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.

AVM MANAGEMENT

Sir, a 16-year-old male presented with a history of pain and swelling on the right side of his face. On examination it was found that there was Grade III mobility of tooth 16. There was no history of any past or present significant illness such as coagulation disorders, liver disorders, prolonged hospitalisation or medications. He was put on antibiotics and pain killers to reduce the inflammation and swelling with instructions to report back after five days for extraction of the tooth.

The patient returned three days later with no decrease in the size of the swelling and was sent away with advice to continue medications for two further days. Routine preoperative investigations were not completed and the dentist planned to extract the tooth under local anaesthetic with adrenaline (1:80,000), which was administered. A jet of blood started gushing out as soon as the tooth was removed from the socket. The concerned dentist tried to achieve haemostasis with compression followed by an ice pack and ethamsylate 0.5 mg IM, but with no desired effect. The case was referred to the emergency department of a large tertiary level hospital and diagnosed as arteriovenous malformation (AVM). Bone wax and barrel bandaging along with a blood transfusion was carried out, however haemostasis could not be achieved and the patient was declared dead due to shock consequent to the blood loss.

On general examination at autopsy it was seen that there were dried blood stains all over the body, which looked pale. Gauze and wax packing along with ante-mortem blood clots were recovered from tooth 16's alveolar cavity, which was 1.5 cm in length, 1 cm broad and 3.5 cm in depth. The visceral organs were pale but no other abnormality was observed.

In this case radiological study may have shown little or no change at all but a CT scan may have shown the shape, extent and boundaries of the lytic expansion of intraosseous AVM. An MR study would have been the best imaging technique employed to study the vascular characteristics of the lesion, although angiography is currently the gold standard for determination of the location and flow characteristics of vascular lesions.

For management of small AVMs, most surgeons advocate embolisation of the feeder vessels in combination with intraosseous injection of embolising agents to permanently obliterate the lesion. For management of a large AVM, maxillectomy or mandibulectomy is the treatment of choice even though it is associated with significant disfigurement of the face.

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DCP COALITION

Sir, it was with some concern and disappointment that we, the undersigned, read of the BADN, BSDHT, CDTA, DTA and DLA rebuttal of a suggestion to 'join' the BDA in the 8 May edition of the *BDJ* (*BDJ* 2010: **208:** 379). Such a defensive and isolationist stance is a contradiction to the concept of a team approach to delivering patient care. While we disagree with M. Austin's description of DCP organisations as being 'disparate', and with his notion that DCP organisations should be encouraged to join the BDA as a means of increasing revenue (*BDJ* 2010: **208:** 244), we believe DCPs could benefit greatly from a closer affiliation to the BDA.

The British Orthodontic Society, which represents orthodontics and orthodontists in the UK, has actively engaged to affiliate its DCP colleagues into a coalition which is of benefit to the membership of all parties and to improving patient care delivery. The affiliation, which engages the British Orthodontic Society (BOS), Orthodontic National Group (ONG) and Orthodontic Technicians Association (OTA) does not seek to reduce the independence or integrity of these organisations but gives common ground, where common ground is both needed and useful.

We can only reflect on the positive outcomes of the closer affiliation between the orthodontic groups. We will continue to build on the team approach of ALL DCPs. We can only suggest that DCPs in the 'dental' field reconsider their current stance and adopt a more 'inclusive' approach.

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MOBILE DENTAL CARE

Sir, we have noticed the ongoing debate on how to solve the increasing oral health needs and demands of older people, recently highlighted by Dr J. E. Gallagher *et al.* (*BDJ* 2010; **208:** E6), and the question of poor access to dental care for frail older people, raised by P. Wright, and reviewed by C. Fox (*BDJ* 2010; **208:** 119-122). We would like to share some of our experiences in Sweden.

In the current Swedish public dental health insurance system, the cost of dental care for community-dwelling elderly, as well as certain other prioritised groups, is extensively subsidised by the Swedish County Councils. Individuals belonging to the subsidised