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.

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LETTERS

EASY ACCESS

Sir, I have discovered a cheap, simple and easy way of directly delivering Corsodyl gel to furcation areas which may be of interest to your readership. The Ultradent 1.2 ml disposable syringe can be loaded with Corsodyl gel easily as the syringe diameter matches that of

the gel tube. Once loaded the syringe tip is easy to direct into otherwise difficult to access furcation pockets (Figs 1-4). The tip is non-traumatic and if given to a patient can be used at home for many months assisting them greatly in their daily oral hygiene regime.

M. Lowey,
Norway

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DEFINITIVE CARE

Sir, we would like to take issue with J. Flexen's letter (*BDJ* 2011; 211: 399) regarding the management of maxillofacial patients in the Emergency Department (ED). The medical undergraduate curriculum broadly exposes students to most aspects of medicine and trains them to manage conditions safely. Doctors are also trained to seek senior help as appropriate. The medical degree would be a never-ending course if medics were expected to also competently manage dental conditions.

The role of the ED is to triage and stabilise acutely unwell patients. The breadth of knowledge demonstrated by the ED staff is outstanding and evidence-based. They need to be able to commence the initial management of patients, of any age and background, with any complaint which may present unannounced, from any medically recognised specialty. Within four hours, patients need to have been referred to another specialty for definitive care or discharged home.¹

It would be unfeasible to add further maxillofacial training to an already very packed medical curriculum, particularly when only a small fraction of medical graduates go on to work in emergency medicine. It is unrealistic

to expect the ED team to master skills which take dentists five years to learn. This attitude also undermines the role of the maxillofacial team. Definitive care should be provided by staff with appropriate specialist training.

The busy maxillofacial on-call shifts described are a reflection of how much the ED values your specialist skills and knowledge. You and your team should be proud to be able to provide such expert advice and high quality patient care. Lastly, we were concerned by the suggestion that our medical colleagues should attempt treatments such as dental incision and drainage. This risks compromising patient safety and would surely be illegal under the Dentists Act.

J. V. Williams, R. M. McKearney,
Bristol

1. Department of Health. *Reforming emergency care: first steps to a new approach*. London: Department of Health, 2001, publication no. 25635.

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HYPERMOBILE TONGUE

Sir, we would like to share an unusual finding seen in a 12-year-old child during routine oral examination (Fig. 1). He was able to move his tongue backwards beyond the uvula and reach the nasopharynx, as well as touch the tip of his nose with his tongue. The tongue appeared to be of normal size and position and the lingual fraenum was normal but stretchable, a condition that has been called idiopathic hypermobile tongue.

In another case, a 16-year-old boy with a hypermobile tongue which moved backward and reached the nasopharynx and who had a history of loud, disruptive snoring was treated with laser assisted uvuloplasty, which relieved the snoring in approximately

Figs 1-4 Applying Corsodyl gel to furcation areas using a disposable syringe

seven days.¹ In addition, there is an ancient practice in yogic art termed *Khecari Mudra*,² where the position of the tongue is designed to awaken spiritual energies in the body by stimulation of pituitary and pineal glands. Considered as the best of all the *Mudras*, people are trained to place the tip of the tongue on the uvula or in the nasal cavity behind the uvula.

Fig. 1 Open wide...

S. Surendran, E. Thomas,
Chennai
S. Asokan,
Tiruchengode

1. Cincik H, Cekin E, Gungor A, Poyrazoglu E. Does a hyperflexible tongue cause snoring? *Internet J Otorhinolaryngol* 2005; 3(2).
2. Definition of Khecari Mudra. Wikipedia. http://en.wikipedia.org/wiki/Khecari_mudra

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A CURIOUS PARADOX

Sir, the recent letter and articles by Kelleher¹⁻³ and the recent case reports in the *BDJ*^{4,5} which have featured veneers and all ceramic crowns have provided significant food for thought and raise some interesting questions.

The provision of ceramic crowns or veneers can result in prettier 'cosmetic' results which are likely to be met with some satisfaction by the patient. The question needs to be asked whether this treatment is unnecessarily damaging, both biologically and structurally, to the remaining healthy tooth tissue? The long term clinical justification for the removal of significant amounts of existing remaining sound tooth structure, particularly in patients who already suffer with tooth surface loss, always seems a curious paradox to me.

