

# Letters to the editor

Send your letters to the Editor, *British Dental Journal*, 64 Wimpole Street, London, W1G 8YS. Email [bdj@bda.org](mailto: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.

## Dental research

### Gender-sensitive analysis

Sir, I have read that for a gender-sensitive analysis of studies, Nature Portfolio journals are encouraging authors to use the Sex and Gender Equity in Research (SAGER) guidelines to conduct their research work.<sup>1</sup> These are designed to elaborate on the reporting of sex and gender and are applicable to studies with human participants, animals, and cells originating from humans and animals.<sup>2</sup> The assignment of sex in a study can be through a self-report, or after examination of external/internal body features, or by genetic testing (applicable for cell or tissue cultures).

As sex and gender characteristics of a population are critical considerations for healthcare and epidemiological studies, as dental professionals we must be cognisant of these guidelines. Meta-research publications in dentistry have focused on the 'methods' and 'reporting' of studies, so a closer look into how these characteristics are reported in dental research would help improve the transparency and quality of a study design.<sup>3</sup> Additionally, it could help determine the relevance of sex- and gender-biased data with research findings for proper application under evidence-based practices.

If and when applicable to the study topic, data disaggregated by sex and gender could aid future meta-research publications to better assess the methodological rigor of a study. For broader sociological impact there is a need for specificity in scientific communication regarding this topic.

A. Kaushik, Chandigarh, India

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## International dentistry

### Dentistry in Russia

Sir, a review of dentistry in Russia since the 1970s has been published recently;<sup>1</sup> this letter is a brief update. The motto of Soviet healthcare was the priority of prophylaxis, realised by mass examinations (so-called dispensarisations), a programme which is currently revitalised.<sup>2</sup> Initial and questionable carious lesions were treated by dry cutting, sometimes with dull rotary instruments, which led to excessive removal of hard tissues. At schools, dental dispensarisations were recommended to be performed twice yearly although consent for treatment was not always sought, especially from children and adolescents or their parents. The checkups and treatments were performed under time pressure.

An early start of the restoration cycle and suboptimal quality of filling materials caused progressive enlargement of cavities: the restorations failed, the cavities were further enlarged. This led to fractures and extractions at a relatively young age. Radiographs reveal that the quality of root canal treatment was often insufficient. The procedural quality was additionally impaired by the limited availability of effective anaesthesia. With regard to orthodontics, domestic postgraduate programmes have been organised, which do not meet the requirements for postgraduate education by the World Federation of Orthodontists.<sup>3</sup>

The large-scale privatisation of Russian dentistry in the 1990s created new problems. Some practitioners avoid conservative treatment of advanced lesions and manipulate patients towards extractions and prosthetics, often choosing treatment plans based on commercial considerations rather than clinical indications. With tooth extraction, some dentists at state polyclinics offer a choice: 'Do you want a paid or free injection?' Anaesthesia after a free injection is incomplete. Formally, the obligatory insurance in Russia covers basic dental treatments, but some personnel at polyclinics accept payments. The level of care has been limited by a shortage of resources.<sup>4</sup>

Admittedly, a general improvement tendency is noticeable. The growing economy had allowed for the acquisition of modern equipment and consumables.

In conclusion, dental treatment at polyclinics, providing free care to patients with obligatory medical insurance, must be performed on a state-of-the-art level. Economic change in dental practices is needed, to guide preventive and minimally-invasive methods. Finally, in a recent experience the author of this letter received free dental treatment from the NHS in the UK. Thereafter, I went together with a visiting British citizen to a state dental polyclinic in Moscow, where the latter was refused free treatment.

