and dental fields, as well as Dr Google.

A 2009 study¹ reported that 12% of medical students suffer from operating theatre related syncope. Causes noted included hot temperatures, prolonged standing, wearing a surgical mask, and the smell of diathermy. Its solutions concurred with some of the advice from friends – eating a big breakfast, keeping well hydrated, moving legs throughout the operation, sitting down and taking regular breaks. More unusual suggestions from others included consuming large quantities of crisps, and squeezing the legs and buttocks (one's own, of course).

I applied all of these on the first day, but to no avail. About an hour into the operation, I found myself on a trolley, hooked up to a blood pressure monitor while being served apple juice. A long year was ahead...

One new suggestion came in – to try compression socks. Yes, compression socks, normally reserved for deep vein thrombosis, varicose veins, and long-haul flights. With nothing to lose, and plenty of pride to regain, I ordered them to arrive before the next theatre session. It has now been over two months, and I can safely say that they have been the best investment of my career. No more fainting episodes, and cosy legs to boot. This is, of course, anecdotal evidence, but I highly recommend anyone who experiences light-headedness or fainting during theatre or oral surgery to give them a try.

M. Hennigan, Scotland, UK

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