COMMENT

Letters to the editor

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Gerodontology

SCD and education

Sir, we congratulate Jada Britton and Natalie Bradley on their inspiring and enthusiastic opinion paper on special care dentistry (SCD).[1] All three of us have great admiration for dentists and dental care professionals (DCPs) who practise SCD and their approach to undertaking appropriate routine dentistry on patients who have challenging needs. We echo the authors' observations that they are adaptable, performing demanding work with determination and expertise.

However, from our recent research[2,3] as well as at the University of Portsmouth Dental Academy, SCD clinicians also play a significant role in the education of hygiene therapy (HT) students in gerodontology. In HT schools, the theoretical content of gerodontology was delivered through lectures (92.3%); in 53.8%, this was accompanied by seminars and in a smaller number of schools through information embedded in other courses (38.5%) and e-learning (30.8%). Some schools also reported the use of workshops, clinical placement visits and case-based learning (61.9% response rate from UK schools responsible for training dental hygiene therapy students, n = 13 out of 24 schools). Clinical gerodontology teaching was embedded in SCD (80%), with lesser amounts in restorative dentistry (70%), and in approximately half of schools, it was also taught within community dentistry (50%) and periodontology (40%).

Further, in the qualitative arm of the research,[3] participants generally shared the notion that patients in care homes may initially need input and care planning from a special care dentist; however, a few were concerned that this speciality is already over-committed with other patient groups. One participant stated 'specialists should only be treating the very complicated…and they should be…overseeing treatment plans etc, for others but in terms of special care dentistry…especially on its own, managing this problem, it would not touch the sides'.

Dental professionals with a passion and skill in SCD have clearly inspired young dentists,[1] but they are also making a considerable contribution to the education of DCPs in gerodontology. DCPs are increasingly contributing to the UK dental workforce and will have to provide care to the growing number of older dentate adults in the UK.

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References

1. Britton J, Bradley N. Why should everyone care about special care dentistry? *Br Dent J* 2021; **231:** 331–333.
2. Prosser G, Radford D R, Louca C. Teaching of gerodontology to dental and dental hygiene therapy students in the UK. *Br Dent J* 2021; manuscript submitted for consideration.
3. Prosser G, Radford D R, Louca C. Potential educational and workforce strategies to meet the oral health challenges of an increasingly older population in the UK: a qualitative study. Strasbourg: ADEE Online Annual Meeting Networking for Dental Education (May–August), 2021. Abstract number 97.

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Paediatric dentistry

Foreign body inhalation

Sir, I read with interest the recent correspondence in the *BDJ* entitled 'Ingested not inhaled'.[1]

The authors mentioned that paediatric foreign body inhalation possesses a 'lack of clinical manifestation'. The reference quoted, however, states that aspiration of foreign bodies in paediatric practice lacks a 'specific' clinical manifestation which may result in a delay in diagnosis and ensuing complications.[2] The clinical spectrum ranges from an obstruction with an acute and life-threatening nature to one with initial symptoms with a subsequent asymptomatic period followed by the re-emergence of symptoms.[2]

Between 75–85% of patients report with paroxysmal cough, making it the most common symptom. Cough has been evidenced to possess a high sensitivity and low specificity in the diagnosis of foreign body aspiration.[2] A history of choking has been observed to have greater sensitivity in patients with an early (<2 weeks) onset of symptoms and a higher specificity in patients with late (>2 weeks) onset of symptoms. Other symptoms and signs pointing towards a diagnosis, the absence of choking does not by itself rule out the possibility of a foreign body aspiration.[2]

Wheeze, cough and reduced air entry, which form the classical triad, have been reported in fewer than 40% of paediatric patients. This triad exhibits low sensitivity but high specificity.

Cyanosis, fever, dyspnoea and stridor are some other clinical manifestations, the occurrence of which is variable in the patient population.[2]

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References

1. Radford P, Corsar K. Ingested not inhaled. *Br Dent J* 2021; **231:** 371.
2. Singh H, Parakh A. Tracheobronchial foreign body aspiration in children. *Clin Pediatr* 2014; **53:** 415–419.

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Endodontics

Detecting vertical root fractures

Sir, precisely identifying vertical root fracture (VRF) in endodontically treated teeth is very challenging and can cause needless suffering for patients and dentists if not diagnosed early.[1] It requires diagnostic expertise and timely clinical judgement. Though it is believed that cone beam computed tomography (CBCT) plays a paramount role in the accurate identification and prognosis assessment of teeth with VRF, routine CBCT scans are not affordable or accessible