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.

LETTERS

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.

D. Nath, M. Kumath

Mumbai

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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.

L. Joffe, CEO BOS

J. Robins, CEO ONG

D. Worthington, Chair ONG

C. Bridle, Chair OTA

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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

categories are entitled to receive an annual oral health assessment, free of charge, and need to pay a relatively small individual fee for required dental care (ie dental care within certain limits), corresponding to the fee charged for visits at the health care centres in each individual county.

In the treatment programme developed by us, dental hygienists provide the elderly patients with annual oral health screenings in their homes. The dental hygienists also recommend daily oral hygiene measures, as well as professional dental contacts, on an individual basis. To facilitate the oral health screenings, an IT support system for field work was developed and implemented.¹ Thus, the dental hygienists use handheld computers for the field work data registrations, and the administrative staff receive the oral health data electronically to a back-office system, which is used for booking, invoice distribution, etc. The data are also stored in a database for epidemiological purposes.¹ Besides the reduced amount of paper work, most importantly, the lead times from diagnosis to provided dental care have been dramatically shortened.

Whenever needed, fully mobile teams provide the dental care for older people in their residences (eg bedside in nursing homes), with easily portable dental units. Thus, instead of exhausting patient transports to a clinic, often requiring sedative medication, older people are treated in their familiar home environments.

To improve the often insufficient oral hygiene among nursing home resident older people, an oral hygiene educational model has also been developed.² Since nursing staff often consider oral hygiene tasks unpleasant, methods from cognitive behavioural therapy were integrated into the education.² The educational model has shown promising results in terms of improved attitudes towards oral hygiene tasks among the staff members, and has sustainably improved the oral hygiene among the residents.^{2,3}

The dental profession needs to be integrated as a natural part of the current care-chains of older people. This is not only a matter of reducing suffering among older people, but can also lead to a considerable net gain in dental and medical care costs, since preventive dental

care is cheaper than restorative care, not to mention the costs of general health complications due to poor oral hygiene.⁴

P. Sjögren, M. Forsell, O. Johansson

By email

1. Forsell M, Häggström M, Johansson O, Sjögren P. Personal digital assistant application (MobilDent) for dental field work data collection, information management and database handling. *Br Dent J* 2008; **205**: 494-495.
2. Kullberg E, Forsell M, Wedel P, Sjögren P *et al*. Dental hygiene education for nursing staff. *Geriatr Nurs* 2009; **30**: 329-333.
3. Sjögren P, Kullberg E, Hoogstraate J, Johansson O *et al*. Evaluation of a dental hygiene education for nursing home staff after 1.5 years. *J Adv Nurs* 2010; **66**: 345-349.
4. Sjögren P, Nilsson E, Forsell M, Johansson O, Hoogstraate J. A systematic review of the preventive effect of oral hygiene on pneumonia and respiratory tract infection in elderly in hospitals and nursing homes: effect estimates and methodological quality of randomized controlled trials. *J Am Geriatr Soc* 2008; **56**: 2124-2130.

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UNFAIR SUMMARY

Sir, I wish to reply to the letter written by J. Fell (*Unfounded allegations*; *BDJ* 2010; **208**: 331) who responded to my letter that was recently published in the *BDJ*. I think it is only fair that readers are made aware that J. Fell was a dentist who knew me personally as a work colleague when I worked for the corporate dental company in question.

With respect, J. Fell is a retiring dentist who 'sold out' to the corporate company that he now works for. I remain bemused to say the least at his reply to my letter.

In writing my letter to the *BDJ* it was not my intention to air any 'personal grievances' publicly or make any 'unfounded allegations' as suggested by J. Fell. I think this was an unfair summary of my letter. I simply wished to express my genuine experience and concerns regarding the situation with corporate dental companies and the impact that I feel this is having on the reputation of dentistry in the UK.

I think the editor of the *BDJ* was right to publish my letter and I thank the *BDJ* for doing so.

C. H. Griffiths

By email

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ORAL SYSTEMIC INTERFACES

Sir, the apposition of an Assisted Conception Unit (now the Centre for

Reproductive and Genetic Health) to the clinics of the Eastman as observed by Mr Allen (*BDJ* 2010; **208**: 244) does at first glance seem unusual (it actually reflects our NHS partner's careful use of their resources). However, it does raise the issue of the relationship and integration of oral with systemic health and in turn the interaction of the delivery of dentistry with medical care.

It has long been known that the oral tissues may be adversely affected by systemic disease and that systemic illness may compromise the delivery of oral health care. There is now evidence that oral disease might drive common systemic inflammatory processes and chronic diseases. There are many other examples of possible oral systemic interfaces, and although some remain controversial, the clear message is that oral health is entwined with that of the rest of the body. As a consequence local decisions and national policies that could enhance possible integration of oral and systemic health care initiatives are welcomed.

S. Porter

London

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PUTTY TECHNIQUE

Sir, we read with great interest the letter *Intubation litigation* regarding the dangers of trauma to upper anterior teeth during intubation by anaesthetists.¹ This has been a long standing problem for anaesthetists and as the author described, a common source of litigation.

We would like to highlight to the readers a technique we devised with an anaesthetic consultant colleague of ours in 2007 that was published in *Anaesthesia*, and well received in the anaesthetic world.² It involves using silicone putty to protect the anterior teeth temporarily during placement of the laryngoscope.

It is simple to use for non-dentally trained physicians, cheap and extremely effective. It is now being regularly used by anaesthetists.

B. Collard, S. Lee, J. Azzopardi

By email

1. Esmail Z. Intubation litigation. *Br Dent J* 2010; **208**: 274.
2. Collard B, Lee S, Azzopardi J. Silicone impression putty for protection of teeth during intubation. *Anaesthesia* 2007; **62**: 1080-1081.

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