removable palatal expander presented to the ENT surgeons after the appliance lodged in his oropharynx after coughing. After two failed attempts at removing the appliance in the hospital's accident and emergency department, he was placed on the emergency list for removal of the foreign body under general anaesthesia.

When assessed by the anaesthetist, the patient, who preferred to remain sitting up, was unable to talk or swallow and drooled profusely as a result. His mouth opening was limited by discomfort and the acrylic of the appliance was barely visible. The patient's oxygen saturations were normal as were his other clinical observations.

An inhalation induction with sevoflurane was performed and inspection of the airway carried out under deep anaesthesia with the patient breathing spontaneously. A molar 'C' clasp had pierced his left posterior tonsillar pillar preventing retrieval of the appliance directly through the mouth. In addition haemorrhage from the oropharyngeal laceration started to complicate airway issues further. Fortunately it proved possible to intubate the patient despite the presence of the appliance. The appliance was removed following insertion of a Boyle-Davis tonsillectomy gag which provided access to the palatal expander which was subsequently unhooked and retrieved. Figure 1 illustrates the palatopharyngeal (PP) and palatoglossal (PG) folds before (left) and after (right) removal of the appliance. In the latter photograph, a retractor (R) has been inserted to demonstrate the laceration. The epiglottis (E), and endotracheal tube (ETT) are also shown. Haemostasis settled spontaneously (Fig. 1). The patient received intra- and post-operative dexamethasone and antimicrobials and was discharged home the following morning.

Although at least one case of tonsillar fossa laceration from an orthodontic appliance has been reported previously,¹ general anaesthesia was not required for its retrieval and such cases of upper airway trauma are unusual. It is not unheard of, however, for removable appliances or fixed appliance components to be either inhaled or swallowed. This case serves as a reminder of the need to avoid sharp

Fig. 1 Illustrates the palatopharyngeal (PP) and palatoglossal (PG) folds before (left) and after (right) removal of the appliance. In the latter photograph, a retractor (R) has been inserted to demonstrate the laceration. The epiglottis (E), and endotracheal tube (ETT) are also shown

'C'-clasps on removable appliances where possible and to ensure that the appliances are sufficiently retentive not to become dislodged.

K. D. Johnston
J. D. Snelling
By email

1. DiBiase A T, Samuels R H A, Ozdiler E, Akcam M O, Turkkahraman H. Hazards of orthodontics appliances and the oropharynx. *J Orthod* 2000; **27**: 295-301.

DOI: 10.1038/sj.bdj.2010.350

UNFOUNDED ALLEGATIONS

Sir, I am writing in response to the letter written by C. H. Griffiths complaining about his/her treatment at the hands of a body corporate (*Therapist woes*; *BDJ* 2010; **208**: 197-198).

I do not think that it was correct for the editor of the *BDJ* to have printed these unfounded allegations and I would be most surprised if a similar letter had been printed if the allegations had been directed at an individual dentist.

Published communications in the *BDJ* should be confined to points of general, political and/or dental interest, not individual grievances which only demean the letter writer and the reader. C. H. Griffiths has a very valid point to make regarding the non-availability of positions for therapists but that is a reflection of what the dental profession think about employing a therapist in general dental practice.

I am an associate dentist who has worked for the last eight years for a dental body corporate and in my experience the clinical governance of this particular company is far higher than many practice owners that I know.

By all means have a debate about corporates and where the profession is heading but please do not personalise and trivialise the discussion.

J. Fell
By email

DOI: 10.1038/sj.bdj.2010.351

LISTEN TO THE PEOPLE

Sir, I am moved to write after listening to the sad news re: the woeful performance of the Mid Staffordshire NHS Foundation Trust. This has been attributed to a tendency to pursue targets rather than patient care and in my view has parallels in dentistry.

Since the imposition of the new dental contract in 2006 NHS dentistry has been largely driven by the need to achieve a target number of UDAs.

Unfortunately the needs of the patient are often in direct conflict with the dentist's need to generate UDAs. For instance, if a new patient requires eight fillings and a root canal therapy this only generates three UDAs. The effects of this perverse disincentive to treat have been demonstrated in changed treatment patterns. For example the dental laboratories report a large fall in business and it is less common to provide more than a single crown in a course of treatment.

'Splitting' treatment has also become an issue which has been used to demonise dentists who in many cases are only trying to generate a reasonable number of UDAs from an extensive course of treatment.

That these problems would arise was obvious and widely predicted by GDPs.

I am very disappointed that instead of protecting patients and the profession from the effects of UDA targets the chief dental officer sought to defend the introduction of the system without even piloting it.

I feel that it is time that our leaders started to listen to the people who actually provide the treatment and abandon systems which do not promote quality care.

I. Massie
Pocklington

DOI: 10.1038/sj.bdj.2010.352