Letters to the Editor

Send your letters to the Editor,
British Dental Journal,
64 Wimpole Street,
London
W1G 8YS
Email bdj@bda.org

Priority will be given to letters less than 500 words long.
Authors must sign the letter, which may be edited for reasons of space.

PLEA FOR TRANSPARENCY

Sir, the other day I received something very strange in the post: an anonymous letter from a 'concerned dentist'. I believe that I was not the only person to receive such a communication, but one of many, and the letter was specifically sent to executives of local LDCs.

Why anyone would write an anonymous letter, especially a dentist, beggars belief, but there was something about the content of the letter that filled me with sadness, dismay and unfortunately a great deal of sympathy.

The letter was in support of a dentist who had recently had their name erased by the GDC, and enquired what I, as an officer of the LDC and a GDPC member, was going to do about it. The letter then went on to castigate the injustice of a GDC whose non-professional membership outweighs that of the professionals. The flavour of the letter was also enhanced with what it describes as the stupidity of CQC as well as HTM 01-05, interspersed with a rant about unobtainable UDA targets and the strong arm tactics of the PCT. It was one dentist's total frustration with the system in which we work, which I suspect is echoed by many of us.

Addressing the points to an anonymous letter writer and hoping that he or she would read the answers is somewhat akin to sending a message in a bottle and throwing it in the North Sea when the tide is out. As I said my sensibilities were disturbed and therefore by making my answer and my thoughts as public as possible I can only hope that it might be read by the writer of the anonymous letter.

Firstly the LDC, GDPC and the BDA have no say whatever in a GDC matter, especially a fitness to practise one, and in my opinion rightly so. A practitioner who is called to account has representations from his or her indemnity society and is backed up by excellent solicitors and barristers.

There is no doubt that the numerical make up of the GDC and most of its committees is top heavy with non-dentists, a sore point for most of us as without adequate peer representation we will always be dubious that the defending dentist has had a fair hearing. The old adage 'it is not good enough for justice to be done, it has to be seen to be done' still rings true. I am not in any way saying that every dentist up before the GDC is squeaky clean, far from it, and many get their just desserts. However, the lack of transparency within the reporting of such cases leaves a lot to be desired. GDC communications rarely report the case in full giving the impression that the defendant dentist was hung drawn and quartered for a minor or single offence. My anonymous writer, after reading the GDC report about the erasure of this particular dentist, had put two and two together and come up with 38, and who could blame him or her.

May I respectfully suggest that the GDC, when reporting the outcome of a fitness to practise hearing, should just publish the name of the dentist and the outcome. Perhaps nothing more, other than to add a reference to a web page where a reader can find a full factual report which includes the names and qualifications of the committee members in attendance at the said meeting.

Surely a profession should have faith and trust in the people that govern and control it, be it the GDC or the CQC or indeed the offices of the CDO. Without faith and trust morale declines to such an extent that practitioners are forced to write anonymously in the hope that someone will hear their plea for transparency in the system and give them hope for the future.

S. Shimberg
By email

DOI: 10.1038/sj.bdj.2011.389

OMFS TEAM SNOOKERED

Sir, an 18-year-old man presented to the hospital at night team in our unit complaining of an alleged assault. He claimed that he was struck on the left side of his face. He was unaware of being struck with an object. There had been no loss of consciousness or other injuries. He had been drinking alcohol. There was no medical history of note.

Clinical examination revealed a 1 cm laceration on his left cheek. No other injuries were noted. The hospital at night team did not suspect a penetrating injury and therefore did not perform radiographic investigations. The provisional diagnosis of a simple facial laceration had been established. The oral and maxillofacial surgery (OMFS) team was asked to treat the facial laceration.

However, on examining the patient, the OMFS team noted left sided preauricular tenderness. For that reason, radiographs were ordered. These revealed evidence of a penetrating foreign body embedded in his left cheek (Fig. 1). The patient was brought to theatre to have the foreign body removed. Preauricular incision revealed a metal foreign body below the left zygomatic arch (Fig. 2). The foreign body was carefully removed and an 8 cm section of the tip of a snooker cue was removed, complete with the rubber tip (Fig. 3). The snooker cue had been lying in a tract from the laceration at the left cheek, passing

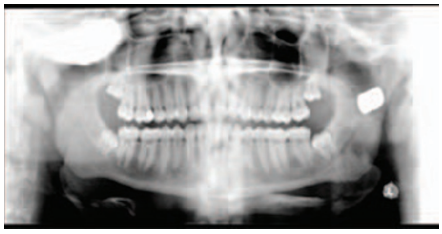

Fig. 1 Radiograph showing penetrating foreign body embedded in the left cheek

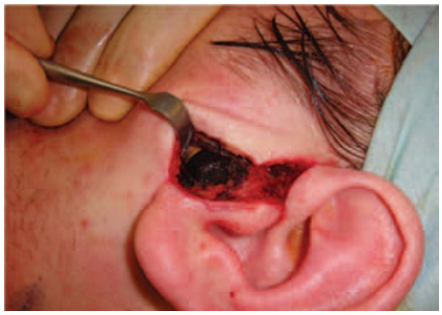

Fig. 2 The metal foreign body below the left zygomatic arch

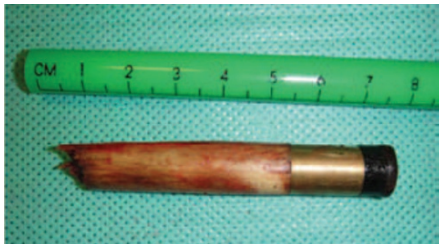

Fig. 3 The 8 cm section of the tip of a snooker cue complete with the rubber tip

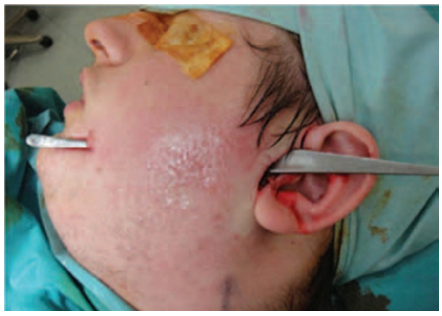

Fig. 4 Meticulous irrigation and debridement was performed and the wounds were closed primarily

