

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.

DOI: 10.1038/sj.bdj.2010.406

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

DOI: 10.1038/sj.bdj.2010.407

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

DOI: 10.1038/sj.bdj.2010.408

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 deprivation¹ 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.

DOI: 10.1038/sj.bdj.2010.409

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