

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.

Readers may now comment on letters via the BDJ website (www.bdj.co.uk). A 'Readers' Comments' section appears at the end of the full text of each letter online.

PRAISE WHERE DUE

Sir, recently there have been two letters to the editor in the *British Dental Journal* which reported on a very uncaring attitude demonstrated by an NHS organisation when an employee had experienced devastating personal circumstances. This led to resignation (*BDJ* 2011; 211: 151 and 2011; 211: 244).

I would like to report that my experience in LCFT has been quite the reverse.

On Friday 20 May my husband and I were woken at 2am to be told that our 29-year-old daughter, who had severe learning difficulties and lived with us, had kidney failure. I emailed my Clinical Director to say that I would not be able to work on the following Monday and before 8am she had replied and taken over that worry. Every attempt I made to work or support our daughter was made as easy as possible by the whole dental team. Sadly two months later she died.

We were very touched that a number of staff came to the funeral.

After two months on sick leave during which no pressure has been put on me to go back to work and during which I have been well supported by all my colleagues, I am starting the slow return to 'normality', and going back to work.

During this time, we changed Trusts so all these arrangements have been even more difficult to organise and have had to be authorised twice.

I hope that I will be able to repay the support by continuing to work for the Trust. We are all very quick to criticise. I would like to praise where it is definitely due.

J. Bairstow
By email

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JUST FOLLOWING ORDERS

Sir, an article/letter is always a pleasure to read as it will have been written from both the heart and the head.

M. Kelleher (*Abuse of dental practice; BDJ* 2011; 211: 347) speaks of the 'elective destructive dentistry' which we all see coming into our practices from elsewhere, frequently under that dentist's pretence of 'I'm only doing what my patient asked/told me to do'. The criminal defence of 'just following orders' did not work in the Nuremberg Trials and our colleagues should not use it to justify their abuse of the patient's trust in their professional ethics.

Anyone providing a service to another has the option to state that the request will not be to that person's long-term benefit and that alternatives should be explored. If the potential recipient persists in their demand then the provider always has the option to decline to provide such treatment, and yet this option seems to be unknown to those providing 'elective destructive dentistry'.

C. Marks
Southampton

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FOOD DEBRIS INDEX

Sir, measures of oral health are essential for epidemiological and clinical studies in order to provide accurate data for health promotion, prevention and therapy of diseases.

We recently performed an observational study on the oral and dental changes in a group of 12 elderly patients who were suffering from the chronic outcomes of stroke, including hemiplegia, and compared them with a healthy, matched control group.

There was an abundant accumulation of food debris in the mouths of the stroke patients which we were unable to classify with any of the existing indices¹⁻⁴ (plaque, oral health assessment and tongue coating). Although the Kaiser-Jones⁵ Brief Oral Health Status Examination (BOHSE) assesses the oral cavity and surrounding tissues and considers oral cleanliness, the evaluation is limited to the presence of tartar and/or foods on teeth and dentures.

We propose the following index which considers debris accumulation in the left and right vestibular oral arches, as a complementary tool to other indexes of oral cleanliness.

The examination of the oral cavity begins in the upper right quadrant, proceeding clockwise to the lower right quadrant, with a time requirement of all four vestibular arches of less than 30 seconds. Each arch must be rated by assigning a score from 0 to 3 (Table 1).

Using this procedure we calculated the OFDI value for the left and right

Scores	Criteria
0	No food debris in the oral fornix
1	Pinpoint food debris, accumulation in the vestibular arch of food debris less than 1 cm long (<1 cm)
2	Accumulation of food debris between 1 and 2 cm (>1, <2)
3	Accumulation of food debris more than 2 cm (>2)

halves of the mouth and with reference to the whole oral cavity. The index appears to have good specificity and sensitivity: most of the healthy subjects (n = 11) recorded score = 0, with one registering score = 1; in contrast, most

of the post-stroke patients recorded positive scores indicative of the inability to remove debris most likely on account of their neurologic disease.

These findings may offer care givers the possibility of quantifying the accumulation of food in their patients' mouth in order to be able to evaluate the positive effects of an educational programme directed at nursing staff.

M. Migliario, L. Rimondini
Italy

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EROSION AND POLYOLS

Sir, we read with interest the recent article by Nadimi *et al.*¹ The authors reviewed studies regarding sugar-free products and dental caries or dental erosion and raise a concern about sugar-free confections and dental erosion.

