Letters to the editor

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Restorative dentistry

Other ways

Sir, I write in response to the Opinion article 'Occlusion: is there a third way?' (*BDJ* 2021; **231**: 160–162). After many years struggling with occlusion and occlusal concepts, it is with dismay that I read this paper.

Instead of encouraging learning in this fascinating and essential subject, the authors appear to signal another sad step towards the 'dumbing down' of standards as a convenient and easier path.

As a profession, are we sinking lower and giving up on excellent treatments? If this attitude is being instilled into undergraduates, it is even more worrisome. I wonder if the authors have given a thought as to how this paper might be used as supporting material for the hapless practitioner facing a GDC hearing for a case that went wrong? One can imagine counsel for the defence arguing that experience wasn't actually required and it is just unfortunate it went badly and the patient has been left in worse trouble than at the start.

To make it worse (as the authors admit in the paper), it is harder to remediate.

H. Stean, Kew, UK

Corresponding author Stephen Davies responds: I am grateful for the interest that Dr Stean has shown in our paper, and for his contribution to the debate. His is a valid view, and as we state in the paper comes from a direction in which we anticipated some criticism. Many of us, including he and I, have spent considerable energy and time studying occlusion.

My own view is that an occlusion can be judged only by the patient's reaction to it, rather than the didactic view of what is right or wrong. I hope that we made it clear, both in the title monitored developmental approach

[MDA] and in the text of the discussion paper, that it is the responsibility of the clinician to watch out for signs of a lack of adaptive capability in their patient.

I think the suggestion that we are 'dumbing down' the subject, or providing a defence for careless restorations, is a little harsh. On the contrary, adopting the MDA might be harder than following the script of either the conformative approach or the re-organised approach.

I am sorry if Dr Stean has mistaken our invitation for a discussion as the suggestion that the restoration of the worn dentition should be anything other than careful and thoughtful.

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Lacking useful detail

Sir, I was most interested to read 'Occlusion: is there a third way?' (*BDJ* 2021; **231**: 160–162). Whilst I actively encourage any discussion that broadens the general understanding of occlusion, being a card-carrying member of the composite reconstruction club, I feel the suggested approach lacks any useful detail for a dentist to follow. For example, no advice was given as to what one should do if the patient is suffering from TMD before the proposed treatment (very definitely make them a splint).

Following treatment, it was proposed that the direct composite restorations could be modified if problems arose which, though true, again gives no clue as to how this should be done. What it appears is being proposed is that teeth can be restored at a new OVD (which stands for occlusal vertical dimension and not overall vertical dimension as stated) with the condyles in an arbitrary position; if the patient then develops TMD or occlusal trauma (though interestingly, no mention is made of composite debond or bulk fracture),

the suggestion is to simply make the patient a splint, or carry out an unplanned occlusal equilibration. The fatal flaw in this approach is that a practitioner who lacks the skills to mount study models in centric relation (or more descriptively, retruded axis position [RAP]), at the proposed OVD, will lack the same skills required to make an effective splint or carry out an occlusal equilibration, both requiring an RAP recording. The other risk is that by carrying out these adjustments, the anterior teeth then lose contact and are therefore no longer able to guide excursive movement, thus unfavourably loading any posterior restorations. As an aside, opening the OVD on the articulator should only be performed if a very niche and arduous kinematic hinge axis recording is made. The sensible approach is to set the desired OVD using an anterior deprogrammer, then record the jaw relationship in RAP.

The good news, however, is that there is indeed a third way. If direct composite restorations are used to first restore the palatal surfaces of the upper anterior teeth, then you have in effect a fixed anterior deprogrammer, or Lucia jig. If there is also posterior occlusal wear to restore, then this can be completed at later visits once the mandible has taken up a new, more distal position in RAP. Because the patient now has their new intercuspal position coincident with their RAP, any adjustments to these restorations are well within the comfort zone of the uninitiated.

J. Baker, President of the British Society for Restorative Dentistry, London, UK

Corresponding author Stephen Davies responds: I am grateful for the opportunity to comment on Dr Baker's letter, although I hope he will forgive me for not entering into an argument on the best terminology in occlusion.

