A second traumatic incident is not uncommon in active young boys. However, in this particular instance he had been relaxing, or slouching as his mother put it, at home on the sofa playing a game on his iPad 2. Such was his excitement or absorption in the game that he dropped the iPad 2, hitting his tooth and decoronating it. We believe that this may well be the first incident of dental trauma by iPad 2 and wish to bring it to the attention of the profession so that the dangers of ownership may be taken into consideration when treating and advising patients!

We prescribe a mouthguard for those who play contact sports. Should we now consider doing the same when we know that our patients own an iPad 2 and in the knowledge that an obvious danger to the developing dentition exists? Perhaps we should consider referral for lessons in deportment as injury is surely less likely when slouching is removed from the equation? Can we take any positives from the incident? Is there now a potential gap in the market for mouthguard provision to the iPad 2 owning population? And significantly, it is surely another point in favour of encouraging an active lifestyle in our patients given the obvious danger to the developing dentition when sedentary in one's own sitting room.

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SYSTEMIC HEALTH SCREENING

Sir, reviewing the literature reveals an abundance of suggestions as to how the dental professional can investigate issues related to patients' systemic health.

Screening for hypertension, diabetes, HIV, obesity and excessive alcohol consumption are but a few that have been discussed.¹⁻⁵ The mindset underpinning these ideas is noble, as the dental profession is in an ideal situation to interact with patients who may not visit any other primary health care provider.^{4,6} Systemic considerations by dentists can be valuable additions to improving the nations' health, particularly in detecting asymptomatic conditions.⁷ One example is Engström *et al.*,⁸ who excellently demonstrated the value of screening

for hypertension in Sweden, and there seems to be no real reason why this effect could not be duplicated in the UK.

We are aware of referral letters contacting general practitioners and where necessary facilitating pathology requests, however, the dental professional in the UK seems reluctant to participate in these potential interventions.^{1,3} Sproat *et al.*⁹ list possible limitations to hypertension screening, though many of these can be applied to other similar interventions. Reviewing the literature in the UK and abroad outlines barriers, mainly related to referral and lack of guidelines related to screening in dentistry. Guidance is surely needed to ensure our role doesn't expand exponentially and impractically to consider factors far beyond our resources.

We can exercise individual discretion, of course, possibly relating to conditions affecting the provision of oral health foremost.² Examples include checking blood sugars of a patient with refractory chronic periodontitis for example, or measuring the blood pressure of an obese 50-year-old who has admitted to not taking their prescribed antihypertensives. Modern clinical practice strives to be evidence-based and using our discretion is insufficient to fully facilitate optimum patient care beyond the oral cavity. In the UK, we should strive to echo the efforts implemented internationally.

With even basic guidelines in place, we could be assured of the value of referrals we may generate whilst being sure we are appropriately using our limited clinical time. Does anybody else feel the need for clear guidance to ensure we can optimise our patient care beyond their dental health, whilst not venturing beyond our traditional role?

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DOUBLY IMPOSSIBLE

Sir, I wish to endorse wholeheartedly the views of Varley, Kanatas and Carter (*An impossible position*; *BDJ* 2012; **212**: 153-154) in their wish to improve access of appropriate care for those patients on bisphosphonates. I would like to add to this 'impossible position' from my perspective for those patients who are on or about to commence high dose intravenous/oral bisphosphonates as part of their oncology care for their multiple myeloma or for their metastatic bony lesions from breast, prostate or renal carcinoma.

Where I work as a consultant in special care dentistry (SCD), the SCD and oncology teams have worked very hard and closely to be proactive in the care of this cohort of patients. We now have a streamlined/fast-tracked referral system which endeavours to see these patients as an absolute priority *before* commencing their bisphosphonate treatment, as they are at an even higher risk of developing bisphosphonate related osteonecrosis of the jaws (BRONJ) following exodontias, or, spontaneously.

Although they are being referred from an oncology consultant to a SCD consultant, and 50% of the time are seen in a hospital location, there is a catch. I am employed as a consultant in primary care and as such these patients are subject to the normal NHS patient charges as they would be on the high street (other than normal exemption). For many of these patients these charges come at a time when they are not receiving their usual salary, when they are already having to come to terms with their diagnosis, difficult treatment and prognosis, on top of the