COMMENT

Letters to the editor

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Restorative dentistry

Veneers or crowns?

Sir, sadly, in our view, Mr Hassall's defence of his destructive overtreatment in the case he described in part two of his *BDJ* articles does him little credit.[1] It was flawed by dubious assertions, an advertorial for Bioclear and sophistry about '360-degree veneers'. Our criticisms are reiterated, particularly about the elective gross destruction of residual intact tooth structure of mildly worn teeth, under the cover of increasing vertical dimension and allegedly improving the patient's appearance.[2]

Mr Hassall's diatribe has left his descriptive and diagnostic skills open to question. Figures 10 and 19 (*BDJ* 2021; **230:** 86) show a local small gap between the moderately worn upper and lower incisors in ICP, but there were occlusal contacts on the canines and premolars which had minimal wear visible. The maxillary canines certainly did not appear to be suffering from 'hyperenamelosis', nor from 'ceramic deficiency' disease. Most sensible dentists would consider that such wear was trivial for a 58-year-old male (Fig. 19). There was no need to destroy the marginal ridges of any of those mainly sound anterior teeth for such questionable appearance changes, and certainly no reasons on TMD grounds[3] (Fig. 22, *BDJ* 2021; **230:** 87).

'Catch all' causes were trotted out as being 'multifactorial' and due to parafunction, abrasion, abfraction and erosion. Factually, there was no visual evidence of any cervical prisms having been broken off any of the upper anterior teeth palatally, which would be the absolute minimum prerequisite to confirm the ridiculous 'abfraction' belief of the occlusionista tribe.[4]

The localised wear and discolouration of the teeth might have suggested erosion with possible previous pipe smoking, or use of a localised anterior occlusal device of some sort and smoking. In any event, selective night-guard vital bleaching followed by additive direct bonding of the canines and premolars in the appropriate thickness and then by direct bonding of the incisors (in a decent thickness to stop it flexing) would have improved the appearance adequately.[4] That additive approach would have accomplished the beneficial increase in anterior vertical dimension which, we agree, probably helped to get space for the restoration of the weak upper molar teeth.

The spurious term '360-degree veneer' is oxymoronic. It is a catchy but disingenuous marketing gimmick which is not valid, either scientifically or logically. We asked over 250 experienced dentists to view those preparations to give their opinions as to whether they were for veneers or crowns. The overwhelming majority called them crown preparations. Describing those proposed restorations as veneers is, at best, misleading and might be viewed, by some, as potentially deceptive.

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Communication

For whom the bell tolls

Sir, the pandemic has forced us to adapt and change many aspects of our clinical practice. Surgeries are kept minimally stocked to prevent aerosol contamination and the role of a clean 'runner nurse' has been established in many departments and settings.[1] In our departments, the runner nurse may be responsible for several aerosol generating procedure (AGP) surgeries during a session, with tasks including the escorting of patients and the provision of additional equipment as required. With the use of single side surgery rooms, there have been barriers to communication between staff members. Runner nurses have been unable to enter the surgeries and those in surgery have struggled to gain the attention of those outside, with concomitant delays in treatment provision. With restricted operating time due to the incorporation of fallow time, procedures need to be carried out as efficiently as possible.

Communication barriers have been overcome by the introduction of a common household electrical device: the wireless doorbell. Available at an affordable price from many retailers, the doorbell receiver can be placed outside of the surgery in the vicinity of the runner nurse and the doorbell button covered within the surgery or placed in an AGP staff member's pocket. It allows those working in an AGP surgery to gain the attention of the runner nurse with the press of a button. This efficient and cost-effective method of communication avoids unnecessary doffing and donning of PPE, reduces the risk of aerosol spread and can summon assistance rapidly, for example during a medical emergency. With many teaching hospitals moving towards clinical pods to overcome the challenges of open clinics,[2] we hope this novel idea will be useful to colleagues to aid communication between staff members.

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