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.

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.

LETTERS

PROCESSING ERRORS

Sir, we would like to draw your readers' attention to the potential for processing errors that can result when converting conventional film radiographs into digital copies by the use of a scanner. This is common practice for the purposes of electronic storage and transfer, where digital radiographs, from either direct or indirect X-ray sensors, are not available. Several recent orthodontic referrals to our department have identified inaccuracies in dental records accompanying referrals, with potentially serious consequences for the patient.

To illustrate the case in point, a recent hospital referral involved a 14-year-old boy with congenitally absent lateral incisors, who was referred for an orthodontic consultation. The dentist reported that the unerupted palatally ectopic upper left canine appeared to be causing severe resorption of the upper left central incisor. The referral was accompanied by printed copies of recent panoramic and upper occlusal radiographs that had been taken using conventional radiographic film, before being scanned for electronic storage.

In this case there was no left or right marker to orientate either of the printed radiographs, and clinical examination did not suggest anything untoward since both upper central incisors had a degree of mobility due to a traumatic occlusion resulting from a class III skeletal pattern. While considering options for surgical intervention, fortunately it was decided to take a supplemental radiograph to assess whether the upper central incisor had since sustained any further damage.

This additional radiograph revealed that the tooth that had undergone severe resorption was the contralateral incisor tooth to that which the dentist's referral and records had stated.

It transpired that both the upper occlusal and panoramic radiographs had inadvertently been flipped in the horizontal plane during conversion to electronic images but this error had gone undetected due to a lack of identification markers on the images accompanying the referral letter. Fortunately in this case, the error was identified prior to confirmation of the treatment plan, and any potentially serious consequences were averted.

We would like to highlight this potential for error, not only to those referring patients, but equally to those receiving referrals. All clinicians have a responsibility to ensure good clinical governance with respect to processing and storage of digital images, and must be vigilant to potential errors in dental records. Best practice must ensure that all radiographs have clear orientation markers included at the time of exposure, and that care is taken not to remove orientation markers either when cutting conventional panoramic films to size for storage in record cards, or indeed when cropping digital panoramic films to reduce the size of the file for electronic transfer.

E. Smithard, M. Coupland
Lincoln

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CROWDING WITH TOOTH WEAR

Sir, I have read the *BDJ* news story 'Less chewing linked to dental crowding' (*BDJ* 2012; 212: 10) and I would like to present a counterpoint.

We have examined an isolated indigenous population in the Amazon. One of our papers has been published in *PLoS One*¹ and our main results suggest that genetics plays the most important role in dental malocclusion aetiology, including mandibular growth and dental crowding.

I am including an intraoral image of an indigenous person showing dental crowding even in the presence of a severe tooth wear (Fig. 1).

Fig. 1 Dental crowding in the presence of tooth wear

D. Normando
By email

1. Normando D, Faber J, Guerreiro J F, Abdo Quintão C C. Dental occlusion in a split Amazon indigenous population: genetics prevails over environment. *PLoS One* 2011; 6: e28387. <http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0028387>

DOI: 10.1038/sj.bdj.2012.147

AN IMPOSSIBLE POSITION

Sir, it is apparent from the literature that there is no universal agreement in the management of bisphosphonate induced osteonecrosis.¹ Teeth with poor prognosis inevitably present a challenge and may result in significant morbidity with a direct effect on the patient's quality of life.

In view of the significant incidence of osteonecrosis in those taking oral

bisphosphonates even with no additional risk factors,² it is reasonable or even advisable to go to every length to maintain an intact dentition. Clearly there will be clinical cases where an extraction will be inevitable.

The root treatment of teeth with apical pathology is an effective procedure with very high success rates. Specialist endodontic colleagues report success rates in excess of 90% in selected cases.³ Such high quality endodontic treatment may avoid or significantly delay the requirement for extraction.

The current NHS contract fails to recognise the complexity and importance of endodontic therapy and puts general dental practitioners in an impossible position. Without improvements in funding to both enable them to easily provide quality endodontic care and, where necessary, ensure timely involvement of specialist endodontists, the number of cases of this debilitating and essentially untreatable condition will continue to rise.

I. Varley, A. Kanatas, L. M. Carter
Leeds

1. McLeod N M H, Patel V, Kusunale A, Rogers S N, Brennan P A. Bisphosphonate osteonecrosis of the jaw: a literature review of UK policies versus international policies on the management of bisphosphonate osteonecrosis of the jaw. *Br J Oral Maxillofac Surg* 2011; **49**: 335–342.
2. Otto S, Abu-Id M H, Fedele S et al. Osteoporosis and bisphosphonates-related osteonecrosis of the jaw: not just a sporadic coincidence – a multi-centre study. *J Craniomaxillofac Surg* 2011; **39**: 272–277.
3. Ng Y-L, Mann V, Rahbaran S, Lewsey J, Gulabivala K. Outcome of primary root canal treatment: systematic review of the literature – Part 1. Effects of study characteristics on probability of success. *Int Endod J* 2007; **40**: 921–939.

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NOT A PROPHET

Sir, apropos ‘how long will it last?’ in your editorial *The ethics of cosmetics* (BDJ 2011; 211: 501), I was a first born child, to my parents, in Darwen, Lancashire on 1 December 1922, and soon caught double pneumonia, being picked up once for dead.

My mother asked the doctor ‘will he get well?’ who replied ‘I am not a prophet, nor the son of a prophet’.

I am still here, paying my subs.

H. C. Green
Weston-Super-Mare

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KITCHEN STANDARDS

Sir, in the evening, I enjoy relaxing in front of the television watching *Masterchef* (other cookery programmes are available).

Is it just me or is it unusual to see that it is quite acceptable for chefs to put food they are cooking into pans with their bare hands, wipe their furrowed brows and dripping noses with the same hands, and then turn the food over, again bare fingered. Hair is then pushed out of tearful eyes with those artistic hands, tastefully adorned with a bit of blue Elastoplast (other sticky plasters ... etc) followed by a tasting of the exotic dish with a spoon then used to stir the dish. Those hands and spoons seem to be kept clean by a tea-towel tucked into their belt, so no hygiene issues there, and then we are happy to eat this food, maybe delighted or ecstatic.

Now, my question is, why didn't we use the people who decide on these commercial kitchen standards to negotiate HTM 01-05, or when drawing up CQC regulations? Then we wouldn't have needed 3-in-1 syringes; a quick blow into the patient's mouth would do, and we could have kept our long white coats on which to wipe our hands between patients.

By the way, I once had a meal in an Indian restaurant, where my companion found pieces of the chef's watch in the dish, and it was a Chicken Tikka. Honest!

C. Johnson
Kingsbridge

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