COMMENT

Letters to the editor

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Restorative dentistry

Myths and fallacies about ceramic veneers

Sir, a number of Americans claimed to have invented ceramic veneers, including Simonsen & Calamia (1983), Calamia (1983) and Horn (also 1983).[1] In the mid-1980s, one enterprising USA company claimed that it had obtained a patent for 'Chameleon Veneers' as well as their associated luting products. Their patent lawyers demanded royalties from UK dentists to use 'their' technique and claimed that all dentists had to use a 'Chameleon certified' laboratory for the manufacture of any ceramic veneers.

The truth, as proven in a *BDJ* letter[2] and article,[3] is that the development of etching of ceramics for uses in dentistry goes back to the 1960s and was based on the work of Professor William Mc Culloch, a Scotsman, who was head of Prosthetic Dentistry in University College, Cork, Ireland. 'Bill' had completed his MSc project on etching ceramics in Manchester from 1966–1967 and it is published there (Dental Ceramics MSc Thesis Manchester 1967).

He applied for various patents in the UK and USA (Mc Culloch W.T. Great Britain Patent Application No10779 March [1967]; Mc Culloch US Patent Application 815225 [1967]).

His 1968 *BDJ* article was illustrated by photographs of a set of anterior ceramic veneers, taken by the Department of Medical Illustration of the Manchester Royal Infirmary and dated 1 March 1967.[3] In his 1987 'letter to the editor of the *BDJ*' entitled 'USA patent problems', Bill Mc Culloch rejected outright the claims of validity of USA patents for ceramic veneers (mainly because they were not original) and urged dentists to resist any company's demands for royalties for their use.[2]

He wrote: 'I also claim that the fabrication of pre-formed or custom ceramic was described, illustrated and implicit in the publication in the article in the *BDJ* in 1968 and also in my MSc thesis in 1967. For my part, therefore, I am quite willing that any of my colleagues should use the procedures on castable ceramics and on anterior veneers based on the research which I performed in Manchester University from 1966–1968 without having to consider royalties. If any of my other colleagues, or their legal advisors, choose to challenge my inventions as not being the original, I invite them to prove prior claims antedating mine in 1967. I am quite convinced they cannot, and the onus is on them to prove the originality of their patents, especially if they wish to impose any industrial restrictions.'

I assured Bill that I would help to dispel some myths about various Americans developing veneers and, hopefully, ensure that credit for the original etching for conservative ceramic veneers was attributed correctly to him … hence this current letter.

M. Kelleher, London, UK

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Social media

Limited guidance from regulator

Sir, the General Dental Council's (GDC's) guidance on social media was updated in January 2024.[1] This is the second iteration of the guidance, being first issued in 2013, and then revised in 2016. Readers may be interested to know that changes from the 2016 and 2024 version are minimal. In fact, they amount to two new additions – replacing the word Twitter with its new name X (pp 1) and the insertion of a new web link for guidance on raising concerns (pp 3).

Some registrants may be happy with this minimal change, feeling that the GDC's social media guidance already extends enough regulatory oversight into their personal lives and social media activity. However, others may be surprised by this considering how much social media has advanced in the intervening years, and the new issues and concerns it brings for us to consider. These include, but are not limited to: the meteoric popularity of TikTok and the creative and imaginative ways users interact with and create content for this platform;[2] the continued rise of 'influencers' in social media and how they are shaping public perceptions of general and oral health;[3] how the increased sophistication of artificial intelligence-enabled technology, such as ChatGPT and deepfake technology, has brought into sharp focus what we mean by authentic and 'true' and 'false' or computer-generated content, images and videos;[4] and the role that social media plays in the creation and dissemination of misinformation and false news.[5] Individually, and collectively, these digital and social media changes contribute to further blurring of the boundaries between personal and professional spheres, recognition of the psychological impacts of social media, and the realisation that personal and professional digital footprints are more susceptible to falsities or fabrications.

It is worth remembering that the GDC offers guidance for registrants' use of social media, signposting options and choices for how they should remain professional online. It is not a social media policy which comes with the expectation of compliance, and as such has an element of flexibility built into it. Nevertheless, the risks social media poses to personal and reputational harm continue,

and have grown exponentially, and it is unfortunate that the GDC didn't take the opportunity for a more substantive review of its guidance, considering the above issues, to ensure the best interest of registrants and patients.

P. Neville, Bristol, UK

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Xerostomia

Tips for management

Sir, we would like to contribute to the tips for management of dry mouth by Y. Lin *et al.*[1] Besides general measures for the relief of oral dryness, they also provided a comprehensive list of local measures. However, a recent study in patients with Sjögren's disease showed significant differences in the efficacy of therapies in relieving dry mouth complaints.[2] In line it is also important to realise that different causes of oral dryness can lead to differences in the perception of oral dryness between patients. Using the Regional Oral Dryness Inventory (RODI), we recently demonstrated that subgroups of dry mouth patients perceived different intra-oral regions as most dry.[3] The use of dry-mouth interventions was related to this local severity of oral dryness. For example, the use of a mouth gel was significantly associated with dryness of the anterior of the tongue. Therefore, we hypothesise that by using the RODI, in combination with other parameters, it will be possible to give patients more individually tailored advice on the most appropriate interventions for relief of oral dryness symptoms.

H. S. Brand, Amsterdam; Z. Assy, Amsterdam; C. P. Bots, Bunschoten; D. H. J. Jager, Amsterdam; F. J. Bikker, Amsterdam, The Netherlands

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Orthodontics

Recyclable aligners

Sir, we are writing to address the concern raised by Al-Hashimi[1] regarding the carbon emissions associated with clear aligner (CA), an increasingly popular orthodontic therapy.

The use of CA presents a notable challenge, owing to its reliance on petroleum-derived thermoplastic hydrocarbons. These substances are nondegradable and environmentally detrimental when subjected to incineration. Furthermore, their categorisation as medical waste renders them unsuitable for conventional recycling.[2]

Climate change is an undeniable global concern, with experts warning that its progress may exceed the initial projections. As professionals in the field of dentistry, we face significant deliberations regarding our ability to initiate positive change.[3]

Fortunately, a solution has emerged in the form of the Spotlight Oral Care Aligners Recycling Initiative, established in collaboration with the specialised recycling enterprise TerraCycle.[4] This initiative allows the recycling of both aligners and their packaging, representing a commendable advancement in mitigating the environmental impact of such orthodontic therapies.

Additionally, each dental clinic had an opportunity to participate in this programme. Patients are advised to bring their aligners to dental practice, either during their next appointment or when they are nearby. They can then deposit aligners in the designated recycling receptacle at no cost.

E. Veseli, K. Veseli, E. Behluli, Pristina, Kosovo

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