Letters to the Editor

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LETTERS

SMOKELESS EVIDENCE

Sir, I write further to the news item (*BDJ* 2012; 212: 310) and draft guidance by the National Institute for Health and Clinical Excellence recommending a greater role for dental professionals in smokeless tobacco cessation.¹ While this is a welcome move, making the guideline to specifically target the South Asian population is unjustified because smokeless tobacco (ST) use is prevalent in all communities and also globally eg Sudan (*toombak*), Sweden and other European countries (*snus*) and even in the USA where about 3.5% of the population currently uses ST.²

Secondly, there are issues regarding effectiveness and cost-effectiveness of tobacco cessation interventions pertaining to ST use. The evidence available for the efficacy and cost-effectiveness of pharmacotherapy for ST is highly inadequate as compared to that for smokeable tobacco. A recent Cochrane review on the effectiveness of available pharmacotherapy on ST use concluded that there is inadequate evidence to comment upon the efficacy of these interventions.³ The dose of nicotine absorbed per use of ST, the physical sensations, reinforcement, ease of availability and the level of societal acceptance are different for the two habits, and there is also no separate model to assess cost-effectiveness of tobacco cessation medications for ST. The most commonly used BENESCO model used for measuring cost-effectiveness for smokeable tobacco is not recommended because it takes into consideration only four tobacco-related diseases, not including dental problems, oro-naso-pharyngeal cancers and pre-cancerous lesions like oral submucous fibrosis.⁴

Many questions therefore still need to be answered.

B. Chatterjee, New Delhi

1. National Institute for Health and Clinical Excellence. Public Health Draft Guidance. *Tobacco: helping people of South Asian origin to stop using smokeless tobacco*. UK: NICE, February 2012. Available from: www.nice.org.uk/nicemedia/live/12999/58278/58278.pdf (accessed Sept 2012).
2. US Department of Health and Human Services. *Results from the 2008 National Survey on Drug Use and Health: National Findings*. Substance Abuse and Mental Health Services Administration, Office of Applied Studies, 2009. <http://oas.samhsa.gov/12nsduh/2k8nsduh/2k8Results.pdf> (accessed August 2012).
3. Ebbert J, Montori V M, Erwin P J, Stead L F. Interventions for smokeless tobacco use cessation. *Cochrane Database Syst Rev* 2011; CD004306.
4. Critchley J A, Unal B. Health effects associated with smokeless tobacco: a systematic review. *Thorax* 2003; 58: 435–443.

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BANANA ROOT FRACTURE

Sir, a 92-year-old male patient attended as an emergency stating that his bridge and a tooth had fallen out that morning whilst eating breakfast. He was in no pain and reported that he was medically fit and well. Examination revealed a 23-year-old avulsed three unit fixed-fixed bridge retained from a maxillary left canine and metal post in the left central. The patient also presented a tooth-like item measuring approximately 15 mm by 8 mm by 6 mm with signs of apex, root groove and potential root fracture all being noted. Intra-oral clinical examination revealed abutments without signs of significant damage but no sign of the loss of any tooth and absolutely no signs of soft tissue abnormality. The reason for the tooth-like structure remained a mystery and manipulation of the apical crack revealed a potential root canal space and further speculation that a tooth root had indeed been lost. Without evidence of any tooth avulsion the dif-

ferential diagnosis of the foreign body was nothing more than conjectural and mysterious; odontome, salivary calculus? Only further and detailed questioning as to the contents of the patient's breakfast elucidated that he had indeed been eating a bran based product supplemented with dried fruit...the mystery was solved...dried banana! The perils of a healthy breakfast led to much merriment for all and a lesson learned on the need for a detailed diet analysis on occasion.

R. McAndrew, A. Bowkett

By email

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STEP IN THE RIGHT DIRECTION

Sir, I read with interest the news article published in the *BDJ*, *Microscope created for early oral cancer diagnosis* (2012; 213: 9). I am of the opinion that Britain is playing second fiddle to the Americans when it comes to oral cancer screening in general practice and this is something we should encourage our practitioners to pay more attention to on a daily basis.

The above article highlights that the invention was conceived at the University of Texas and this should come as no real surprise. During my recent visits to the United States where I was shadowing a variety of dentists throughout the Carolinas, I was in awe as to the effort spent per patient on oral cancer screening. Every patient was routinely given a standard visual oral cancer screening followed by the use of a solution called ViziLite. For your readers who may not be aware, ViziLite is a solution the patient uses to rinse their mouth, after which the dentist performs an oral inspection using a disposable handheld light source to pick up any potential dysplastic areas.

Appropriate clinical management is then taken on any 'suspicious' lesions.

Recent announcements by the GDC that 'Oral Cancer: improving early detection' is to be included as a recommended topic in the CPD scheme is definitely a step in the right direction and one that we as a profession must build upon. By increasing awareness of the disease amongst our patients as well as continually educating our dentists in the latest methods and techniques, I feel that we will be one step closer to controlling cancer rates in our communities.

