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.

Rare conditions

Giant cell arteritis

Sir, giant cell arteritis (GCA) is a condition which may result in blindness in one or both eyes, may result in a cerebrovascular accident, and which may be initially presented to the dentist. In two recent medico-legal cases in which a dentist was the first port of call for jaw pain, both patients went on to lose vision when early intervention with systemic glucocorticoids (steroids) may have prevented permanent vision loss. There have been previous case reports describing GCA following presentation to the dentist with jaw or facial pain.[1,2]

The temporalis and the masseter are the main muscles of mastication. These are nourished by branches of the superficial temporal and the maxillary artery. Inflammation of those arteries causing narrowing of the lumen will result in the typical claudicant pain experienced by those suffering with GCA. Blindness occurs because of inflammation and narrowing or occlusion of the ophthalmic artery or its branches. In a recent British study of clinical features of GCA, 143/318 (45%) had pain or difficulty in chewing and 59/318 (19%) had complained of a toothache. This may mean that potentially half of those with GCA may seek the attention of their GDP.[3]

Although commonly presenting with symptoms that may be confused with local oral or dental issues, GCA is a rare condition with an annual incidence of 2.2/10,000 in the UK, which may add to the problem of early recognition.[4] In addition, dental practices may have established referral pathways with the maxillofacial surgery department, but not with the ophthalmology or rheumatology departments, further complicating the process of referral to secondary care. We believe that GCA should be a topic in continuing professional development programmes for dental practitioners to assist early diagnosis of this potentially devastating disease.

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Vocational training

Extended in Scotland

Sir, vocational training in Scotland has been extended by an additional year in light of the impacts of the ongoing COVID-19 pandemic. The decision was taken to ensure trainees gained sufficient clinical exposure and were competent in general practice outwith the restrictions currently imposed such as fallow times and reduced patient footfall. This contrasts with foundation trainees in England, Wales and Northern Ireland who are on track to complete their year as planned in August 2021 and proceed to take up either associate or dental core training posts.

Similarly, Scottish undergraduate dentistry courses have been extended by a further year; another point which has not been consistent across UK dental schools. It is thought provoking to see the significant differences in the approach to the length of training between the nations given that the clinical experience of all foundation dentists and students across the United Kingdom has been negatively impacted. Across the UK, many foundation dentists were assisting other dentists for an initial portion of their training with others being very limited in the number of AGPs that they could carry out, even to the current day. It will be interesting to see if those in Scotland who remain in vocational training for a further year will have increased clinical confidence and competence as a result.

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Systemic health

Obesity: a growing problem

Sir, the obesity crisis within the UK, particularly in Scotland, has drawn large media coverage over the last decade. The World Health Organisation has identified obesity as a chronic disease.[1] Those with an increased Body Mass Index (BMI) often suffer from a range of comorbidities including heart disease, hypertension, diabetes and more recently have been shown to have poorer outcomes following COVID-19.[2,3] Dentists are knowledgeable regarding the oral consequences of these conditions, alongside the effects upon general health.

The impact of lockdown upon obesity cannot be ignored. Following a reduction in dental provision many patients have required re-assessment for dental procedures, in particular conscious sedation. Safe sedation within the dental setting is recommended for those with a BMI <35kg/m^2. Reassessment has highlighted an increasing number of patients around or above this threshold, who prior to the lockdown period, were assessed suitable for dental-setting sedation. Assessment also identifies other parameters of significance: hypertension or reduced oxygen saturations, alongside anatomical complicating factors, such as airway management.[3]

An observation within the last year has highlighted an increased number of younger and otherwise healthy patients of an increased BMI who cannot be accommodated by a standard dental chair.[3] Although frequently accustomed to discussions offering healthy choices regarding sugar content, practitioners may be less well-versed in the sensitive discussion of weight and implications upon other health conditions. Dental practitioners regularly review patients and as such often gain a level of rapport due to frequency of visit. This poses the question of the dental team being gatekeepers to weight management services. Do we have a duty of care to liaise with and inform our, often less visited, medical colleagues of these findings? Policies, guidance and training, supported by published evidence, need to be put in place to support practitioners in these discussions.

