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.

Oral surgery

UK vs USA opioids

Sir, we have reviewed the paper on opioids use in the UK and US by Tayara and Ahmed (*BDJ* 2021; **230:** 159-164) and wish to offer the following comments. The cohorts from the three dental schools were small and dissimilar and the results difficult to interpret. No acknowledgement is made of how the cohorts were identified to avoid selection bias and whether the institutions involved approved the survey. No mention is made of the number of opioid pills prescribed, nor of the adjunctive strategies that might have been used in addition for pain control.

Our chief concern is that the authors have made little attempt to view their results in any type of context. They do not account for the dramatic differences between their study (two-fold difference) and the *JAMA* report (37-fold difference).[1] In 2016, the Governor of Massachusetts initiated a Working Group to curb the opioid crisis by involving State officials, faculty from the three Boston Dental Schools and a student group.[2]

Massachusetts General Hospital OMFS Department reduced their average prescription for third molar extractions from 20 to eight pills per patient without decrease in patient satisfaction or increases in post-operative visits or telephone calls.[3] Another group analysed data from 118 New England OMFS for several office-based surgical procedures and respondents indicated they typically prescribed 8–12 opioid tablets, suggesting fewer tablets were prescribed in academic than in private settings.[4]

Tufts University School of Dental Medicine have sponsored CE activities for many years, recently publishing a *Dental Clinics of North America* issue on opioid prescribing, assessment and management.[5] The Massachusetts Dental Society regularly offers CE courses for members on opioid prescribing and pain management.

In 2016, it became mandatory for all Massachusetts prescribers to check the Massachusetts Prescription Drug Monitoring Program (PDMP) database before prescribing opioids to any patient. In the subsequent three years, Massachusetts dentists wrote fewer opioid prescriptions (-47%), less opioid pills (-55%), less days' supply (58%) with a lower mean morphine equivalent (-16%).[6] Massachusetts is one of 24 States requiring dentists to take a course in opioid prescribing and pain management for licensure.[7] While it is difficult to ascribe these lower opioid prescribing rates to specific activities, a combination of these factors may have created a heightened awareness in the dental community.

D. A. Keith, R. J. Kulich, J. Shaefer, Boston, USA

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Restorative dentistry

1930s techniques

Sir, amongst the numerous delightful and moving tributes to HRH Prince Philip the Duke of Edinburgh was a close up picture of him at school in 1935 whilst at Gordonstoun. It is noticeable that his upper central incisors had been in contact with something very hard – possibly a cricket ball.

I graduated in 1975 in the early days of acid etch bonding, so I would be interested to hear what techniques were available to the school dentist in the thirties?

P. R. Williams, Lowestoft, UK

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Prosthodontics

Treatment modality drift

Sir, ten years (2010–2019) of retrospective data of various treatment modalities delivered at the Department of Prosthodontics at Christian Dental College and Hospital, a tertiary centre for oral healthcare in India, have been analysed. The findings throw light on a substantial change in patients' perception, demand, and inclination for the various types of fixed prostheses in India. Over the last decade, the shift in trend was witnessed from metal restoration to porcelain fused to metal restorations, and to a recent desire for all-ceramic crowns. An example of this is the proportion of patients opting for all-ceramic crowns, amongst various fixed prostheses, witnessing a ten-fold rise. The total annual units of all-ceramic crowns saw an increase of 894% in our audit. Further, there has been a definite escalation in the number of patients opting for dental implants and implant-supported prostheses in recent years.

This drift corresponds to a parallel increase in per capita income of the general population during the same period (54%),

which echoes the seeking of advanced care.[1] The growing economy allows people to spend more on their oral healthcare needs and not limit themselves in the choice for better care. An upsurge in the country's per capita income and heightened awareness regarding oral health and aesthetics has resulted in the average population seeking superior modes for oral rehabilitation. Dentistry and related industries warrant studies to understand better the general population's approach and desires for more aesthetic and advanced outcomes and be prepared to meet new challenges.

N. Kurian, V. S. Varghese, N. Gandhi, K. G. Varghese, A. A. Thomas, Ludhiana, India

Reference

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Paediatric dentistry

Odontopaste alternatives?

