

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.

ADVOCATING CHANGE

Sir, I would like to congratulate Nairn Wilson CBE, Chairman, Oral Surgery Services and training Review Group and his team for the excellent MEE report on Oral Surgery Services and Training. Although this report looked at this situation in England, its findings can be equally applied to all of the UK including Northern Ireland. Indeed, an important part of the evidence behind the report was gathered in Northern Ireland.

Northern Ireland has had 'high street' OS (oral surgery) practices for nearly 25 years. Currently there are four OS practices with two satellite practices, employing 12 OS specialists. In the East of the province, home of the majority of the population, there is good provision of OS services in primary care. If the Department of Health Social Services and Public Safety (DHSSPS) is supportive of high street OS practice then the West will also benefit from similar services.

In 2009, the OS practices treated over 12,000 health service patients. Patients are primary referrals directly from general medical and dental practitioners. Not every patient can be treated in the primary care sector and the OS specialists refer appropriate cases to their colleagues in secondary care. None of us would deny that hospitals need OS specialists with appropriate facilities to manage difficult patients. Unfortunately, practitioners without access to OS specialists in practice refer patients to secondary care who could easily be treated in an OS practice. If the recommendations in the report are implemented the problem could be solved.

Last year the Western Trust in Northern Ireland awarded a waiting list

initiative contact to one of the high street oral surgery practices. These were patients that general medical and dental practitioners had already sent to the secondary care sector. Of 181, 180 patients were examined and treated without even setting foot in a hospital. One patient due to age was referred back to the hospital sector. The cost to treat these patients was just less than £30,000. Using the National Tariff figures the minimum cost per patient would have been £558. The total cost to a health authority would have amounted to £100k. Surely this must be attractive to any health authority in today's climate of financial pressures.

However, not everything is perfect even in Northern Ireland. The current 'fee per item' remuneration for OS specialists is totally outdated. It was designed for general dental practitioners. No OS practice could survive without cross-subsidising NHS practice with a significant number of private patients. The DHSSPS is currently negotiating with the BDA to design a pilot scheme for OS specialist practice. I sincerely hope the DHSSPS use this as a golden opportunity to create a new contract and thus cement high street OS practices across Northern Ireland for the benefit of all patients.

No system of care can survive and improve unless new young enthusiastic talent is developed and trained to take over from us 'oldies'. In Northern Ireland the training of OS trainees takes place in primary and secondary care. Trainees learn how to perform the surgery and run a practice. If the remuneration of specialists was addressed the system could be expanded to give the opportunity to specialise in OS to more trainees.

In life we cannot progress without change. This is one change I personally have been advocating for years and I look forward to when the recommendations of the report been implemented.

M. W. Curran, by email
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BEST OVERALL CARE

Sir, I would like to draw the readers' attention to an interesting case which I recently encountered in practice. A fit and healthy 20-year-old presented to me as an emergency complaining of pain from a lower right molar tooth. The pain had started approximately ten days previously and had gradually got worse becoming a constant throbbing pain, which painkillers were not helping.

On examination I noticed that the only molar teeth in his lower jaw were the first permanent molars. He did not recall having any extractions done. The lower right molar was extremely tender to percussion, and he was 'gingerly' pointing to this tooth as the source of the pain. This tooth had a large amalgam restoration present, and it was grade 2 mobile.

A long cone periapical radiograph was taken which is shown (Fig. 1). As can be seen the lower right six has secondary decay impinging on the pulpal space and a radiolucent lesion associated with the



Fig. 1 Long cone periapical radiography

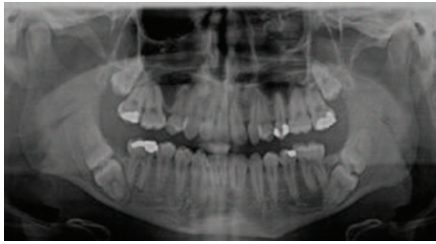


Fig. 2 OPG showing the lower left and right second and third molars impacting into one another

mesial and distal root. The lower right seven is distally impacted in to the mesially impacted lower right eight.

An OPG was taken to fully assess the extent of these impactions (Fig. 2). As can be seen, this patient has both the lower left and right second and third molars impacting into one another. He is also missing the upper lateral incisors.

Upon further questioning the patient said that from time to time he has felt bilateral tingling sensations in his lower lip, which have increased in frequency, and there have been periods when part of his lower lip has gone numb. This could be explained by the proximity of the inferior dental nerve to these impacted teeth and the possible resorption of the bone. The patient has now been referred to the local oral and maxillofacial unit for further investigations and treatment.

