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.

ACUTE CORONARY SYNDROMES

Sir, acute coronary syndromes (ACS) are the most common cause of malignant arrhythmias leading to sudden cardiac death and can be encountered in dental practice.[1] Usually signs and symptoms of ACS are typical such as radiating chest pain, shortness of breath or sweating, but atypical symptoms or unusual presentations may occur with even craniofacial pain as the sole symptom of cardiac ischaemia.[2] This may result in missed diagnosis and treatment delay.

An 80-year-old man presented to the dental emergency department of a general hospital complaining of pain in the area of a dental extraction radiating to his forehead and neck. With a past history of hypertension and diabetes mellitus he had had teeth 14 and 17 extracted 12 days previously and clearly identified the procedure as the cause of the pain.

Extra-oral and intra-oral examination showed that there was no sign of alveolitis and oral palpation did not provoke pain. There was a general, moderate alveolar bone loss but no caries or other obvious pathology. Careful questioning revealed that symptoms had begun three days previously and that the craniofacial pain was accompanied by chest pain on walking, suggestive of angina pectoris. The patient was transferred to the medical emergency department for an electrocardiogram, where he was diagnosed a myocardial infarction with ST elevation. He was admitted to an Intensive Cardiac Unit and an angioplasty of the circumflex coronary artery with implantation of a sirolimus-eluting stent was performed without any complication.

Dentists may well have to deal with acute coronary syndromes with unusual presentations and atypical symptoms, sometimes as a toothache or craniofacial pain. It is crucial that, faced with this situation, detailed questioning is undertaken, especially if a dental context cannot explain the pain.

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Paris

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2. Kreiner M, Okeson J P, Michelis V *et al*. Craniofacial pain as the sole symptom of cardiac ischemia. A prospective multicenter study. *J Am Dent Assoc* 2007; **138:** 74-79.

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CDT IRONY

Sir, I was very amused to read Stephen Hancocks' editorial titled *Beware the irony of the humble full-full* (*BDJ* 2010; **208:** 327). As amusing as it was, it raises a few interesting points. Firstly, the demographic wave of the baby boomer generation and the fact that generally more people are living longer than ever before. Secondly, mastication is the first part of the digestive process and without the ability to chew food, digestion is compromised, diet is compromised, general health and wellbeing is compromised, life expectancy is compromised. Apart from that we also have communication problems, not only between those that can hear, but even bigger problems for those that have partial hearing or lip read. We could then go on to discuss the social and emotional problems associated with the loss of teeth. When you start to consider all of the above issues, the humble full-full or humble partial denture, fabricated and fitted by a humble clinical dental technician (CDT) is not so humble after all.

Technicians are aware of the current limitations in their scope of practice and will also be very aware of the fact that full-full denture clients will represent a decreasing proportion of denture wearers in the future. The role and scope of practice for CDTs must broaden and evolve quickly otherwise, as the editorial suggests, it would be ironic.

S. Judge
By email

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EQUAL ACCESS

Sir, I congratulate Owens, Dyer and Mistry on opening the debate about 'specialist services' for people with a learning disability (*BDJ* 2010; **208:** 203-205). There being no equivalent to the Salaried Primary Care Dental Services within general medical care, a DES (Direct Enhanced Services) payment for people with LD (learning disability) was introduced into the General Medical Services contract in 2008 in order to overcome the identified health inequalities and provide annual health checks for those on the Social Services LD registers. This was subsequently prioritised in *Valuing people now*[1] and is being monitored by strategic health authorities.

Uptake of the DES has been particularly slow amongst general medical practitioners in Surrey where I am conducting a pilot project and feasibility study to provide an annual oral health check linked to the annual health check and an oral health action plan as part of the health action plan.

In other parts of the country uptake has apparently been much faster and I would be interested to know what effect this has had on dental referrals both within the SPDCS and the GDS. I would

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