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

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.

F. Laurent, N. Segal, J. Foucher, P. Augustin
Paris

1. Arntz H R, Bossaert L, Filippatos G S. European Resuscitation Council Guidelines for Resuscitation 2005. Section 5. Initial management of acute coronary syndromes. *Resuscitation* 2005; **67** Suppl 1: S87-S96
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

be pleased to hear from colleagues who can email their comments and experiences to me at michele.howarth@surreypct.nhs.uk.

In Surrey, general dental practitioners were invited to take part in this initial project but were reluctant to do so unless a similar enhanced payment could be assured. Assessments will therefore be carried out by appropriately trained dentists from both of the counties' SPCDS. Any patients who are currently under the care of a GDP or who express a wish to be seen within the GDS will be referred on with an oral health assessment and oral health action plan.

I have no doubt that much can be achieved in the future by all branches of dentistry working together as part of an appropriately funded and managed network that will ensure equal access to appropriate dental care for all including those with a learning disability.

M. Golding, Surrey

1. Department of Health. *Valuing people now*. 2009. <http://valuingpeople.gov.uk>

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FORMALIN BURN

Sir, promoted by the paper by Gilvetti *et al.*,¹ we would like to report a further case. A 50-year-old male was referred to our oral medicine clinic complaining of a painful ulcer on his upper lip. The patient reported a previous history of long-standing recurrent aphthous stomatitis (RAS) that had been treated elsewhere without relief of the symptoms, which had recurred nine days previously. In an attempt to alleviate the local pain he placed cotton wool soaked in formalin (37%) on his upper lip mucosa. Oral examination revealed a white pseudomembrane covering an extensive ulcer (2.5 x 2.5 cm diameter) with irregular borders. The lesion was associated with intense pain during mouth opening and lip palpation (Fig. 1) and was diagnosed as traumatic chemically induced oral ulceration. The patient was informed about the risks of self-treatment without professional advice and received instructions to maintain excellent oral hygiene. The mucosa injury completely resolved spontaneously after 21 days of clinical follow-up (Fig. 2).

Fig. 1 Clinical features of the ulcer in the upper lip mucosa following the use of formalin

Fig. 2 Complete resolution of the ulcer after 21 days of follow-up

To the best of our knowledge this is the first case reporting an oral chemical burn associated with formalin, an irritating and toxic corrosive liquid that can be absorbed from all surfaces of the human body.²

A. C. P. Ribeiro, L. E. Simonato,
A. R. Santos-Silva, N. Perri de Moraes,
A. M. P. Soubhia, Brazil

1. Gilvetti C, Porter S R, Fedele S. Traumatic chemical oral ulceration: a case report and review of the literature. *Br Dent J* 2010; **208**: 297-300.
2. Pandey C K, Agarwal A, Baronia A, Singh N. Toxicity of ingested formalin and its management. *Hum Exp Toxicol* 2000; **19**: 360-366.

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HAND HYGIENE

Sir, it is difficult to find fault with the opinions contained within the letter written by J. M. Ewart and A. A. Jack entitled *Crass advice* (*BDJ* 2010; **208**: 243-244), highlighting their concerns, as educated patients and microbiologists, about the guidance from HTM 01-05 to prevent cross infection in dentistry. We entirely agree that it is easy to contaminate the sterile instruments before they reach the patient's mouth.¹

It is much easier to find fault with the advice from the Department of Health contained within HTM 01-05 on social hand hygiene: that we should only wash our hands after visiting the toilet if they become visibly soiled!²

We await with interest the results of the BDA's Health and Science Committee in scrutinising the evidence base for HTM 01-05, received from our CDO.

We do not suppose that it will include the meta-analysis of hand hygiene trials which shows that washing hands in the community setting can prevent gastrointestinal illness by 31% and respiratory illness by 21%.³

This is a pity as handwashing is such an important infection control practice.

G. Palmer, C. Plumb
By email

1. Ewart J M, Jack A A. Crass advice. *Br Dent J* 2010; **208**: 243-244.
2. Department of Health. Health Technical Memorandum 01-05: Decontamination in primary care dental practices. p 85. 2009.
3. Aiello A E, Coulborn R M, Perez V, Larson E L. Effect of hand hygiene on infectious disease risk in the community setting: a meta-analysis. *Am J Public Health* 2008; **98**: 1372-1381.

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BRASH APPROACH

Sir, I wish to support the comments by A. Carmichael (*BDJ* 2010; **208**: 441) on the refusal of the GDC to offer a reduced fee registration for retired practitioners.

In addition to the loss of know-how gained from 46 years at the chairside, in the present climate of difficulty in finding an NHS dentist willing to take them on, I am more and more being consulted by ex-patients or others who are in pain or in need of urgent treatment.

Yet as I discovered to my horror, non-registration bars me from writing even a private prescription for antibiotic or simple pain killer. Indeed I must not indulge in any form of succour for troubled citizens without risking the wrath of the law for illegally practising dentistry.

My retired medical colleagues do not get treated as criminals but may offer remedial help if approached by the public for guidance.

Apart from the insult which the GDC imposes on its retired members by this off hand and brash approach, there are many, many ways in which we could contribute to the profession, in all sorts of advisory capacities.

It really is time that GDC took a second look at its attitude to retirement.

G. Webster
Ayr

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