In the meantime we have explained to the patient that it is prudent to try and save the lower first molar, and we have commenced root canal therapy on the lower right six and other necessary restorative work.

This case highlights the importance of good radiographic examination to provide the best overall care for patients.

P. Raval, by email

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GIANT CALCULUS

Sir, we would like to present a very unusual case of giant dental calculus found on the maxilla and mandibular arches leading to facial swelling, lack of labial sealing and oral function impairments. The patient, who was female and 64 years old, was referred to the dental clinic of Varzelândia, Minas Gerais State, Brazil, due to a facial swelling and difficulties closing the lips. Her medical history revealed that she chewed tobacco, was malnourished and at gen-

eral clinical examination revealed a noticeable cognitive impairment. It was noted in the history that the lesion had 20 years of progressive growth and the patient had not sought dental evaluation in that time. Due to the lesion, the patient reported severe difficulties socially and in swallowing, eating and talking. General haematological and coagulatory exams, glycaemia and blood pressure tests were normal. Renal dysfunction and diabetes were not shown. At ectoscopy, an evident facial swelling leading to absence of labial sealing and a perceptible oral mass and loss of weight were seen. The clinical oral exam revealed an extensive painful whitish brown mass, with hard consistency, absence of bleeding and detachment from the dental surface, involving the mandibular and maxilla right arches, mimicking a neoplastic lesion (Fig. 1). The teeth had generalised severe periodontal disease, intense amounts of dental calculus and dental mobility and evidence of oral care was absent. With the clinical diagnosis of giant dental calculus, the patient was submitted to mass removal with periodontal curettes and dental extractions were performed due to the periodontal disease. Following this treatment, complete healing was observed. The calcified material was radiographed and submitted to demineralisation and to haematoxylin and eosin staining. The microscopic examination revealed an amorphous basophilic material with mineral crystals (Fig. 2).

Giant dental calculus has been previously described and could be associated with systemic conditions such as poorly controlled Type 2 diabetes.¹⁻² In this case, we removed the incredible size of the calculus and important oral function impairments associated with its presence. Microscopic findings also revealed basophilic material and crystals compatible with calcium phosphates.¹ Indeed, 'tumoral presentation' can lead to misdiagnosis.

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2. Minoru M, Akinori I, Hitomi S, Yumiko O, Shun'ichiro N. A case of a giant dental calculus suspected to be a neoplastic lesion. *Jpn J Oral Maxillofac Surg* 2004; 50: 442-445.



Fig. 1 The extensive whitish-brown mass mimicking a neoplastic lesion

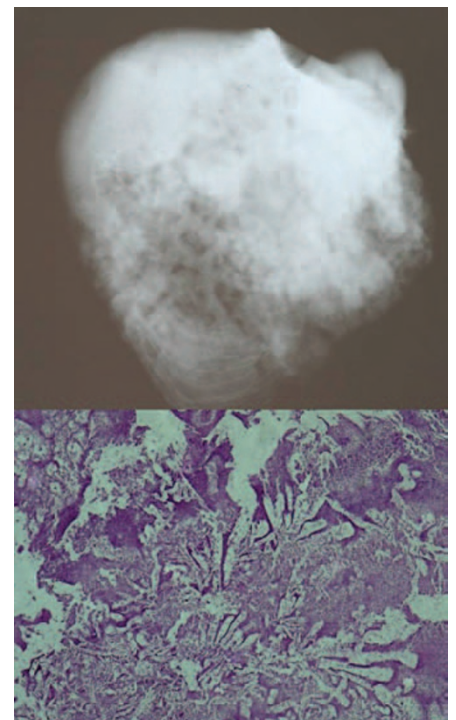


Fig. 2 Radiopaque lesion with dental involvement and pseudolamellar formation. Basophilic material with crystals formation (Haematoxylin and Eosin, low magnification)

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WRONG SIDE SURGERY

Sir, wrong side surgery is a rare occurrence but can have serious implications. In oral surgery taking a tooth out constitutes 83% of serious untoward incidents (*Beware of wrong tooth extraction*; Medical Defence Union, 8 December 2004).

The WHO surgical safety checklist is used in all theatres in hospitals across the country prior to every surgical procedure. In Whipps Cross University Hospital a Surgical Safety Checklist was instituted for all minor oral surgical procedures carried out under local anaesthetic as a measure to improve the standards of patient care. We are delighted to say that we have not had any wrong side surgery since then and audits being carried out every six months have shown 100% compliance.