Safeguarding

Protecting our patients

Sir, I am fortunate to be a part of Freedom Charity and engage with their initiatives to bring to an end female genital mutilation (FGM) and forced marriage (FM). As healthcare professionals we hold the privileged position of being able to take effective steps to protect our patients, thereby saving them from becoming victims. We may well be the only available safeguard, recognising the signs from behaviour and things said by patients and taking swift action to alert relevant authorities. Sadly, these two practices still exist in the UK where approximately 130,000 women and girls are victims of FGM, the figure being much higher globally.

As my foundation dental (FD) scheme was based in a region where FGM and FM are prevalent, many other members of my scheme were keen to get involved to tackle this issue. We attended training sessions conducted by Freedom Charity and were shocked that in forced marriages 17%

involved young men and boys, 18% were of children aged 15 years and under and 7% take place entirely in the UK with cases in 2018 up 47% from 2017. Here, we were first introduced to two books – *Cut flowers* and *But it's not fair* which explore the topics in a novel, light-hearted, yet real and challenging way.

We each took the knowledge we gained back to our respective dental practices, sharing the stories we had learned as part of training and providing some practical steps on measures we can take to stop this from happening to a family member, friend, colleague or 'stranger'. We received extremely positive feedback from our dental teams. Some even shared personal stories of their own encounters with persons who had been through this tragic fate. To help raise funds for the charity and awareness of its work, we hosted a raffle at an annual FD conference.

For those interested, I would encourage you to check out the Freedom Charity website which provides excellent content, read the books noted above and wear

the Red Triangle 'End FGM' pin which supports the cause and leads to meaningful conversations about these issues.

K. Mahendran, London, UK

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Dental education

Pressure and overload

Sir, we concur with the views expressed by Dr Mahmud in his letter *Mental health at dental school*¹ and we have previously commented on whether dental schools are doing enough in providing our 'just more junior colleagues' the strategies in ensuring mental wellbeing.² Indeed at the University of Portsmouth Dental Academy we provide ongoing support for the dental hygiene and dental therapy students in recognising and addressing their psychological well-being.^{3,4}

However, one trend that we have observed is the increasing pressure that our more recently qualified dental colleagues face in gaining a job to undertake dental foundation training (DFT) and if they aspire to, in dental core training (DCT).

As these appointments are made using a national recruitment process, they are placed into a national pool to gain a DFT job then again for DCT 1, 2 and 3. These processes pit applicant against applicant to obtain the positions that they wish, but naturally also have to fit into their lives as maturing adults. This is as opposed to traditional examinations where if a standard is reached the candidate passes, the candidates for these assessments have to out-do one another. This creates increasing peer to peer pressure with a continued ramping up of standards. At DCT 2 and 3, only two/three years post qualification, not only do young colleagues have to sit more situational judgement tests, but they also need to produce a portfolio giving evidence of publications in peer reviewed journals,

presentations at national and regional level, and of 1 and 2 cycle audits with measurable clinical gain, to obtain high assessment marks.⁵

As the Editor-in-Chief correctly points out in his editorial, young dentists are academically endowed and highly impressive, but this continual ranking and re-ranking and expectation of achievement places significant pressure and possibly overload on our recently qualified colleagues.⁶ We thus worry about not just the wellbeing of students at dental school, but also of our colleagues in obtaining their post qualification jobs and their subsequent wellbeing as practitioners. Therefore, in our view, stress resilience workshops incorporated into every DFT training programme are an ideal avenue to

address these concerns, as has already been implemented in the HHE Yorkshire and Humber Deanery.

D. R. Radford, M. Harris. Portsmouth, UK

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CASE REPORT

Emergency dentistry

Double rooted lateral?

Sir, a new patient recently presented with a draining sinus between the 12 and 13 apices although they did not report any symptoms and were unaware of its presence. Sensibility testing confirmed a non-vital 12 and a periapical radiograph

revealed what appeared to be two roots, surprising as there was no evidence of abnormal anatomy (Fig. 1). A further periapical was taken using the parallax technique which confirmed this.

The patient was made aware of the guarded prognosis of the tooth, based on the bone loss and unusual root morphology. A CBCT was taken to assess the canal morphology and assess the viability of carrying out root canal treatment (RCT). This revealed one

main root with one central canal with an additional root fused in the apical third, this did not contain any canals or communicate with the central canal. The scan also showed a palatal invagination in the coronal third. Based on these findings the patient was presented with the options of attempting RCT or extraction and they opted for the first.

The tooth was accessed, and one canal was found located centrally in the crown. Pus was found to be draining through the canal; necrotic pulp tissue was removed and copious irrigation with sodium hypochlorite was used throughout. Calcium hydroxide was placed between visits.

On return a few weeks later the patient reported no pain or problems and that the sinus was now gone. On re-access the canal was found to be dry, with no evidence of infection. It was cleaned and shaped to full working length using Wave One Gold rotary files, before a final flush through with EDTA. Elements Obturation Unit and AH plus sealer was used for warm vertical and backfill obturation. The post-obturation radiograph shows a well condensed root filling with flow of GP into the start of a lateral canal and sealer through the apical delta (Fig. 2).

Fig. 1 Pre-op

Fig. 2 Post-obturation