superiolaterally up along the external oblique ridge of the mandible, and embedded beneath the arch of the zygoma. Meticulous irrigation and debridement was performed and the wounds were closed primarily (Fig. 4).

Penetrating facial foreign bodies are relatively uncommon.[1] However, their identification and removal from wounds is often necessary. In adults, most cases of soft tissue foreign bodies after trauma or accidents are asymptomatic. Symptoms, if present, could be pain or discomfort, local swelling and facial cellulitis.[2] The discovery of an occult penetrating facial foreign body on routine dental radiograph has been previously described.[3] However, their presence may not be considered if they do not show up on radiographs.[4]

The localisation of facial foreign bodies is important so that adjacent structure injury can be avoided and the time of removal can be reduced. Various imaging modalities, including plain radiography, xerography, computed tomography, and ultrasonography, have been advocated for detecting facial foreign bodies.[5] If plain radiographs, history and clinical examination fail to reveal the presence of superficial FBs, ultrasound or computed tomography can be used as an alternative method.[6]

Prompt diagnosis and appropriate treatment of penetrating facial injuries may lead to only minor sequelae. However, these patients may be in need of prompt resuscitation, due to bleeding both externally as well as intracranially. If an intracranial foreign body is suspected, urgent neuroimaging is mandatory to determine exact location and depth of the pen.[7]

This was an unusual case; firstly, there was absolutely no recollection of a snooker cue being used during the alleged assault and secondly, there was no exit wound suggesting a penetrating injury. Despite a history of assault, foreign bodies may not be suspected clinically leading to a delay in diagnosis. Clinical surgery is reliant on thorough history taking and careful examination. However, surprises can still occur and a surgeon has to be prepared for the unexpected. We recommend that hospital at night contact the maxillofacial team on call when suspected penetrating facial injuries present to the emergency department.

S. Colbert, M. Algholmy, M. Gray, P. Ramchandani

Poole

1. Ryu C H, Janf Y L, Kim J S, Song H M. Removal of a metallic foreign body embedded in the external nose via open rhinoplasty approach. *Int J Oral Maxillofac Surg* 2008; **37:** 1148-1152.
2. Tay A B. Long-standing intranasal foreign body: an incidental finding on dental rediograph: a case report and literature review. *Oral Surg Oral Med Oral Pathol Oral Radiol Endod* 2000; **90:** 546-549.
3. Kirtle P E, Aaron G R, Jones H L, Duncan N O. Incidental finding of an intra-nasal foreign body discovered on routine dental examination: case report. *Pediatr Dent* 1991; **13:** 49-51.
4. Robinson P D, Rajayogeswaran R, Orr R. Unlikely foreign bodies in unusual facial sites. *Br J Oral Maxillofac Surg* 1997; **35:** 36-39.
5. Ginsburg M J, Ellis G L, Flom L L. Detection of soft-tissue foreign bodies by plain radiography, xerography, computed tomography, and ultrasonography. *Ann Emerg Med* 1990; **19:** 701-703.
6. Oikarinen K S, Nieminen T M, Mäkäräinen H, Pyhtinen J. Visibility of foreign bodies in soft tissue in plain radiographs, computed tomography, magnetic resonance imaging, and ultrasound. An in vitro study. *Int J Oral Maxillofac Surg* 1993; **22:** 119-124.
7. Sharif S, Roberts G, Phillips J. Transnasal penetrating brain injury with a ball-pen. *Br J Neurosurg* 2000; **14:** 159-160.

DOI: 10.1038/sj.bdj.2011.390

SOUND VIA TEETH

Sir, I have a keen interest in advances in technology and find it a fascinating topic to keep informed of. As of late, I have learned of an exciting development which has recently been granted a European CE Mark and may possibly be a technology that could change the future of how personal audio is transmitted to our ears via our teeth.

A company in the USA has developed a hearing aid which picks up sound from a microphone located behind the ear and wirelessly transmits these data to a removable intra-oral prosthesis. The intra-oral prosthesis is attached to the patient's maxillary molar teeth and converts these data into vibrational energy via micro actuators which in turn is picked up by the cochleae bypassing the middle ear all by conduction of bone. It is intended for patients with 'single sided deafness, conductive hearing loss or mixed hearing loss' and is the first non-surgical and removable hearing prosthesis which transmits sound via teeth. The company claims it delivers high-fidelity sound and eliminates the need for surgically placed cochlear implants.

I can appreciate there will be refinements made to this device, and could be developed into exciting technologies of the future such as wireless intra-oral personal headphones, hands-free headsets for mobile phone users and even military communications. However, I can also envisage dental difficulties, for example, how this attaches in an edentulous patient, plaque retentive factors and risk of inhalation. Also if this device requires a repair would this become a service a dentist should provide and