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.

Dental tourism

Eagle-eyed Swiss

Sir, a patient arrived for a check-up today who I had seen as an emergency last summer when she had lost a veneer and the tooth was sensitive. I was limited as to what I did as at that stage I could not perform any AGP or even use air or water out of a syringe, so cemented it as best I could. She reported that it lasted a few weeks but then came off in a 25 metre swimming pool whilst on holiday in Switzerland. She was unable to find the veneer but reported it to the attendant at the pool. Amazingly she got a phone call six days later informing her it had been found and she subsequently had it recemented in Switzerland. Today it was still firmly in place some 20 weeks later. I share this story in admiration of the observation powers of Swiss pool attendants.

P. Williams, Lowestoft, UK

https://doi.org/ 10.1038/s41415-021-2894-2

South East Asia

Sir, over the past decade dental tourism has become an exceedingly popular phenomenon across South East Asia, in particular in countries such as Cambodia and Thailand.[1] It was popularised by individuals looking for dental care outside of their regional healthcare systems coupled with scenic holidays. In countries such as Cambodia treatment options for procedures such as implants, ceramic crowns etc are affordable without compromising on quality.

The pandemic has brought the entire world to a standstill with international travel almost non-existent, impacting dental tourism. In the year preceding the pandemic, global medical tourism was valued at US$44.8 billion and dental tourism formed a vital component.[2] Additionally, healthcare delivery shifted to emergency procedures. The financial impact to dental tourism has been dramatic as it is still not possible to predict when patients will be able to travel normally.[3] Dental clinics that were thriving on tourists seeking treatment in countries such as Cambodia, Thailand and Vietnam have been forced to reduce their staff for the foreseeable future. The effect seems more prominent in SE Asian countries where tourism is a major contributor to the national economy.

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

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https://doi.org/10.1038/s41415-021-2900-8

Coronavirus

A problem shared

Sir, thankfully our mental health and wellbeing has been recognised as equally important as our physical health and we are all encouraged to talk more. Do we need to talk to someone about how we are feeling, about our concerns and worries? Would it help to talk to another dentist or DCP? In matters of faith and work, would it help to talk to a Christian dental colleague?

There are many good listening and counselling services out there specifically for dentists and the dental profession to be recommended. In addition, the Christian Dental Fellowship (CDF) (cdf-uk.org) has a pastoral care scheme, provided by dentists and DCPs, and whilst we are not a professional counselling and listening service, we are happy to listen to and talk with any member of the dental profession about any matter, and signpost where appropriate to other services. Prayer is optional but we believe a problem or situation shared and prayed for is a powerful thing. Enquirers don't need to be a member to access the scheme and all enquiries are welcomed, dealt with in confidence and it is free to all.

The CDF is recognised as a faith group in the recently published *Wellbeing Support for the Dental Team* document.[1]

K. Paterson, CDF Pastoral Care Scheme Coordinator, Christian Dental Fellowship, UK

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https://doi.org/10.1038/s41415-021-2901-7

Public health

HIV – the forgotten virus?

Sir, I write further to the letter from J. Winterburn in relation to syphilis.[1] It is important that history taking should include the possibility of sexually transmitted infections (STIs), especially in relation to oral manifestations. As a recently graduated dentist it is surprising to find that HIV testing is not routinely requested when investigating lesions such as recurrent aphthous stomatitis (RAS).

Whilst investigations are routinely carried out to assess full blood count and the serum B12 levels, a request to identify the antigen p24, which is indicative for exposure to HIV, is not routinely made. However,

multiple studies have demonstrated the benefits of providing routine HIV screening in the A&E environment to be both feasible and effective. We are aware of the oral manifestations which are common in HIV-positive patients, such as candidiasis, RAS, hairy tongue and periodontal disease.

In providing routine HIV screens as a form of investigation, we can collectively increase the number of undiagnosed positive patients which would in-turn not only aid in the appropriate management of these patients, but also reduce the risk of HIV transmission to other members of the population. I feel that all clinicians should consider the deduction of STIs, particularly HIV, when investigating and thus diagnosing oral diseases.

