COMMENT

Letters to the editor

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Dental implants

Backstreet implantology

Sir, we would like to bring to the attention of your readers our recent experience with a 41-year-old female patient. She had a dental implant placed in relation to her upper right canine tooth, which was missing, whilst on a visit to India. The implant placed with the coronal restoration 'fell off' whilst eating when she returned to the UK. The local dentist took a radiograph which showed that the implant was in fact drilled into the ectopic canine tooth (Fig. 1). She was referred to the Oral and Maxillofacial Surgery department where she underwent general anaesthetic removal of the damaged upper right canine tooth (Fig. 2).

Kelleher emphasised the absurdities and callousness of dental tourism recently in your esteemed journal.[1] However, the deeper issue remains that the dental system in the UK is decaying. Post-pandemic effects on inflation and costs have further increased this burden on the people and our beloved NHS. It cannot be doubted that the expensive treatment in the UK is pushing the general population to take a 'risk' and seek help elsewhere with an added holiday at 'reduced' costs. Although general dental treatment may sound 'catchy' overseas, complex treatments such as dental implants come with increased physical, economic and psychological impact to the 'bargain-hunting' patient. Lack of follow-up appointments add to the insult for these vulnerable patients.[2]

We urge the government and Department of Health to take measures to restore patients' confidence in the NHS and dentists in particular to prevent the pandemic of charlatans making easy money from susceptible patients.

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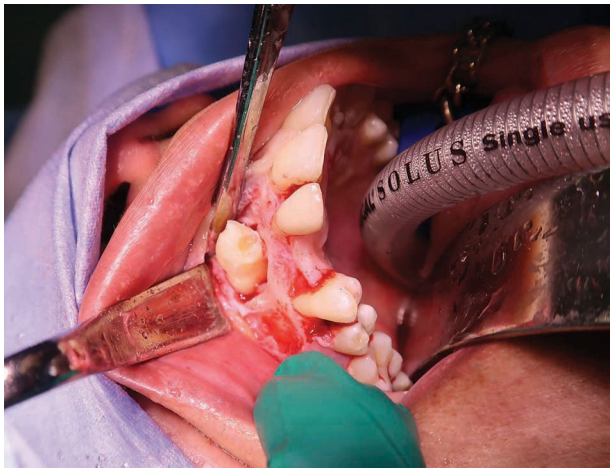

Fig. 1 Radiograph showing iatrogenic damage to ectopic upper right canine tooth

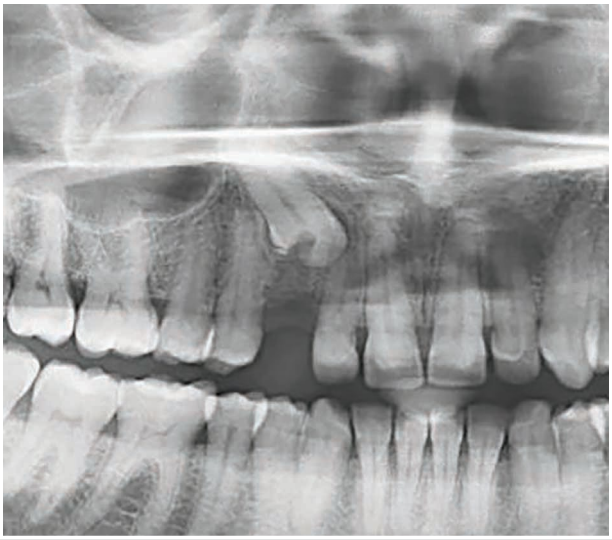

Fig. 2 Damaged ectopic upper right canine tooth

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Minimal intervention dentistry

Interceptive minimal intervention

Sir, further to the Editorial of 12 January,[1] two points about minimal intervention came immediately to mind.

While at dental school in the 1960s and immediately on entering general dental practice in the 1970s, it was very clear that minimal intervention very rarely answered the pressing need for dental care in the community, and that the mantra 'Teeth for Life' was no more than a dream.

Contrast that with the situation on retirement 45 years later. Few dentures either partial or full had to be made, a sense of shame was felt if any child under care needed so much as a single filling, and much if not most dental disease found in an adult could indeed be treated with minimal intervention. And very noticeably ANUG had become a horror story of the past.

The answer to this phenomenon was threefold – prevention, interception, and pharmacological – if mainly in two categories, dental decay and gum disease. For the first, the domestic freezer allowed the diet to move from sugar preservation of food, and fluoridation protected enamel. For the second, pharmacology and the dental hygienist.

At the time, first based on custom, then on observation, children were seen three times a year, once a term, or once a holiday. Changes in diet were intercepted at an early stage when the first signs of caries were spotted, and enquiry led to the cause, an annual trip to the hygienist meant instruction, serious cleaning, and topical fluoride. Simple orthodontics or referral for more complex treatment both sorted out crowding and led to improved oral awareness.

For adults the ideal was seen as two visits a year, commonly with one at least to the hygienist. And for new patients attending with acute gingival conditions, Flagyl was a miracle of pharmacological intervention. The twice-yearly visit meant that as with the young, any early change in diet or health could be spotted – and moreover a professional relationship of mutual trust was established and maintained.

We, on a successful day, and at the end there were many such, had enjoyed the immediate satisfaction of minimal intervention on the rare occasions when that was necessary, but mostly had been remunerated for interceptive minimal intervention – for successfully 'doing nothing'.

And to get to 'doing nothing' and maintaining that steady state, was indeed in retrospect one of the most satisfying aspects of a career well spent and therefore enjoyed.

M. Bishop, Hertford, UK

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Primary care dentistry

Point of care technology for screening and referrals

Sir, I write further to a recent publication in the *BDJ* entitled 'Diabetes and perio screening' which highlights the importance of the bi-directional relationship between periodontal disease and diabetes, particularly in the background of primary care screening strategies.[1]

The aMMP-8 point of care diagnostic test, commercially available as PerioSafe and ImplantSafe for full-mouth and site-specific diagnosis respectively, is a multiply validated and standardised test, apart from being safe and non-invasive.

The modality has been demonstrated to be more effective at diagnosing subclinical/initial periodontitis in adolescents as compared to the conventional testing for bleeding on probing.[2]

This PoCT has also been observed to be able to perform the detection of initial periodontitis in genetically predisposed adolescents.[3]

The aMMP-8 PoCT has also been demonstrated to correlate positively with glycated HbA1c values which can aid in primary care referrals.[4]

The test has also been utilised as an economical screening tool for diabetes/pre-diabetes to yield quick results.[5]

Since the administration and interpretation of this test does not require any specialised training, the knowledge and utilisation of this point of care testing technology can aid primary care screening and referrals.

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