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.

NON-INVASIVE TESTING

Sir, we write prompted by the paper by Sproat *et al*. (*BDJ* 2009; **207:** 275-277) regarding screening for hypertension in general dental practice (GDP), as we recently carried out a feasibility study to assess the prevalence of previously unrecognised glycosuria in patients attending a GDP, inspired by the potential link between diabetes and periodontal disease.

We used simple urinalysis to give an indication of glycosuria, as in undiagnosed diabetes, which although exhibiting a low sensitivity compared with blood testing, is non-invasive and therefore potentially acceptable in a primary dental care setting as well as indicative of the need for further investigation..

A total of 195 adult patients took part in the study which involved them bringing a urine sample to the practice when attending for their routine dental examination.

Each sample was tested by one of the dentists in the practice using Bayer Reagent strips and the results recorded on a specially designed proforma. One patient tested positive and, with his consent, his GP was informed. He has now had a glucose tolerance test carried out.

The cost of materials delivered to the patients plus the reagent strips was in excess of £700, which could be regarded as a cost of £3.64 per completed test excluding the cost of staff time. If such testing was routine this cost would reduce considerably as sample bottles and reagent strips could be purchased in bulk and be given to patients rather than being posted.

The majority of patients who were invited, but who did not take part in the study had either changed or missed their appointment, forgot to bring a urine sample with them or were unwilling or unable to produce one at the practice. There were no adverse comments from those patients participating and the majority were supportive, both of the research initiative and of the concept of non-invasive testing outside a purely medical setting, considering that it was a valuable intervention and one that added value to their dental care. There was only one negative comment from a patient who declined to take part expressing the opinion that people had medical tests to excess. The high proportion of patients who agreed to take part could be considered to indicate a high level of acceptance of this form of testing.

Regarding the acceptance of urine testing by members of staff at the practice, there was some aversion by the non-dentally qualified team members to handling the sample bottles. However, other than this and within the limits of the study, it may be concluded that it is feasible to carry out simple health testing in the setting of GDP and the finding of one patient with glycosuria may be considered to justify this.

E. Cox
F. J. T. Burke
By email

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COMPACT CAMERAS

Sir, firstly, my heartiest congratulations to Dr Irfan Ahmed and the *BDJ* for the ten part article series on digital dental photography. It's high time the topic was treated with due respect.

I would like to put forward a few comments and queries in this regard.

1. Whilst discussing various camera types, the high end compacts offering manual controls like aperture, shutter speed, ISO and flash output have not been discussed at all, leaving a gap in the readers' knowledge of the various camera types
2. Whilst ruling out compacts, the primary justification given is parallax, whereas many, rather most current compacts don't have the Optical Viewfinder (OVF) and function only with the LCD or the electronic viewfinder (EVF), thereby avoiding parallax. Poor image quality resulting from less than ideal optics should basically be the reason for ruling out compacts
3. Most literatures refer to the ring flash as the ideal light source for dental photography, whereas the said series hardly talks about it, laying more stress on twin flashes, which to my understanding are primarily a requisite for aesthetic dentistry and not all other forms of dental photography since they illuminate anteriors better, not the complete oral cavity
4. Significance/rationale/utility of getting a 1:1 image with macro lenses (four incisors, as has been mentioned).

Where does the significance stand in taking full arch/occlusal pictures? What is the recommendation for orthodontic uses?

A. Naqvi
Lahore

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PSEUDOSEIZURES AND SURGERY

Sir, I would like to highlight to the readers the importance of awareness

of the 'pseudoseizure' patient in the surgical setting.

Pseudoseizures are paroxysmal episodes that often resemble epileptic seizures, but are psychological in origin. Stressful situations such as surgery under local anaesthetic are well known potential triggers of these episodes.

A 58-year-old Iraqi lady attended the maxillofacial department for the routine extraction of a tooth under local anaesthetic. The extraction was carried out without incident.

Ten minutes post-extraction I was urgently called to see the patient who had collapsed in the hospital stairwell. On inspection the patient was lying on the floor moaning, crying and exhibiting bizarre asynchronous movements. Her vital signs remained normal as she waxed and waned between periods of lucid normality and paroxysmal seizures. The on-call anaesthetist was summoned and supportive care was given in the anaesthetic recovery area until the pseudoseizures had completely subsided.

