Letters to the Editor

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LETTERS

BETTER PREPARED

Sir, further to the well-argued letter from Dr Len D'Cruz *A fascinating insight* (*BDJ* 2012; 212: 356), this is just what we are doing for final year students from King's College London. Working in an inner city Dental Academy with and alongside hygiene therapy and dental nursing students of the University of Portsmouth, the clinical teaching is delivered by general dental practitioners with accumulatively hundreds of years of high quality general dental practice experience. They are enthused and passionate about delivering an experience to the students that is both reflective and contemporary to modern dental practice. The aim of this primary care outreach experience is to bridge that gap between the dental school experience and FT1.

The Dental Academy operates to a PDS plus contract with UDA and KPI targets which is commissioned by the NHS commissioners in Hampshire and the Isle of Wight, with students providing appropriate care for patients. They learn to give brief interventions for smoking cessation and sign post for alcohol awareness and chlamydia screening. The restorative dentistry is far from being 'composite exclusive', with the students using both high level rotary and conventional endodontic therapy, amalgam restorations as well as getting to grips with surgical dentistry and immediate dentures. We are evaluating both the students' experience of team care provision as well as the actual dentistry they are doing with two concurrent PhD studentships. The students tell us they love the experience, which has been

reported many times previously by other outreach projects both in this country and in the USA.^{1,2}

We are confident with this approach that these very able young dentists are better prepared for general dental practice as 'safe beginners'.³ Moreover, they are well able to meet the challenges and benefit from the developments in dental practice over their next 30-40 years of practising life.

D. R. Radford, M. W. Woolford,
S. M. Dunne, S. Holmes
Portsmouth and London

1. Lynch C D, Ash P J, Chadwick B L. Student perspectives and opinions on their experience at an undergraduate outreach dental teaching centre at Cardiff: a 5-year study. *Eur J Dent Educ* 2010; **14**: 12-16.
2. Formicola A J, Bailit H L. Community-based dental education: history, current status and future. *J Dent Educ* 2012; **76**: 98-106.
3. General Dental Council. *Preparing for practice. Dental team learning outcomes for registration*. London: GDC, 2011.

DOI: 10.1038/sj.bdj.2012.619

METHADONE AND ORAL CARE

Sir, it has been found that methadone patients in Scotland are not being given effective, evidence-based advice concerning their oral hygiene.

Generally, dispensing pharmacists do not feel confident giving effective oral hygiene advice. To address this issue, an oral hygiene leaflet has been created using evidence-based advice where possible, as well as adding other carefully worded and helpful information.

This will be distributed to every dispensing pharmacy in Scotland to ensure methadone patients can be given effective, evidence based oral hygiene advice.

At university, I treated a patient who had never been given any form of oral hygiene instruction. This patient was

a long-term methadone patient with several carious lesions but very motivated to improve his oral health and, in particular, the appearance of his teeth. He associated the poor appearance with a 'misspent youth' and felt this contributed to his depressed state. To me, this patient was an opportunity not only to restore the teeth but also to impact positively on the psychological wellbeing and perhaps help the patient from methadone dependence altogether.

After talking with a number of pharmacists I found that, generally, most are not confident in delivering effective, evidence-based oral hygiene instruction to methadone patients. To tackle this problem, I created a leaflet (Fig. 1) using simple instructions which could be backed-up with evidence from an evidence-based dentistry textbook. Once this was achieved and set out in an appropriate way, several consultant

Fig. 1 Advice leaflet for methadone patients

from different specialities were asked to contribute. The leaflet was then taken to the Assistant Chief Dental Officer for Scotland, Mary McCann, who put me in touch with a dental public health consultant, Colwyn Jones, who has been instrumental in making the project a success through his contacts and previous experiences.

Further ideas were contributed by a second multidisciplinary group, this time involving specialist addiction pharmacists, and an NHS design team who ensured that the leaflet met NHS rules and regulations relating to the leaflet design.

It has taken three years, but finally, the number of leaflets chosen to be produced by NHS Scotland was 25,000. The cost of printing these was £627 (or 3p per leaflet). Dentists can now work alongside pharmacists in order to make a small but important contribution in reducing drug-related problems in Scotland.