I make no apology for not giving clear clinical instructions, because this is a discussion paper not a manual.

If he sees the paper as an attack on the re-organised approach, he is mistaken. In our paper, he will see that we encourage all dentists to pursue the sort of training that his and other academically based organisations provide. However, I would be interested to know if he feels that not following the guidelines that he gives will always give a poor result for the patient. Our starting point was the assumption that it probably does not, which may be upsetting for those of us who can find and record his RAP or our CR [ophs!].

If this non-orthodox re-organised approach is currently being adopted by some dentists when restoring the worn dentition, then I hope that our paper will encourage them to keep a very close eye on how the patient's articulatory, dental and periodontal systems are reacting to the occlusions that they are providing.

I am grateful for his observation that a dentist, who cannot find the jaw relationship of which we speak, is going to struggle to make a stabilisation splint and mount the models to do a mock equilibration. He is absolutely right. Maybe this will be the stimulus for that dentist to seek some help. Not ideal, but better than the dentist being unaware of the need, because the patient was not being carefully monitored.

I hesitate to contradict the President of such an esteemed society, but I think his last paragraph describes the re-organised approach by a specific means.

His comments are most welcome to the discussion that we hoped would arise.

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Coronavirus

COVID-19 and consent

Sir, the results of a local completed audit cycle in our oral and maxillofacial surgery (OMFS) department have raised some interesting points for discussion that I wish to share with the wider dental community.

Outpatient elective activity has gradually resumed since April 2020¹ and continues to take place in line with the latest Royal College of Surgeons COVID-19 safety guidelines.^{2,3} These guidelines state that the decision to bring vulnerable patients into a hospital or dental clinic environment during the COVID-19 recovery phase should be decided after careful consideration and discussion of the risks and benefits as part of informed consent.

In line with the Montgomery v Lanarkshire ruling,⁴ it is the opinion of the authors that the significant risk of contracting COVID-19 by attending hospital during the pandemic should be communicated to patients undergoing surgery.

A two-cycle departmental audit was conducted to identify if this risk was being communicated and documented by clinicians for patients undergoing OMFS procedures. The results of the first cycle and an education session were presented at a local clinical governance meeting. The audit was then repeated to assess any changes to practice.

The results showed an improvement for the inclusion of COVID-19 risk on written consent forms from 20% to 44%. The audit concluded that there is still scope for improvement in the department for consenting for COVID-19 infection and a further cycle will be considered for the new cohort of DCTs.

Presenting the audit revealed substantial differences in clinician opinion and raised questions on whether COVID-19 is indeed a material risk that should be included in the formal written consent process. Those who objected to including coronavirus as a

CASE REPORT

Emergency dentistry

Ingested not inhaled

Sir, a three-year-old boy presented to the Accident and Emergency Department with his mother. He had hit his face after colliding with another child in a fall that was witnessed by his parents. There was no loss of consciousness. Examination revealed traumatic dental injuries including an avulsed upper primary incisor (62) which was unaccounted for. In line with international guidelines,¹ a chest radiograph was requested and Figure 1 shows a radiopaque object projecting adjacent to the left aspect of the L4 vertebral body, crucially

indicating that the avulsed tooth had been ingested rather than inhaled.

We would like to emphasise that both the child and his parents were not aware, or perhaps in the case of the child, did not communicate that the tooth was swallowed during the sudden collision. This tooth could well have been inhaled. When considering that inhalation of foreign bodies in children has a 'lack of clinical manifestation' and is therefore often not diagnosed immediately, ensuring that the child has a chest radiograph undertaken is important.² A lack of intervention when a foreign body has been inhaled can have serious consequences.³ We appreciate, especially when based in primary care, that having this imaging undertaken via the local hospital can be a time-consuming process, but we urge colleagues to consider if this is clinically necessary for some patients presenting with traumatic dental injuries.

P. Radford, K. Corsar, Wakefield, UK

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Fig.1 A chest radiograph showing the avulsed 62 clearly visible to the left of the L4 vertebral body