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The practice of dentistry

Guidelines are not standards

Sir, I commend Robert L. Caplin's Opinion (*BDJ* 2021; **230:** 337-343). As an expert witness and specialist in periodontics, I frequently see breaches of duty being defined by guidelines with little consideration of clinical judgement or mitigating factors.

The GDC have provided a set of generalised standards that do not allude to particular treatments; defence organisations want to settle civil cases to avoid court costs and the NHS provides a system for dentists to work in which is not fit for purpose. In addition, the dearth of reliable evidence provides little sound basis for many breaches to be adequately assessed by experts.

Guidelines are not standards; this is not their purpose and such use is unjust. The requirement is for a GDP to be 'reasonably competent'. Today's straight 'A' students learn the basic knowledge and technicalities of dentistry, but as graduates they enter the real world of NHS fees, time constraints and the idiosyncrasies of the general public which do not align with dental school tuition and complicates provision of NHS dental care. Are we not to allow these highly intelligent graduates to use the tools of their education to form a strategic plan of treatment using their developing clinical judgement without fear of being found in breach of duty?

The advent of dental implants, the blame culture of UK society and the sometimes unrealistic expectation of teeth for life has led to an era of allegations of substandard dentistry in order to replace lost teeth. While every assistance should be given to individuals who have suffered harm from dental treatment or lack of treatment, it is appropriate to ask what exactly constitutes a breach of duty. Fraud or infection control issues are understandable breaches, but infrequency of radiographs or inaccurate BPE implies there is a script from which deviation is disallowed. While not wishing to belittle these diagnostic aids, civil claims for dental implants to replace periodontally affected second molars in long-term heavy smokers with poor oral hygiene seems inappropriate and even unnecessary. Perspective is paramount in consideration of such claims.

Treatment of periodontal disease will only be beneficial with the compliance and cooperation of a patient regarding their duty of care with oral hygiene. A patient may not be able or willing to provide adequate care making ideal treatment difficult. Dental therapists/hygienists offer a great service but they are costly to an NHS practice. There is limited recourse to NHS periodontal specialist provision leaving only private high street specialist care. The GDP is stuck between a rock and a hard place.

The delay of the overdue updated NHS dental contract has likely seen some of the best talent leave the system to provide dentistry privately, overseas or not at all. Change in the system is imperative to provide appropriate dental care in the NHS and avoid the huge costs to the profession of the litigation machine, which only questionably improves overall standards.

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Restorative dentistry

But surely

Sir, I write in response to the letter *Of little consequence* (*BDJ* 2021; **230** 553-555).

A 360-veneer is a crown, is it not?

Correct me if I am mistaken, but surely the only way to place a 360-veneer on an incisor is to fit adjoining veneers on the labial and palatal aspects!

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Oral microbiology

COM crisis

Sir, clinical oral microbiologists (COMs) form a specialty that has been highlighted by the COVID-19 pandemic as vital to supporting the quality and safe delivery of dentistry. Their Association raised several concerns in 2016, still unaddressed, around meeting the needs of the population and profession.[1] Currently, there are only seven COMs on the GDC register, the most recent added in 2014, and no trainees. With the five-year duration of training the number is not projected to increase in the immediate future, meaning that there will have been no COM training posts open for a continuous seven years. COM are involved in education and training undergraduate and postgraduate dental students and actively undertaking research, but the small number means that this is not the case in every UK dental school. Recently, level 7 and 8 postgraduate programmes were launched in two UK universities, preparing future candidates to be eligible for competing on shorter training pathways (nationally and internationally).

COM are involved in specialist management of systemic and local oral and maxillofacial infections caused by microorganisms, and are trained in medical microbiology to make strategic decisions on the most effective therapy for acute and chronic infections guided by clinical presentation and laboratory reports. This highly specialised focus is needed and unlikely to be fulfilled by any other groups. For example, the successful management of infections such as osteomyelitis, stage II and III of medication-related osteonecrosis of the jaw (MRONJ) and actinomycosis in the head and neck region, requires specialist COM input with an