

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.

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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.<sup>1</sup>

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.<sup>2</sup>

This PoCT has also been observed to be able to perform the detection of initial periodontitis in genetically predisposed adolescents.<sup>3</sup>

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

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

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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