Sir, I write with reference to the letter by H. Al-Saffar and D. Dadnam regarding the use of Odontopaste as an alternative to Ledermix in children.[1]

Both medicaments have been shown to provide symptomatic relief in the management of pulpal symptoms, eg irreversible pulpitis and hyperaemic pulp, due to their analgesic and antimicrobial properties. It is also not a relatively technique sensitive (or moisture sensitive) procedure, therefore is easy to place in a cavity after simple removal of caries with an excavator or slow hand piece and simple isolation with cotton wool rolls. This may be beneficial in children who suffer from severe dental anxiety and are in acute pain.

I note, however, and agree with the authors, that there should be caution undertaken with the use of Ledermix due to it containing tetracycline as an antibiotic component, which can cause developmental defects in a child especially with the developing dentition. Perhaps most notably is the staining that forms on the dentition as the teeth are being formed. Furthermore, licensing for this product contraindicates its use for children under 12 years of age. As a result, Odontopaste is advocated as the far safer alternative. However, a review of dental retailers has shown that the product has been discontinued in the last year in the UK. Thus it seems that Ledermix is the only available intracanal medicament currently on the market. Are there any other available alternatives that could be used in place of this?

Y. Lin, Plymouth, UK

Reference

1. Al-Saffar, H., Dadnam, D. Ledermix in children. *Br Dent J* 2021; **230**: 273.

https://doi.org/10.1038/s41415-021-3100-2

CASE REPORT

Dental radiography

Holistic radiographic interpretation

Sir, a nine-year-old child was referred to the Birmingham Dental Hospital Children's Department regarding poor prognosis first permanent molars. Interestingly, the orthopantogram (OPG) included with the referral resembled the appearance of supplemental teeth in the upper and lower left quadrants (Fig. 1). The referral did not reference the radiographic findings. Clinically, the patient presented in the mixed dentition with no supplemental teeth evident. The OPT was in fact of the correct patient, though did not correlate with the intraoral findings seen clinically. A radiograph report was requested to identify the cause of the discrepancy which highlighted a discontinuity in the inferior cortex of the mandible in the lower left premolar region, indicating the patient had moved during the exposure resulting in a duplicate image.

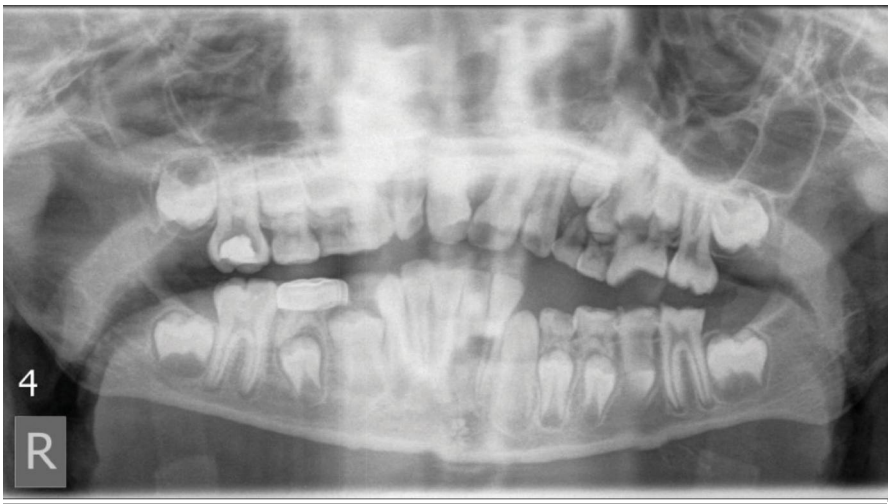

Fig. 1 The orthopantogram included with the referral resembled the appearance of supplemental teeth in the upper and lower left quadrants

Comparing left and right sides of the image is valuable in detecting asymmetries, as structures appearing bilaterally are normally anatomical. Tracing the periphery of the mandible/maxilla and examining other hard tissue structures and air spaces is advisable before assessing the teeth to avoid 'tunnel vision'. Patient positioning is the most common error resulting in unequal horizontal and vertical magnification, the appearance of overlapping teeth and loss of image sharpness.[1] Similarly, failure to place the dorsum of the tongue against the hard palate results in an air shadow (palatoglossal air space) superimposed over the maxillary teeth, thereby obscuring the presence of periapical pathology.

In this instance, the clarity of the duplicate image may have led to incorrect diagnoses. This highlights the importance of employing a holistic approach to radiographic interpretation, ensuring patient identity has been confirmed and that the image has