Mouth cancer

More defensive dentistry

Sir, I note, with concern, the observations raised by Bradley, Barratt *et al.*[1] regarding the inappropriate referral of suspected oral malignancies, and the proposed reasons for such a pattern developing.

I speak as a GDP with hospital experience and an interest in the subject, and would note that the sentiments expressed are commonly voiced by surgical colleagues who find their departments swamped with common, benign conditions which have been fast-tracked with all the attendant worries, fears and inconvenience that this engenders.

My view is simple: what else could we possibly expect? The much-publicised antics of the GDC and the medical negligence lawyers have created a climate of fear and defensive dentistry of unprecedented proportions. No-one dares run the risk of missing a malignancy, the consequences for all involved can be disastrous. There has been a tendency for postgraduate courses to stress the need for immediate referral of any white patch as it could be a deadly cancer. This, coupled with the comparative paucity of oral medicine training in an increasingly crowded undergraduate curriculum, means that younger colleagues have, quite literally, never seen any of the common oral lesions, or had any experience in their management.

I would note that there is a world of difference between an 80-year-old, non-smoking, teetotal lady with bilateral reticular LP and a firm white patch in the sublingual pouch of a 50-year-old alcoholic, but, in the utter chaos of regulations, compliance, protocols, endless, mindless templates, threats and fears, the finer points are lost. Refer, stat; it's safer; you've Done Your Bit. It is also far easier to hit the refer button than invest the effort and clinical time taken to fully assess a suspect lesion, when the NHS is only interested in targets. A referral takes one time unit, a full evaluation plus biopsy may take several.

I feel that this pattern will continue to evolve to a point where any and all slight variations from the absolutely normal will be referred on to secondary care. The only way to circumvent this inevitability is a fundamental change in the system. Mentoring by experienced colleagues, roving senior colleagues to observe and advise practices which have a high referral base, not with the aggressive, punitive approach of the GDC, but a trusted helper who can really guide those starting out on their professional journey, would be one idea. Electronic referral and not the unwieldy and clumsy Rego, with a dedicated assessment and two-way communication, is another. This will mean a move away from this infernal target-based mentality, which is, perhaps, a step too far for the current establishment. It could all be so different, but, with the current adversarial set-up, things can only get worse. And who can blame them?

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Reference

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https://doi.org/10.1038/s41415-020-2416-7

Aesthetic dentistry

Fashionable dentitions

Sir, social media and the fashion industry are regularly regarded as having an impact on mental health and perceptions of what is attractive. It has become easier to compare and idolise celebrities, models and influencers with 'perfect' dentitions. This can be seen by the growth in demand for straighter, whiter teeth.

However, fashion brands with high visibility on social media now appear to be acknowledging the diversity in dentitions amongst the population. This has been shown in recent lipstick advertisements by Gucci centred around a model with hypodontia, resulting in missing lateral incisors. Furthermore, large brands such as Urban Outfitters, Primark and MAC cosmetics have used a model with a missing central incisor as a result of trauma. Models with a midline diastema have been used regularly and this has been reflected with the potential positive outcome to change the public's perceptions.[1]

It is important to consider patients holistically. For some, there may be a detrimental long-term impact of trauma or hypodontia on patients' confidence and psychosocial wellbeing, affecting overall quality of life.[2] The push from large companies to show a wider range of models indicates a progressive portrayal of what is deemed desirable, evidencing the positive impact social media and fashion brands can have. These campaigns may be beneficial to those affected, helping to change the public's perceptions on what is deemed the 'perfect smile'.

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2. Azami-Aghdash S, Azar F E, Azar F P *et al.* Prevalence, etiology, and types of dental trauma in children and adolescents: systematic review and meta-analysis. *Med J Islam Repub Iran* 2015; **29:** 234.

https://doi.org/10.1038/s41415-020-2419-4

Paediatric dentistry

Tongue-tied

Sir, ankyloglossia or 'tongue-tie' is a condition affecting the attachment of the tongue to the floor of the mouth via the lingual frenulum. It has a cited prevalence of up to one in ten newborns in the UK. Despite working in several oral and maxillofacial units in England and Wales over the past six years, it was not a condition I had routinely encountered, or even treated. Discussion with colleagues would often present a very mixed picture of opinions ranging from the die-hard proponents for swift surgical intervention, to those who believed there was no objective benefit from doing so.

It was only when I was presented with personal experience of the condition in our own newborn that the minefield of risks, benefits, treatment options and their sequelae facing parents and patients became evident. The range of professionals advertised as having a hand in this was also a potential for confusion; the Association of Tongue-tie Practitioners (ATP) lists ten types of healthcare professionals including dentists, doctors, registered midwives, registered nurses, advanced neonatal practitioners, lactation consultants and breastfeeding counsellors. Coupled with the sudden challenges a newborn can bring to a household, particularly for mothers trying to breastfeed, this can add an unwanted level of strain. Discerning who to contact for advice and who can provide the best care is not always straightforward, and that is speaking as someone working in the profession.

The decision to treat is based on early history and assessment, examining any feeding difficulty, mastitis, low milk production, dread of feeding time, latch problems and colic. A subsequent clinical examination will follow which often involves observation of feeding for