Blurred line on nicotine

Sir, I agree with the author of the letter on nicotine pouches that we as dentists should update our knowledge regarding new products under the garb of being 'safe' when the only word we have is that of the manufacturer.[1] While they may be utilised for recreational purposes, nicotine pouches are sold as a means of nicotine replacement therapy in Norwegian pharmacies, approved by the Norwegian Medicines Agency for the purpose of smoking cessation under the brand name 'Zonnic'.[2,3]

The manufacturer recommends using not more than 8–12 pouches per day, never to exceed 24. A stated feature of these pouches is that the user can control the release rate by moving the pouch around the mouth for a faster release and leaving it in place for a slower effect.[4]

Another major difference between this product and other nicotine replacement therapies is the fact that this particular product is manufactured by a commercial tobacco company rather than a pharmaceutical. These products should be viewed with extreme caution as they threaten to blur the line between nicotine replacement therapy and smokeless tobacco.

V. Sahni, New Delhi, India

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Aesthetic dentistry

Clip-on questions

Sir, on wasted hours scrolling through Instagram and Facebook feeds, I have been bombarded with 'clip on veneers' (COV) adverts. One showed several pictures of a lady grinning, displaying a large whiteboard smile enhanced with a fancy filter but the 'pre-op' photo showed several clear ongoing dental issues including anterior caries, gingival inflammation, and broken-down teeth. It does not surprise me that people are drawn to these kinds of products; the rise of social media advertising has facilitated an endless drive for the 'perfect smile'.

The company website selling these prostheses shows multiple client cases, many with the aforementioned dental issues. Obviously, these clients want a quick fix which is affordable, and at only £200 for both the impression kit and veneers, you cannot blame them for purchasing these products. The company claims that their COV are not only an aesthetic treatment option but also an 'alternative' to dental implants, dentures and other fixed prostheses and add that there is no need for any dental visits or complex procedures. These claims are both worrying and damaging.

A previous letter to the *BDJ* highlighted the short-term risks of COV which can become fixed *in situ* and cause oral ulceration and further deterioration of the oral tissues.[1] Furthermore, these veneers can delay patients seeking dental professional intervention, only compounding the issues further. I feel as our regulator, the GDC should be looking into these companies as there is a similarity between the cases brought forward against direct-to-consumer orthodontics.[2]

J. Eaton, Gloucester, UK

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Canine trends in SE Asia

Sir, there is a popular trend in the South East Asian region that involves patients in need of orthodontic treatment preferring to align all the other teeth leaving high canines untouched, due to traditional beliefs. Despite explanation of the problems with carrying out such treatment, patients insist on keeping their high canines or avoiding orthodontics altogether.[1]

There are also many patients desiring sharp pointy canines which is in stark contrast to what most published literature reports. A few years ago there was a trend in Japan where young teenage patients were visiting clinics asking for elongated canines or 'Yaeba'. This was principally for aesthetic reasons and dentists placed artificial resin-made canines on top of the natural canines with temporary cement. This procedure has gained massive popularity in the last decade and the trend has slowly but surely spread to SE Asia.

The Asian region is known for dental trends that rise every few years in part due to media frenzy.[2] In the first decade of this century, a sudden surge of patients requested small diamonds to be bonded to their teeth, a popular procedure with female patients still in demand. Then came the era of fake braces which gained popularity among patients even after being denounced by orthodontists and dentists alike. Despite the efforts of dental and orthodontic associations, cases suffering from the ill-effects of such fake braces are still seen.

A prominent researcher in the field of communication studies reports that even though the aesthetic and beauty concepts keep changing, the factor responsible for their rise and fall is the fixation with youth.

A. Marya, A. Venugopal, Phnom Penh, Cambodia

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Urgent dental care

Inpatient dental care

Sir, in England, urgent dental care for inpatients is not described within the commissioning standard for urgent dental care and this means that regional commissioners will exclude inpatients when commissioning primary care services, such as Community Dental Services (CDS) who might have historically provided domiciliary care to hospitals without dental or maxillofacial units.[1] This is in comparison to Scotland and Wales, where dental treatment for hospital inpatients is provided by the CDS.[2,3]

Reflecting on the impact of COVID-19 and the call to work more collaboratively with health partners within integrated care systems to improve overall health of the population, there should be discussion about local responsibilities to provide urgent dental care for inpatients. This applies not only to hospital trusts but rehabilitation and community hospitals who look after many at-risk groups for significant periods of time.