Like many others, I am concerned that the current popularity of cosmetic

dentistry seems now to have dominated 'sects' or 'cosmetic cults' to the point where the professional status of dentistry could be threatened. The combined drivers of financial incentives for the 'cosmetic' clinician, the patient's undoubted desire for an improved dental appearance, coupled with demand for immediate gratification of both parties, could result in a shift away from dental 'health' as the priority. The current growth of cosmetic dentistry has created a situation that could result in an epidemic of iatrogenically induced co-morbidities that will impact on patients and their future dentists for many years to come. Of course patients are 'fully' consenting adults, but to what extent is this consent 'fully' informed?

The recent Adult Dental Health Survey⁶ identified a cohort of patients with extensively restored teeth in their 50s and 60s, the so called 'heavy metal generation' who will require increasingly complex restorative support as they age. The future needs of the current generation of allegedly 'cosmetic' patients, whose teeth have been irreversibly damaged in order to provide elective ceramic restorations, can only be ignored by the most short-sighted of clinicians.

We as a profession are, just about, still regarded as traditional reliable professionals as are most doctors and lawyers. Electively destructive procedures, conveniently couched as 'cosmetic' treatment, with no significant long term health gain, involve real risk to patients and to our professional status. In dentistry is the 'customer always right'? Hairdressers cut and colour hair which requires significant skill, can change the appearance for better, or sometimes worse, but the customer can usually sit comfortably in the knowledge that their hair will eventually grow back.

One absolute certainty is that the healthy enamel and dentine that disappear up the suction tube will never return. In contrast the negative consequences of elective 'cosmetic dentistry' may remain with the patient forever and can potentially damage the patient-dentist relationship.³

Sadly, engagement of an air rotor inevitably means you are married to the subsequent problems.

A. Alani,
Newcastle

1. Kelleher M. Abuse of dental privilege. *Br Dent J* 2011; 211: 347.
2. Kelleher M G D. The 'Daughter Test' in aesthetic ('esthetic') or cosmetic dentistry. *Dent Update* 2010; 37: 5-11.
3. Kelleher M. Porcelain pornography. *Faculty Dent J* 2011; 2: 134-141. Available at www.rcseng.ac.uk/news/docs/Kelleher_Veneers_5_July_2011.pdf
4. Mizrahi B. All-ceramic silica/glass-based crowns - clinical protocols. *Br Dent J* 2011; 211: 257-262.
5. Rickman L J, Padipatvuthikul P, Chee B. Clinical applications of preheated hybrid resin composite. *Br Dent J* 2011; 211: 63-67.
6. NHS: The Information Centre for health and social care. Adult Dental Health Survey 2009 - Summary report and thematic series. 24 March 2011. Available at: <http://www.ic.nhs.uk/statistics-and-data-collections/primary-care/dentistry/adult-dental-health-survey-2009--summary-report-and-thematic-series>

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OLFACTORY ASSAULT

Sir, I write in response to P. R. Williams' letter (*BDJ* 2011; 211: 397). Throughout my career I have often heard of people wearing dentures constantly for several years, often because instructions to the contrary were never made.

I had never experienced such a case until I saw a patient on an emergency clinic in 2000. It transpired she had been wearing her upper partial denture constantly for 14 years, since 1986.

You can only imagine the assault on the visual and olfactory senses when I removed it to examine her mouth!

R. Kitchen,
Bristol

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INTER-PROXIMAL DAMAGE

Sir, Dr Kelleher is right to be concerned about over-prescription of veneering techniques.¹ Over-prescription of any treatment modality is inappropriate. Criminal damage is criminal damage and should be dealt with accordingly. He is also right to emphasise the potential for composite resin based solutions for anterior teeth aesthetic issues.

Dr Kelleher is, however, wrong, and in a sense abusing privilege himself, to continue to polarise discussion by over-demonising veneer provision. Ceramics are generally more aesthetic and longer lasting than composite resins. There is a much more interest-