Good awareness of how to manage a pseudoseizure is vital to the surgeon, particularly when operating under local anaesthetic. These events can be extremely stressful for the patient, the patient's family and the dentist. Noting risk factors such as a history of abuse or trauma, or previous 'bad reactions to local', and recognising clinical features that differentiate pseudoseizures from epileptic seizures is vital. If the seizure-like episode persists or worsens experienced help should be sought without delay.

B. Collard, S. Johnson, L. Cascarini, S. Lee
London

Useful reading:

1. Haines J D. A case of pseudoseizures. *South Med J* 2005; **98:** 122-123.
2. Bowman E S. Pseudoseizures. *Psychiatr Clin North Am* 1998; **21:** 649-657.
3. Chabolla D R, Krahn L E, So E L, Rummans T A. Psychogenic nonepileptic seizures. *Mayo Clin Proc* 1996; **71:** 493-500.

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DURAPHAT SHORTAGE

Sir, I am writing to express my concerns over the current shortage of Duraphat varnish and inform my colleagues of the information I have obtained.

We are all aware of the Department of Health *Delivering better oral health* evidence-based guidelines which recommend the application of fluoride varnish twice yearly for all young adults and children and four times yearly for high risk individuals (for example those with special needs, orthodontic appliances and those likely to develop caries). The shortage of Duraphat varnish is therefore of concern to those of us wishing to avoid compromising our prevention regimes.

In respect of this I have contacted Colgate who informed me that the current shortage in supply is due to the unavailability of one of the major ingredients of the varnish and that the company do not expect Duraphat to be available to practitioners until January 2010. Having searched the market I have found an alternative solution, Clinpro White Varnish from 3M ESPE, which contains 50 mg of sodium fluoride per ml. Clinpro White varnish is easy to apply, requires the teeth to be only toothbrush-clean, is moisture and saliva-tolerant and has a pleasant mint taste. Please be aware of the recommended dosage which varies dependent on the patient's age. I hope this information is of use to practitioners.

S. Williams
By email

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BEYOND THE TEETH

Sir, the search for truth is behind all legitimate human endeavour. In our profession, the practitioner has to forever make clinical decisions based on a balance between acquired knowledge and the best evidence from research.

It was, therefore, enlightening to find these principles expressed in the letter from A. Toy (*BDJ* 2009; **207:** 345-346). 'We have to understand that no research finding can be applied directly to the problem in front of us... We have to exercise the skill of professional artistry to balance the heart and head.' Both these concepts are contrary to current practice guidelines.

Interestingly, in the same issue, F. B. Naini writes (*BDJ* 2009; **207:** 345) on the negative terminology of 'deaf and dumb' and states: 'The one true deafness, the incurable deafness, is that of the mind'. Perhaps we could serve our patients better if instead of blindly following the 'clinical correctness' of evidence-based dentistry, we employ in addition our clinical judgement based on the years of accumulated knowledge and experience.

We need to recognise the immense complexity of the stomatognathic system and its intimate relationship with the rest of the body. In particular, the dental occlusion and its relationship to head/neck posture and the healthy functioning of the rest of the body. Respiration, deglutition and jaw relationships must be considered when diagnosing and treating malocclusion. The research of early pioneers like Arnold Nove, who wrote on cervico-facial orthopaedia[1] along with many others, has been largely ignored by mainstream orthodontists in favour of a more rigid reductionist viewpoint. The treatment of malocclusion should be based on a more comprehensive understanding of its cause. Simply rearranging the teeth, minus a few premolars, to provide an aesthetic dental improvement does not fulfil our responsibility as physicians of the stomatognathic system. The demands of evidence-based research means that anecdotal reports are not considered when formulating treatment principles. Simple classifications of malocclusion into dental and jaw relationships ignore the often subtle complexity of individual variations.

The inevitable compensations involving head posture, the effects on the cervical vertebrae, spinal column and pelvic alignment require the cooperation and interdisciplinary work of physical therapists (eg osteopaths) if a comprehensive and stable result is to be achieved.

As a profession, we need to look beyond the teeth and jaws and recognise our full responsibility and the enormous contribution we can make to the general health and functioning of the entire body.

R. M. Dean
London

1. Nove A A. Cervico-facial orthopaedia. *The Dental Record*, February 1946.

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