Letters to the Editor

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Priority will be given to letters less than 500 words long.
Authors must sign the letter, which may be edited for reasons of space.

BACK DOOR DENTISTRY

Sir, some while ago I performed a clearance for a patient. I asked where he was to have his dentures made and he informed me that a technician he knew was going to make them. I enquired who and it was apparent that he was not registered to do this work. After a long while, having contacted the GDC, I have been informed that although the technician is not registered to make dentures they are not going to take any further action.

What does this say about the GDC who is supposed to be 'protecting patients and regulating the dental team'? What indeed is the point of registering everyone who goes through the back door of a dental surgery and then not acting when the rules are broken?

S. C. Bazlinton , Essex

Editor-in-Chief's note: Readers are informed that we asked the GDC if they wished to respond to this letter but were told that they were unable to respond unless details of the person working illegally were disclosed, but even then their response would be subject to their disclosure policy.

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PERSPECTIVE ON DENTISTRY

Sir, I would like to add further comment to P. Ramsay-Baggs' letter (*BDJ* 2009; **207:** 191) regarding the management of emergencies in practice. The maxillofacial hospital post was highlighted as being a good source of training and experience for such events – with management of the sublingual haematoma and risk of airway compromise (*BDJ* 2009; **206:** 449) being used as the example.

Yes, I understand the anxiety that some of our seniors within the deaneries have regarding 'dental' SHOs being responsible for patients (who are often quite unwell) on the ward, in A&E etc. May I raise the point that this has been the successful system for years in many institutions.

Indeed, I am not suggesting that following employment as a maxillofacial SHO, the individual has acquired the skill set of a registrar or consultant. If anything, the clinician has learnt to identify the potential clinical emergency, determine its urgency, make the appropriate referral and provide interim care/relief if within his/her remit. Surely, this can only serve to improve quality and consistency of care in both primary and secondary sectors?

As a recent graduate myself (2007), I have just completed six months as a maxillofacial SHO in a London teaching hospital following vocational training. I gained much exposure to a variety of hard and soft tissue facial and dentoalveolar trauma and emergency (often affecting the medically compromised patient) in a supported, safe environment. The time spent 'on call' was invaluable in developing diagnostic and management skills. One learns to prioritise clinical need, refine record keeping and surgical skills and liaise confidently with seniors and colleagues from other specialities.

I wholeheartedly agree with P. Ramsay-Baggs' suggestion of 'on call' being part of a compulsory F2 post and would go one step further in proposing a minimum six-month maxillofacial stint as part of foundation training. SHOs would only feel overwhelmed by, or incapable of, doing the job if they were poorly selected at interview and/or not offered sufficient support and teaching during their post.

I am yet to meet a colleague who regrets doing such a post. For me personally, it gave me perspective on dentistry in the 'wider context' of medicine, general confidence in 'people management' and sheer physical stamina!

M. C. de Souza,
By email

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CLARIFYING POINTS

Sir, we wish to thank Dr Short for her letter and would like to clarify a few points made about our Cochrane review.[1]

Firstly, the review does not suggest that extracting primary teeth is unhelpful, it does, however, point out to clinicians that the practice of extracting primary canines to aid the eruption of palatally displaced canines is not evidence-based. The study by Ericson and Kurol, from which the Royal College Guidelines are based, is a cohort study with no control.[2,3]

Dr Short commented that neither their study or the study by Ericson and Kurol were referenced; I suggest she reads the full review as both are quoted and referenced. With regard to the accompanying photograph of an infant shown in the news bulletin (*BDJ* 2009; **206:** 454) we agree this was inappropriate; the authors of the review were not involved in this publication. The full review states '80% of participants should be aged between ten and 13 years' and intervention prior to age ten is contra-indicated.

The example provided by Dr Short of a patient with bilaterally impacted canines is of interest, however, it is a 'case report' and therefore does not add to our evidence base. We appreciate that clinical experience is of great value, expert opinion and case reports help us

to make treatment decisions. Our feeling is that we still need to question our practice even when it is well-established.

In conclusion, the review neither discourages nor encourages the extraction of primary canines. It does clarify the need for well designed randomised clinical trials on this topic. I suggest that the review is read in its entirety. If anyone is interested in carrying out a randomised clinical trial on this subject, then I hope our systematic review is of help.

N. Parkin

On behalf of the authors

1. Parkin N, Benson P E, Shah A, Thind B *et al.* Extraction of primary (baby) teeth for unerupted palatally displaced permanent canine teeth in children. *Cochrane Database Syst Rev* 2009; **(2):** CD004621.
2. Ericson S, Kurol J. Early treatment of palatally erupting maxillary canines by extraction of the primary canines. *Eur J Orthod* 1998; **10:** 283-295.
3. The management of the palatally ectopic maxillary canine. RCS Guidelines, 1997 (revised 2004).