A. Bains, Hertfordshire
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THYROID PROTECTION

Sir, the American Thyroid Association (ATA) has recently published¹ its recommendations that thyroid protection should be provided to all patients undergoing head and neck radiography in order to reduce the risk to the thyroid gland from ionising radiation: 'With regards to dental X-rays, the ATA recommends the reduction of thyroidal radiation exposure as much as possible without compromising the clinical goals of dental examinations.'

The risk to the thyroid gland from ionising radiation has been well documented. Dr Elaine Ron of the Radiation Epidemiology Branch, National Cancer Institute, USA, and her colleagues in their enormous 1995 study of thyroid cancer² following exposure to external radiation of the head and neck region concluded that: 'The thyroid gland in children has one of the highest risk coefficients of any organ.'

Whilst a relatively rare disease (2,300 cases are diagnosed in the UK each year), the number of thyroid cancer cases in the UK continues to rise, with the highest rate of increase being in the cohort of young females (15–35 years of age).³

Current US,^{4,5} European⁶ and UK⁷ guidelines appear to be clear and unequivocal on the necessity for shielding the thyroid gland during dental radiography. In the course of delivering radiography and radiation protection training ('IR(ME)R' courses) throughout the UK, I encounter a widespread lack of knowledge amongst my dental colleagues either that such a risk exists or

that national and European guidelines recommending the use of thyroid collars during routine dental radiography are still extant – despite no longer requiring the use of 'lead aprons'.

In light of the recent publication of the ATA's recommendations, is it perhaps time for us as a profession to review the necessity of using thyroid protection on our patients whilst undertaking diagnostic imaging? (See Fig. 1.)

I. Hamilton
By email

Fig. 1 Upper anterior periapical radiograph. The likelihood of illuminating the thyroid gland in the primary beam increases if the patient has a shallow palate or raises their head

1. American Thyroid Association. *Policy Statement on Thyroid Shielding During Diagnostic Medical and Dental Radiology*. June 2012. www.thyroid.org/wp-content/uploads/2012/06/ATA_Policy_Statement_June_2012.pdf (accessed August 2012).
2. Ron E, Lubin JH, Shore RE *et al*. Thyroid cancer after exposure to external radiation: a pooled analysis of seven studies. *Radiat Res* 1995; **141**: 259–277.
3. Cancer Research UK. *CancerStats: Cancer Statistics for the UK. Thyroid cancer incidence statistics*. <http://info.cancerresearchuk.org/cancerstats/> (accessed June 2012).
4. National Council on Radiation Protection and Measurement. *2003 Radiation Protection in Dentistry*. Bethesda, MD: NCRP Report No. 145, National Council on Radiation Protection and Measurement.
5. American Dental Association Council on Scientific Affairs. The use of dental radiographs: update and recommendations. *J Am Dent Assoc* 2006; **137**: 1304–1312.
6. European Commission. *European Guidelines on radiation protection: the safe use of radiographs in dental practice*. Luxembourg, Netherlands: Office for Official Publications of the European Communities, 2004.
7. National Radiological Protection Board. *2001 Guidance notes for dental practitioners on the safe use of X-ray equipment*. London: Department of Health, 2001.

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BARRED FROM CONSIDERATION

Sir, the GDC's requirement for all dental nurses to be either qualified or on a training programme is having unintended consequences for our profession.

Local colleagues and I have employed nurses with recent qualifications from a local training college only to find they have little knowledge of how to handle dental materials and are unable to do even basic charting. Without this latter skill they risk the wrong treatment being done to a patient and they are therefore unsafe working in a practice despite possessing a qualification approved by GDC, whose principal role is the protection of the public.

In contrast, I recently needed to employ a part-time dental nurse, a position which would be ideal for a lady who used to be a dental nurse before raising a family and now wishes to do a few days' work. Such ladies are normally highly dependable as well as having a breadth of life experiences which count for so much when interacting within a team and with the patients. Several such ladies would have been ideal but they were unable to consider the post as they have no formal qualifications and it is unreasonable to require them to undertake a 'recognised training programme', at extra cost and in their own family time, for something which they can do standing on their head.

Additionally, each of us GDPs works in our own quirky way and finding the right nurse can be a fine art.

The GDC's well-intentioned rules are therefore forcing a whole group of potential team members to be barred from consideration for positions to which they are ideally suited. This can surely not have been the intention of the GDC and so I propose an alteration to the GDC's rules: dental nurses who have had several years of experience before taking a career break should be allowed to return to work under the supervision of a nominated dentist; that dentist would then be entirely accountable for the actions of that nurse; there could also be a form of in-house assessment which could gain recognition from the GDC.

By adopting this scheme, the profession would welcome back a whole group of eminently suitable (but not officially qualified) nurses, dentists would be able to work with a nurse who matches their quirky ways, and the protection of the