

Hospital dentistry

The burden of dental tourism

Sir, we would like to bring your attention to the increasing burden of dental tourism on our hospital service.

A 53-year-old patient attended our oral surgery department with a history of recurrent infections. The patient had travelled abroad for dental treatment 13 years previously. On clinical examination, a mobile full-arch prosthesis was present in the maxilla; the surrounding gingiva was suppurating and inflamed. Radiographic examination revealed a subperiosteal implant spanning the entire edentulous maxilla with severe bone loss (Fig. 1). These implants are designed to rest on top of the alveolar bone, underneath the mucoperiosteum.¹ The implant was surgically removed to resolve the infection but resulted in oral-antral communication (Fig. 2). Soft tissue closure was not possible due to the degree of bone loss and therefore an obturator was recommended. On discussion with our prosthodontics colleagues, we learned that our patient was not eligible for further treatment in secondary care.

Subperiosteal implants were first described in Sweden in 1942.² They demonstrated good success rates in atrophic

mandibles but are no longer used in the UK owing to the improved success rate of bone grafting to facilitate placement of endosseous implants in atrophic arches.³ It is likely that if this patient had sought treatment in the UK, they would not have been restored with a subperiosteal implant. They would also have been able to access their clinician post-operatively to manage their complications earlier, and likely reduced their morbidity.

The Department of Health, in response to aesthetic surgery tourism, limited responsibility of the NHS to managing emergencies but not remedial work.⁴ We ask: can this reasonably be applied to dental tourism given that teeth are functional and not only aesthetic?

L. Collins, London, UK

References

1. Linkow L I, Ghalili R. Critical design errors in maxillary subperiosteal implants. *J Oral Implantol* 1998; **24**: 198–205.
2. Nguyen T M, Caruhel J-B, Khonsari R H. A subperiosteal maxillary implant causing severe osteolysis. *J Stomatol Oral Maxillofac Surg* 2018; **119**: 523–525.
3. Beddis H, Lello S, Cunliffe J, Coulthard P. Subperiosteal implants. *Br Dent J* 2021; **212**: 4.
4. Jeevan R, Birch J, Armstrong A P. Travelling abroad for aesthetic surgery: Informing healthcare practitioners and providers while improving patient safety. *J Plast Reconstr Aesthet Surg* 2011; **64**: 143–147.

<https://doi.org/10.1038/s41415-022-5109-6>

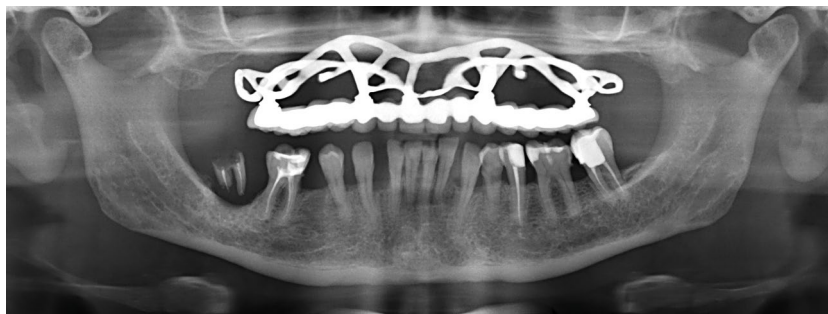


Fig. 1 Orthopantomogram



Fig. 2 The subperiosteal implant following surgical removal

Oral health

Dental implications of laxatives

Sir, constipation is common in childhood; depending on the criteria used for diagnosis, it is reported to affect 5–30% of children.¹ It is usually idiopathic; however, contributory factors may include fluid intake, diet, certain medicines as well as pain and psychological factors. Children with disabilities, such as Down syndrome, cerebral palsy and autism, are also more prone to the condition.¹

The first-line treatment includes education and lifestyle modifications, with the use of resources such as *ERIC's guide to children's bowel problems*.² If that is unsuccessful, then laxatives are commonly used; for example, a macrogol (such as Movicol) is the preferred management. Stimulant laxatives, such as sennosides (Senokot) or softening laxatives, such as docustate sodium (Docusol) can then be considered by the child's doctor if the response is inadequate.³

For many, laxative therapy is tapered gradually over a period of months depending on the response. However, some children with chronic constipation may require laxative therapy for several years. Although some products have released alternative flavourless prescriptions, such as Movicol Junior Flavour Free, many children struggle to tolerate consuming this medication unless it is disguised in flavoured drinks, such as fruit juices or milkshakes. Frequent consumption of such drinks can increase a child's risk of caries and toothwear.⁴

If poorly managed, constipation can become chronic and can lead to anal fissure.² Therefore, good compliance with medication and treatment regimens is imperative. However, where possible, prescription of flavourless prescriptions should be encouraged so that the medicine can be administered in less cariogenic preparations, such as sugar-free cordial or indeed water. This reduces the risk of caries and tooth wear as an indirect consequence of frequent consumption as an oral solution.

O. Jenkins, R. Dave, Birmingham, UK

References

1. NICE. Constipation in children and young people: diagnosis and management. Clinical guideline CG99. 2010, updated 13 July 2017. Available at: <https://www.nice.org.uk/guidance/cg99> (accessed March 2022).
2. The Children's Bowel & Bladder Charity. Advice for Children with Constipation. Available at: <https://www.eric.org.uk/guide-to-childrens-bowel-problems> (accessed March 2022).