A. Shathur, Aintree, UK

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https://doi.org/10.1038/s41415-021-2902-6

Primary care

Aptly coined acronym

Sir, I was pleased to read the article *Introducing the FATLIPS acronym for assessing the red flag clinical features of dental infection*.[1] As a DCT in oral and maxillofacial surgery I am familiar with assessing patients who present to A&E with dental infections and regularly receive referrals from GDPs for suspected infections. I believe this acronym is readily applicable for GDPs as it is based on assessments that don't require tests that are likely to be unavailable in practice. Even with the increased frequency of phone triaging and patients emailing in photographs of suspected swellings, GDPs should be able to successfully work through this aptly coined acronym, identifying those that require management in secondary care and those that don't. Furthermore, this acronym provides not only a useful tool by which a referring GDP can assess patients, but can also provide a framework to facilitate communication between the referring practitioner and accepting on call DCT. This will ensure only appropriate referrals are accepted and avoid patients attending hospital unnecessarily, which is particularly pertinent in the current COVID-19 climate. Upon reading this article I promptly shared it with my other DCT colleagues and it made for an interesting talking point.

C. Devine, Bath, UK

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Romanian insight

Sir, we read with great interest the letter by Dadnam *et al.* presenting the case of a Romanian patient and we felt it might be helpful to provide some additional insight as dentists who trained and/or are practising dentistry in Romania.[1]

We agree with the authors that most dental care in Romania is delivered privately and as evidence suggests, treatment costs can present a significant barrier for accessing care for certain members of the community. However, it is important to point out that socio-economic inequalities regarding access to oral healthcare are not a problem unique to Romania but are prevalent worldwide.[2] Furthermore, it is important to consider the significant limitations of interpreting health insurance data for international comparisons and the need for additional research in this area.[3]

Evidence suggests that privately delivered dental care is being consistently underreported in various Eastern European countries as a way of avoiding fiscal duties.[3] For context, the tariff paid through the limited national health insurance system for a non-surgical extraction is around £12 (free for low income patients) meanwhile the same treatment delivered privately could cost starting from £10 or more depending on the location of the practice (urban/rural) and other factors such as being delivered by a GDP or specialist. It is worth noting that the national minimum wage is around £400/month.[4]

Considering the limitations of the available data, our direct clinical experience of working both in the private and public healthcare systems suggests that the case presented in the letter might be an exception rather than a representative example for the entire population. These are uncertain times for ethnic minorities, and it is important to remember the risk of stereotyping which might lead to some unintended consequences through unconscious bias and may inadvertently increase the levels of inequalities experienced by vulnerable populations.

C. B. Bellu, Cluj-Napoca, Romania; I. F. Dragan, Boston, US; S. Serban, Leeds, UK

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https://doi.org/10.1038/s41415-021-2904-4

Dental physiology

Dentine as a pain perceiver

Sir, the essence of dentistry is pain perception and the alleviation thereof. Accordingly, the existence of the dental profession is essentially founded upon the peculiarities of dentine sensitivity which is undoubtedly the most frequently experienced form of pain perception. The exposure of dentine to salivary solutes of acidity and temperature variations within the mouth make dentine perception as the *sine qua non* of painful experiences. The ability to transmit 'sweetness' as a stimulus for pain is a property shared by no other tissue, and the mechanism of this peculiarity has hitherto never been explained.[1] Presumably, the high osmotic pressure of a sugar solution acting on exposed dentine is productive of a painful sensation. Yet even a strong isotherm salt solution does not elicit a reaction from dentine.

The histology of dentine revealing the contents of the dentinal tubes to be extensions of peripheral odontoblasts in the dental pulp categorises these cells as extensions of the peripheral nervous system. Thereby, the inclusion of odontoblasts as 'nerve tissue' is justified on the basis of their physiological activity rather than their histological appearance. The expanded classification of nerve tissue to include odontoblasts calls for a denouement of neurons and odontoblasts as equal pain perceivers. Essentially then, dentine is