As stated in the paper by Nadimi *et al.*, 'polyol-based sugar-free products may decrease dental caries incidence.' What the authors failed to make clear is that the erosive potential of sugar-free confections actually is derived from acidic ingredients, which may be used in sugar-free products independent from polyols; these ingredients, not the polyols, directly create an acidic pH at the tooth surface.

Polyols are safe for consumption and it is well documented that they provide health and dental benefits. For example, polyols used to replace sugar in sugar-free products can help reduce overall sugar intake, diminish blood glucose response, reduce caloric intake, and lead to improved dental health. Scientists and regulators alike recognise that polyols do not cause tooth decay and labelling indicating this health benefit

is allowed in the US and the European Union as well as many other parts of the world.

Further, polyols can be used to replace sugar for various reasons, but not all sugar-free products are intended to be tooth-friendly. In tooth-friendly products, polyols replace fermentable carbohydrates (sugars) in order to reduce fermentation activity and the resulting acidic pH at the tooth surface. It is possible to successfully develop sugar-free confections with tooth-friendly properties, as shown by the large range of product examples in the marketplace. Those products can be identified by a tooth-friendly claim, in addition to the sugar-free claim.

Current research indicates that individual susceptibility to tooth erosion varies depending on one's behaviour, lifestyle, diet and genetic make-up. It is impossible to single out any one food or beverage as the cause of dental erosion considering the many factors that determine individual dental health, including the types of food consumed, the length of time foods stay in the mouth, the level of oral hygiene, and access to professional dental care.

H. Curtis Stevens
President, Calorie Control Council
(an international association of companies that make low-calorie, sugar-free and reduced-fat foods and beverages, including companies that make ingredients for those products. Companies that make and use polyols are among the Council's members)

1. Nadimi H, Wesamaa H, Janket S J, Bollu P, Meurman J H. Are sugar-free confections really beneficial for dental health? *Br Dent J* 2011; **211**: E15.

Corresponding author Sok-Ja Janket responds: In response to Dr Stevens' letter regarding our article¹ I would like to respond on behalf of my team. Contrary to Dr Stevens' allegations, we have clearly stated that sugar-free products might pose dental erosion risk 'if they contain acidic flavouring' several times in the article. Moreover, we have highlighted all the studies that have shown dental health benefits of polyols on the second and third pages.¹ We further clarified in non-scientific media that it is the acidic flavouring, not the polyols, that causes the harm.

The following are links to some of the interviews we have given.

Dentistry IQ <http://bit.ly/qowuP2>
Sydney Morning Herald <http://www.smh.com.au/lifestyle/diet-and-fitness/the-sugarfree-myth-20111019-1m6z5.html>
Beveragedaily.com <http://www.beveragedaily.com/Formulation/Sugar-free-drinks-may-generate-false-security-on-tooth-decay-study-finds>

The long term safety of polyols on general health appears to be unknown. We would like to inform readers that the European Union has banned the use of polyols in beverages according to a non-scientific medium which can be accessed via the following link. <http://www.beveragedaily.com/Formulation/Sugar-free-drinks-may-generate-false-security-on-tooth-decay-study-finds>

If Dr Stevens wishes to claim long term safety of polyols, she should provide references. For a person who works for an organisation promoting low calorie products, her opinion may not be impartial. This clear conflict of interest gives her comments very little credibility. A renowned diabetes researcher, Dr Bloomgarden, stated that direct testing to rule out human toxicity was not required for FDA approval (for nutraceuticals such as polyols), unlike the approach taken with pharmaceutical products.² Furthermore, Dr Stevens' claim that 'polyols reduce caloric intake' may not be entirely correct, because diet soda drinkers did not lose weight and the sweet taste actually increased the appetite.^{3,4}

As Stevens correctly stated, polyols substitute for fermentable carbohydrates in an attempt to reduce acid production by microbiota and thus decrease subsequent dental caries. However, some sugar-free products with acidic additives deliver acids directly to tooth surfaces which polyols were intended to reduce. So, what is the purpose of using sugar-free products? We encourage the artificial sweetener industry to prove long term safety by a randomised trial, not an epidemiologic study which is prone to biases. Our group is qualified to conduct such studies and has a proven history of not being swayed by outside pressures or established dogma.⁵