Pressures on the NHS have increased during the COVID-19 pandemic and it is important that urgent dental care services are available for

inpatients to reduce the burden on the NHS and in this recovery period, provision must be made to ensure these patients do not fall through the gaps. The dental profession has an important part to play in this, continuing to show that oral health is an important part of general health and wellbeing.

N. Bradley, M. Doshi, East Surrey, UK

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Dental emergencies

Tooth avulsion: does the milk matter?

Sir, a recent study found that almost a quarter of the UK population now use dairy free milks such as soy, oat, almond, coconut.[1] Avulsion injuries are one of the most serious dental emergencies, accounting for 0.5–16% of dental injuries and the actions undertaken after this injury are key to tooth prognosis.[2] The International Association of Dental Traumatology consider immediate reimplantation of the avulsed tooth to be the best treatment. If not possible, the tooth should be placed in a physiologic storage medium. Cow's milk is advocated as this medium because of its physiological pH, lack of added sugar and the assumption that it's readily available, cheap and convenient.[2]

A suitable storage medium can increase the viability time of an avulsed tooth and its survival and this may be especially important during the pandemic where patients may face delays seeking emergency dental care. It is difficult to know if these dairy-free alternatives provide the tooth with such ideal storage conditions. Some contain added sugar for taste and the pH can be variable.[3]

This has led to the question of whether the type of milk used as a storage medium has an impact on outcomes to the avulsed tooth and can be recommended as an alternative. A literature search revealed minimal research with the majority of studies investigating pasteurised dairy milk. Limited studies, including a systematic review, demonstrate conflicting results around the suitability of soy and almond milks as storage media.[4,5] One paper revealed soy milk to show significantly higher ankylosis than the control group.[4] Should the situation occur that people refuse to use dairy milk for storage, it would be prudent for dentists to be able to advise whether storage in other media could be recommended, or whether it would be unsafe, incur damage to the tissues and impact outcomes. Further research, expert advice or open discussion would be welcome to ensure safe dental care.

A. Hamid, A. Carter, West Yorkshire, UK

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Communication

Phone call success

Sir, we write further to the recent paper on the evaluation of a dental nurse-led triage system in a private dental practice.[1] During the first UK national lockdown a method of communication was established with patients with special needs through means of welfare telephone calls. This telephone call reviewed their dental and overall wellbeing. A total of 2,269 telephone calls and outcomes were recorded on an Excel spreadsheet with a ranking of 'how well received was the call?' using a five point Likert Scale. Further information included telephone location, patient demographics and whether the patient was signposted to appropriate services or otherwise.

An enthusiastic response with an agreement for the clinician to call back again at a later date was reported from 778 patients with 58 signposted to other services such as NHS Stop Smoking and 1,688 receiving oral prevention advice. There is perhaps further scope in the future to continue this means of communication.

M. Loh, R. Smith, Liverpool; M. Forde, D. Mills, St Helens, UK

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Reduced digital access

Sir, the pandemic has brought to light the extent of the digital divide in the UK with 11.9 million (22%) adults lacking basic digital skills.[1] Data published by the Office for National Statistics show that 4% of households do not have internet access; this is most prevalent in households comprising of a single adult aged 65 or older.[2] Furthermore, only 20% of people aged 65 and over had used an electronic device for making telephone or video calls over the internet.[3]

Arguably, patients over the age of 65 who live alone are some of the most vulnerable patients; furthermore, it is important to also consider patients from social or religious backgrounds where the use of technology may be limited, one example being the Orthodox Jewish community, but there are many other categories of vulnerable patients to be considered, each with their own circumstances.

The approach taken should be tailored to what is known of the individual's circumstances. This may involve giving priority for face-to-face appointments over remote assessments for patients identified to be high-risk or with reduced digital access. For patients who have reduced access due to religious or cultural reasons it may be helpful to liaise with community or religious leaders regarding the provision of webcam-enabled devices.

As virtual dentistry becomes a more commonplace part of the dental assessment, new approaches should be introduced to