Letters to the Editor

Send your 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.

NO TO BDA

Sir, contrary to the view expressed by M. Austin in the 27 March 2010 edition of the *BDJ* (*Membership tardiness*; *BDJ* 2010; **208:** 244), dental care professionals (DCPs) have no need to join the British Dental Association – a professional association for dentists. DCPs have their own professional associations which provide information, support and advice on their specific professional requirements; provide CPD tailored to their professional needs; represent their members in discussions with the appropriate bodies; and, in most cases, offer indemnity cover designed specifically for that particular class of DCP (rather than being added on to a dentist's cover as an afterthought).

These DCP associations – contrary to M. Austin's description of them as 'disparate organisations' – work together when necessary on behalf of DCPs, whilst maintaining the individuality and integrity of the various professions which make up the dental team.

Any DCP who is seeking to join an association in order to obtain CPD, indemnity and professional support would be better advised to join their OWN professional association, run by and for members of their own profession, and designed to meet their own specific professional needs.

P. A. Swain, Chief Executive, British Association of Dental Nurses
M. Harris, President, British Society for Dental Hygiene and Therapy
C. Allen, Chief Executive, Clinical Dental Technicians Association
S. Adams, Chief Executive, Dental Technicians Association
R. Daniels, Chief Executive, Dental Laboratories Association/British Association of Clinical Dental Technicians
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PRISON DECISIONS

Sir, I read with much interest your editorial *Dentists behind bars* (*BDJ* 2010; **208:** 145). I am a Dentist with Special Interest in Prison Dentistry and attended the 3rd annual NAPD(UK) conference you mention.

Having been a prison dentist for some six years, I am pleased that the NAPD(UK) has brought this small proportion of the profession together and raised its profile. Recent recommendations regarding the reform of prison dental services[1,2] have been positive but the number of clinicians obtaining DwSI in PD remains low. Prisoners have significant dental health needs, have had little previous dental intervention and have a high proportion of mental and physical problems.[3,4] Ninety percent of prisoners have a mental health problem, a substance misuse problem or both. The demand for emergency care is high as inmates undergoing drug detox discover previously masked dental pain. Substance misusers also have a lowered pain threshold and are commonly dentally anxious. Lifestyle habits contribute to poor dental health as well as the substance misuse.[5] A high proportion of inmates have language and/or communication difficulties.[6]

It is unfortunate that the time when the role of the prison dentist has formal competencies in the form of DwSI contracts[2] has coincided with the current financial situation. I have recently had my clinical time reduced by a third and each year 3% of the prison dental budget is reduced. Under these circumstances, it is very challenging to offer a full service, as emergency patients are always prioritised. Such reductions may prove a false economy as the need for dentistry will not reduce and prisoners taken to outside hospital when the prison dentist is not available are escorted by prison officers, the cost of whose time is recharged to the PCT. It will not need many outside transfers before the cost of the reduced sessions is exceeded.

Each PCT is now responsible for commissioning services within prisons falling within their geographical area. With some PCTs having only one prison in their area, there are many commissioners who are faced with difficult financial decisions over a wide range of healthcare services with which they may not have direct experience or knowledge. There is a risk that all commissioners are required to independently familiarise themselves with prison dental services and current recommendations.

At the conference of NAPD(UK) it was obvious that there were many experienced and skilled prison dentists in attendance. It was, however, generally reported that some commissioners were reluctant to recognise demonstrated competencies by considering a DwSI contract, even when this is cost neutral. It is clear that if this field of dentistry is to provide the best standard of care with skilled clinicians, further attention by understanding commissioners is essential.

R. Edwards
Rochdale

1. *Reforming prison dental services in England - a guide to good practice.* Department of Health, 2006.
2. *Guidelines for the appointment of Dentists with Special Interests (DwSIs) in Prison Dentistry.* Primary Care Contracting and Faculty of General Dental Practice (UK), 2008.
3. Salive M E, Epiee H C, Fell P H, Jones J J, Rico M. Oral health status of a federal prison population. *J Public Health Dent* 1989; **50:** 257-262.
4. Lunn H, Morris J, Jacob A, Grummitt C. The oral health of a group of prison inmates. *Dent Update* 2003; **30:** 135-138.

5. Robinson P G, Acquah S, Gibson B. Drug users: oral health-related attitudes and behaviours. *Br Dent J* 2005; **198:** 219-224.
6. Bryan K, Freer J, Furlong C. Language and communication difficulties in juvenile offenders. *Int J Lang Commun Disord* 2007; **42:** 205-220.