G. Isherwood
Edinburgh

DOI: 10.1038/sj.bdj.2012.620

DIGITAL NATIVES

Sir, I attended the opening of the British Dental Conference and Exhibition in Manchester this year when Susan Greenfield OBE gave an excellent session. She spoke for an hour without notes, PowerPoint or any other visual aids but engaged the majority of her audience in such a spellbinding way that it was a surprise when she finished.

During her talk she referred to the 'digital native'. This describes a person who was born during or after the general introduction of digital technology and who has interacted with digital technology from an early age. She quoted research that some young people are spending 30 hours a week interacting with their screens. She suggested that this group of people have an under-developed hippocampus and referred to some evidence for this. One effect upon such a person is a lack of empathy. In my opinion empathy must rank alongside clinical skill and the ability to communicate, as one of the essential qualities needed by dentists.

During this talk I was surrounded by a group of young members of our profession who spent the entire talk turning the pages of their programmes loudly, texting or whispering to each other. What better evidence of the lack of empathy possessed by the 'digital native'?

After the session I spoke to a group of foundation dentists who had, like me, been thoroughly engaged by Baroness Greenfield and for whom the morning had been a genuine pleasure.

Perhaps the future isn't all bad!

M. Green

By email

DOI: 10.1038/sj.bdj.2012.621

LONG-TERM APPEARANCE

Sir, I read the paper by McDowall, Yar and Waring (*BDJ* 2012; 212: 417–423) with some concern. Most orthodontists would accept that dental and facial objectives occasionally conflict¹ and many now avoid closing anterior spaces for fear of 'dishing in the face'. Unfortunately the very regulations that are intended to protect patients may prevent them from making the most important decision about their treatment: 'will it improve my long-term appearance?' Valid consent is only possible if patients can be shown facial photographs of alternative approaches; see www.orthotropics.com.

The authors also recommend moving the lateral incisor mesially without tilting. If this is attempted after the apex has closed noticeable root resorption will take place² especially in laterals.³ They also recommend intrusion but this may increase root resorption even more.

Root resorption often followed by mobility is routine following fixed appliances^{4,5} but due to a lamentable lack of research we are quite unable to forecast the long-term consequences.

J. Mew

By email

1. Bowman S J, Johnston L E Jr. The esthetic impact of extraction and non-extraction treatments on Caucasian patients. *Angle Orthod* 2000; **70**: 3–10.
2. Kjaer I. Morphological characteristics of dentitions developing excessive root resorption during orthodontic treatment. *Eur J Orthod* 1995; **17**: 25–34.
3. Mohandesan H, Ravanmehr H, Valaei N. A radiographic analysis of external apical root resorption of maxillary incisors during active orthodontic treatment. *Eur J Orthod* 2007; **29**: 134–139.
4. Jönsson A, Malmgren O, Levander E. Long-term

follow-up of tooth mobility in maxillary incisors with orthodontically induced apical root resorption. *Eur J Orthod* 2007; **29**: 482–487.

5. Kuroi J, Owman-Moll P, Lundgren D. Time-related root resorption after application of a controlled continuous orthodontic force. *Amer J Orthod Dentofacial Orthop* 1996; **110**: 303–310.

DOI: 10.1038/sj.bdj.2012.622

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FAILED SMILE DESIGN

Sir, we would like to take this opportunity to add to the debate highlighted in *Ethical issues in cosmetic dentistry* by M. Kelleher (*BDJ* 2012; 212: 365–367) and show how failure of this type of cosmetic dental treatment can impact on a patient's life.

Our community dental service treats patients with moderate to severe special care needs. It is uncommon that we come across patients who demand 'ideal smile designs', as our patients generally have pressing complex social, medical and psychological problems to deal with. We were therefore surprised when this 26-year-old female, who is homeless with other complex problems, presented to us as an emergency patient seeking help with her veneers, which she complained 'would not stay on' (Figs 1–2). Further examination revealed 12 veneers extending from UL6 to UR6 of which five had failed. On questioning, the patient revealed that they were fitted less than a year ago, under sedation, and when the veneers

Figs 1–2 A 26-year-old patient with failed veneers and multiple deep carious lesions