S. V. Jargin, Moscow, Russian Federation

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*The Editor-in-Chief notes: In a vote on 26 May 2022 delegates at the World Health Assembly agreed a resolution on the 'Health emergency in Ukraine and refugee receiving and hosting countries, stemming from the Russian Federation's aggression.'*

*Among other issues, the resolution brings attention to the direct and indirect health impacts in Ukraine, in the region and beyond; condemns attacks on health care, as documented by WHO's Surveillance System for Attacks on Health Care; and urges the Russian Federation to immediately cease any attacks on hospitals and other healthcare facilities.*

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## Free dentures in India

Sir, edentulism is common in elderly people which affects an individual's nutrition and taste sensation which can lead to malnutrition. Prevalence of self-reported edentulism among persons 50 years and older ranges from 4% to 22% in the world and this causes functional impairment, physical, psychological and social disability.<sup>1,2</sup> The Government of Karnataka in India has started a programme called 'Danta Bhagya Yojna' to provide free dentures to all poor people with complete or partial tooth loss who are below the poverty line.<sup>2</sup> Giving dentures at doorsteps will encourage affected people to take benefit from this.

*M. V. Math, S. M. Math, Navi Mumbai  
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## Facial aesthetics

### Faces: unmasked

Sir, I am a dental core trainee (DCT) and rotate around different hospitals regularly. This means that I meet new people every few months. All of my DCT years have been during the COVID-19 pandemic and within the period of compulsory mask-wearing. Over the last few weeks, as the

need for mask-wearing has reduced, I have seen people's entire faces for the first time. These are faces of people I have seen, worked with, bonded with daily for four months, but I have often found myself surprised that their faces are not what I had visualised in my mind's eye once their mask has been removed.

Isn't it interesting that we paint a picture of what we think the lower third of an individual's face 'should' look like? I wonder if we link this to their personality, or do we have a 'one size fits all' golden proportion?

A recent research experiment found that individuals were perceived to be more attractive with the lower half of their face covered than without. They suggested that this was linked to the indication of professionalism and responsibility, and that people feel safer around an individual wearing a mask.<sup>1</sup>

As dentists, we are all familiar with the term 'golden proportions' in relation to dental and facial aesthetics, but do we apply this golden proportion to faces which are partly covered? It has been shown that individual attractiveness is optimised when the face's vertical distance between the eyes and the mouth is approximately 36% of its length,<sup>2</sup> and that the mouth and eye regions are among the most important sources of information supporting facial identification.<sup>3</sup>

Studies into the cognitive abilities to 'fill in gaps' of images where part of the image has been covered suggest that when direct input from the eye is obstructed, the brain predicts what is most likely to be present behind the object, by using some of the other inputs to come up with best 'guesses'<sup>4</sup> – is this what we do with faces behind masks?

*L. Wade, Liverpool, UK*

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## Restorative dentistry

### Inlay still intact

Sir, the gold inlay in this photo is 31 years old (Fig. 1). The patient was 55 years of age when the inlay was fitted. See the amount of attrition or the wear by the side of the inlay. The inlay has not come out in spite of all the wear. This inlay was done by direct wax technique.



Fig. 1 Thirty-one-year-old gold inlay

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## OMFS

### A matter of taste

Sir, I would like to draw readers' attention to evidence in the literature to support the fact that surgical third molar extraction can lead to adverse impacts on taste function.<sup>1</sup> This generally is attributable to iatrogenic damage to the sensory taste fibres from the anterior aspect of the tongue which are carried via the facial nerve (chorda tympani division) to unite with the lingual nerve, a branch of the mandibular nerve, before it traverses the *foramen ovale*.

These fibres are prone to damage as a result of their proximity to the retromolar pad. Lower degrees of trauma to nerve fibres as a result of third molar extraction may be unnoticed, with postoperative complaints being more common for somatosensation. Apart from hyposensitivity, there is evidence in literature to support the occurrence of hypersensitivity due to nerve damage.<sup>1</sup>

The literature has generally evaluated adverse effects of third molar extraction on taste for a period of six to nine months and it is generally believed that such effects wane with time.

There is now evidence in literature to support that patients undergoing third molar extractions actually presented