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RUNNING PAIN

Sir, I am writing to draw readers' attention to an interesting phenomenon I have noticed following participation in ultrarunning events. Ultrarunning is a sport of increasing popularity which involves running any distance beyond the marathon which in some cases may be further than 100 miles. I have found that I will predictably have a painful soft palate for about two days following participation in such an event, with a minimum duration of 8-9 hours of running apparently necessary to provoke it. This pain occurs when swallowing only and appears to be related to the period of contact of the posterior tongue with the soft palate. It is intense enough to limit solid food deglutition to two or three cycles before it becomes unbearable, precisely at the time when eating is both necessary and greatly desired! During this two-day period the mucosa in that area seems to have a normal appearance. Fluids thankfully do not pose a problem and the symptom does not last more than 48 hours.

I believe the most likely explanation for this is a prolonged drying effect on the mucosa of the soft palate that may take place during these very long events. However, I do not know any other competitors who have experienced this and cannot find any mention of this symptom in the subject literature. Ultrarunning would therefore seem to be an unusual cause of palatal pain which has apparently not been previously reported.

B. Steel
Hull

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A POOR GRASP

Sir, regarding Mr Mew's latest letter (*Malocclusion challenge*; *BDJ* 2010; **208:** 197) he, yet again, demonstrates that he has not quite grasped the problem that other professionals have with his assertions. It is impossible to prove or test his hypothesis (or any hypothesis) with the debate that he asks for; what is needed is some form of experiment. Since orthotropics is apparently no different from functional appliance treatment, which has been shown not to grow mandibles beyond normal growth, then it would appear safe to assume neither does orthotropics. For Mr Mew's argument to hold water he needs to demonstrate, firstly, that orthotropics is an altogether different therapy from functional appliance treatment.

The advert that he has in the back of the *BDJ* shows a case that any orthodontist will have had similar success with, without invoking orthotropics. I know I have. With such a case the evidence suggests that success is dependent on normal mandibular growth and not on the brilliance of the therapy. Maybe Mr Mew is unaware that we can all get such a good result in some cases and show similar photos.

A. Pearson
By email

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DEPRIVATION MEASURES

Sir, I very much welcome the publication of *What is the effectiveness of alternative approaches for increasing dental attendance by poor families or families from deprived areas?* (*BDJ* 2010; **208:** 167-171). This important piece of research is essential for the future planning of dental services to meet the needs of the population both now and in the future, when increasingly primary dental disease will be concentrated in the most socially deprived and excluded sections of the population.

I was, however, concerned to see that in the paper it described children as having a high index of multiple deprivation (IMD). This demonstrates a misunderstanding of what the IMD is. The index of multiple deprivation[1] is an area measure of deprivation, not an individual measure of deprivation, such as the Registrar General's index of social class.

It is thus not possible to say that just because an individual lives in an area, where the overall population has a set of characteristics which give it a high deprivation score, that that individual is necessarily from a deprived background.

I trust that the authors of this paper find this observation useful.

D. P. Landes, Durham

1. Noble M, Wright G, Dibben C, Smith G A N *et al. The English indices of deprivation 2004.* London: Office of the Deputy Prime Minister, 2004.

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DENTAL STATUS

Sir, I viewed with considerable interest the short *BDJ* CPD paper *Dental implant failure associated with a residual maxillary cyst* (*BDJ* 2010; **208:** 153-154) and note that it made no reference to the following (probable) findings in the OPG report:

- Periodontal summary: generalised moderate-severe attachment loss
- Query the following at the teeth listed:
  - 17 probable lateral perforation with overfill of the perforation; probable apical radiolucencies, poor mesial fit of crown, under-filled root canals, probable periodontal furcation involvement
  - 15 short posts
  - 14 short posts, probable mesial overhang
  - 13 probable distal caries
  - 11 short post, probable apical radiolucency
  - 23 probable apical ligament widening, probable deep extension of wing/restoration onto root
  - 34 abutment defective margin, no post
  - 26(?27) probable short root treatment - distal canal; query sealer in sinus area, probable periodontal furcation involvement
  - 37 defective restoration, radiolucency mesial root, probable periodontal furcation involvement
  - 36 heavy overhang radiolucencies both roots
  - 34 defective distal restoration
  - 32 apical radiolucency
  - 44 short posts, distal overhang
  - 47 area implant, probable osseointegration failure.

Was the patient fully aware of his dental status, as indicated by the OPG, prior to examination, and if not was he advised of relevant findings by the referral centre?

P. Mc Crory
Radcliffe