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DISPOSED TO ADIPOSE

Sir, I read with interest the article *Obesity and dentistry: a growing problem* (*BDJ* 2009; **207:** 171-175). This was timely for me as I also attended a clinical presentation by Professor Goran Dahloff at the FDI World Dental Congress in Singapore in September, entitled *Lifestyle and obesity - the link to general disease and oral health*.

Adipose tissue is loose connective tissue composed of cells called adipocytes and secretes adipokines in amounts proportional to the amounts of adipose tissue present. Adipokines affect the metabolism of the body and are thought to contribute to low grade systemic and vascular inflammation due to accumulation of gram negative bacteria and inflammatory mediators. Increasing body fat may stimulate a hyper inflammatory response as noted in periodontal disease. Obesity may have the potential for transforming the host's immunity and inflammatory system, causing the patient to be more at risk to the effects of microbial plaque.

Obesity is also associated with type 2 diabetes mellitus which results from inadequate insulin secretion to sustain normal metabolism and obese patients require more insulin to achieve this. The cytokine TNF, secreted by adipose tissue, is assumed to be critical in the pathogenesis of non-insulin dependent diabetes mellitus and in insulin resistance. Patients with type 2 diabetes are known to be prone to periodontal disease and obesity is also a risk factor for this and periodontitis.

I believe that obesity could therefore present dentistry with an opportunity to contribute to public health. Preventive interventions with a focus on children would be the key to health before obesity can cause the many medical conditions mentioned in the *BDJ* paper: hypertension, cardiovascular disease, diabetes mellitus, sleep breathing disorder, cancer, fatty liver disease, gall bladder disease, gastro-oesophageal reflux disease, osteoarthritis and reproductive problems. Dental professionals in primary dental care are well placed and could be central in children's obesity services in Primary Care Trusts Healthy Weight Healthy Lives clinical pathways. Similarly, a reverse process could take place with obese children with dental caries referred to primary dental care by both health and non-healthcare professionals such as school nursing teams, community paediatricians, dieticians, psychologists, paediatricians, healthy schools teams, school sports co-ordinators and secondary care clinicians.

P. Wee, Camden

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FOLK REMEDY

Sir, I write in response Dr Ballal's letter on oil pulling (*BDJ* 2009; **207:** 193). Oil pulling therapy with sesame oil has been extensively used as a traditional Indian folk remedy for many years for strengthening teeth, gums and jaws and to prevent decay, oral malodour, bleeding gums, dryness of the throat and cracked lips.[1] The concept of oil pulling therapy is not new and it has been discussed in the Ayurvedic text, *Charak Samhita* as 'Kavala Graha' or 'Kavala Gandoosha'. However, there is no scientific proof to support this therapy as a preventive adjunct, with online searches showing only testimonies and literature on personal experiences. With this in mind, randomised controlled pilot trials were conducted in Meenakshi Ammal Dental College, Chennai, India to assess the effect of oil pulling therapy on caries, gingivitis and halitosis.

A study group used oil pulling with a positive control group using chlorhexidine mouthwash. Both were equally effective in reducing *Streptococcus mutans* count over a six-month period and were better than tooth brushing alone.[2,3] There was no significant reduction in the DMF scores in either group after a follow-up period of one year. However, there was a statistically significant reduction of the pre- and post-values of the plaque and modified gingival index scores with a considerable reduction in the total colony count of the microorganisms in both the study and the control groups. Additionally. there was a definite reduction in the organoleptic scores and BANA test scores in both groups.

Oil pulling promises to be an effective preventive home therapy to maintain oral hygiene and research is currently in progress to discover its exact mechanism of action, which could open new doors in the field of research in oral health care.

S. Asokan, Chennai

1. Asokan S. Oil pulling therapy. *Indian J Dent Res* 2008; **19:** 169.
2. Asokan S, Rathan J, Muthu M S, Rathna Prabhu V *et al.* Effect of oil pulling on *Streptococcus mutans* count in plaque and saliva using Dentocult SM Strip mutans test: A randomized, controlled, triple blind study. *J Indian Soc Pedod Prev Dent* 2008; **28:** 12-17.
3. Asokan S, Emmadi P, Chamundeswari R. Effect of oil pulling on plaque induced gingivitis: a randomized, controlled, triple-blind study. *Indian J Dent Res* 2009; **20:** 47-51.

DOI: 10.1038/sj.bdj.2009.1144

AVERTING DAMAGE

Sir, I refer to the letter entitled *Odd practice* (*BDJ* 2009; **207:** 464-465) and would like to remind readers that atheromatous blockage is not confined to arteries but is at least as important as a neurological risk factor in the internal jugular vein.[1] Early warning of any blockage of blood supply to or drainage from the brain is vital to avert long-term neurological damage and any method that shows this is welcome.

A. Carmichael

By email

1. Zamboni P, Menegatti E, Galeotti R, Malagoni A M *et al.* The value of cerebral Doppler venous haemodynamics in the assessment of multiple sclerosis. *J Neurol Sci* 2009; **282:** 21-27.

DOI: 10.1038/sj.bdj.2009.1145