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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SMILE INFLUENCE

Sir, the authors of *The influence of maxillary central incisor height-to-width ratio on perceived smile aesthetics*[1] are to be complimented on the ingenuity of this study and the beautiful pictures illustrating the variations of the length of the central incisor in relation to the width. This subject has been studied in great depth over the years, to find the optimum aesthetic ratio for length of central incisors.

With regard to the study, the authors clearly illustrate that the optimum ratio of a single incisor is an 80% to 82% ratio but what they didn't say was that this is the **width of the two incisors together** as in Figure 1.

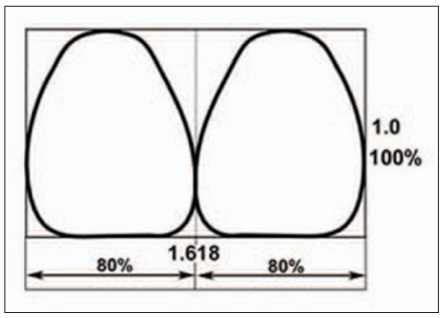

Fig. 1 The Golden Proportion rectangle

As a pair they fit perfectly in the Golden Proportion rectangle (Fig. 1).

1 is to 1.618
As 100 is to 160
160 = 2 × 80

This relationship was described simultaneously by both Stephen Marquardt of the USA and Win Senior of Manchester and was included in my article in *Aesthetic Dentistry* May 2011 (volume 5, number 3, page 25, diagram 14). Also to be found on my website, www.goldenmeangauge.co.uk/dental.htm.

The two central incisors together have the strongest influence on the aesthetics of the smile. It is most unusual to look at the length-to-width ratio of a single incisor, because they are naturally seen and evaluated as a pair. Similarly, one never looks at one eye, but always gets an impression of the two eyes, together, unless of course one deliberately wants to look at one eye or one central incisor.

The Golden Proportion is so often seen in the beauty of nature; why should we not expect to see it in the beauty of natural teeth? In this respect, I find myself in total agreement with Mr P. Erridge's response.[2]

E. Levin
By email

1. Cooper G E, Tredwin C J, Cooper N T, Petrie A, Gill D S. The influence of maxillary central incisor height-to-width ratio on perceived smile aesthetics. *Br Dent J* 2012; **212:** 589–599.
2. Erridge P. The golden ratio. *Br Dent J* 2012; **213:** 489.

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DRAINING THE PUS

Sir, with reference to the letter from P. Williams on fat faces and swellings (*BDJ* 2013; **214:** 48), I am pleased to learn that early interventional treatment for dental abscesses is being employed in emergency dental services. The so-called 'traditional teaching' of routinely prescribing antibiotics for dental abscesses and arranging extractions at a subsequent visit is certainly not contemporary teaching in our oral surgery department. Early reduction of bacterial load in dental abscess by removing the cause of infection and draining pus is essential in preventing further spread of infection. Cases of failure of local anaesthesia for extraction are extremely rare in our unit, even with severe dental abscesses, as careful consideration is given to appropriate type and volume of anaesthetic agent and the importance of local anatomy. Although emergency dental clinics can be busy and dentists are often under time pressure, and I write from personal experience in these services, one would hope the basic principles of decreasing the bacterial load early through drainage or extraction for dental abscesses, rather than relying on antibiotics alone, is one that is firmly fixed in clinicians' minds.

C. Fleming, Bristol

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DENTAL APPEARANCE

Sir, I read your editorial in the 8 December issue with similar interest that I read them all, but found your discussion on the appearance of 'British teeth', the potential psychological benefit of good dental appearance and whether cosmetic dentistry should be allowed on the NHS particularly interesting. To help answer the latter question, may I suggest that there might be a clue in examining the questions asked in recent Adult Dental Health Surveys?

In 1988, the question was asked 'Are you happy with the appearance of your teeth?' Readers may be interested in the findings, namely, that the response was 'yes' for 79% of respondents with four or more anterior crowns, 'yes' for 63% of those with one crown (perhaps indicating our difficulty in getting one anterior restoration to blend with the remaining dentition), 76% for those with six sound anterior teeth and 84% for those with six or more teeth on a denture. Reasons for dissatisfaction with appearance were, for

dentate adults: colour of teeth (38%), alignment/position (36%), spaces in the mouth (13%) and colour of fillings (11%). I fully expected that these questions would be repeated in the 1998 Survey, but they were not. Knowing that a further survey should be scheduled for 2008, I wrote to the Department of Health in 2007 suggesting that these questions be reinstated. I do not recall receiving a reply, but sufficient to add that these questions on dental appearance were not part of the most recent Adult Dental Health Survey, although the severity of oral impacts on some basic functions of daily life was, at least, assessed.[1] You and your readers may draw your own conclusions.

F. J. T. Burke, Birmingham

1. White D A, Tsakos G, Pitts N B *et al.* Adult Dental Health Survey 2009: common oral health conditions and their impact on the population. *Br Dent J* 2012; **213:** 567–572.

DOI: 10.1038/sj.bdj.2013.279

RELOCATING THE JAW

Sir, I write in response to the letter from K. Parker of London regarding their unfortunate experience of a patient dislocating their jaw while performing RCT.[1] There are a few points I would like to make which may be of benefit. Firstly, jaw dislocation is relatively common and can occur during any form of dental treatment, extractions or oral surgery. It can also become dislocated during other scenarios: seizure, oral sex, eating, yawning and vomiting.

The acutely dislocated mandible is often exquisitely painful and timely reduction is paramount for a variety of reasons. It can be done with ease in the dental chair and does not always require administration of local anaesthesia. The earlier a reduction is performed, the easier it is to do, and less likely that the patient will require hospital treatment for sedation or general anaesthesia. There two main techniques of reduction but misconception surrounds both of them frequently. It is a subject often never covered, or poorly covered, in dental school as K. Parker alludes to. This leaves many dentists in fear of attempting reduction at all.

K. Parker describes the classic teaching of 'push back and down' which is incorrect and will fail in a large proportion of patients to reduce the dislocation. The most successful position in which to stand is behind the patient (and most dentists are used to this position, the opposite can be said for doctors). Placing the thumbs onto the external oblique ridge and the fingers under the lower border of the mandible, slowly increasing force should be applied in a caudal direction to overcome the spasm of the temporalis, pterygoid and masseter muscles. Very little 'posterior' force is required as once the condylar head is inferior to the articular eminence the muscle pull will draw the condyle back into the fossa and reduce the dislocation.

For further reading there is a good paper in the literature outlining the anatomy, aetiology and treatment of this injury.[2]

A. V. Parbhoo
By email

1. Parker K. Dislocated jaw. *Br Dent J* 2012; **213:** 377.
2. Luyk N H, Larsen P E. The diagnosis and treatment of the dislocated mandible. *Am J Emerg Med* 1989; **7:** 329–325.

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TICKING TIME BOMB

Sir, I was very interested to read the views of Dr D. Howarth expressed in the letter *Implants and dementia* in the *BDJ* 2013; **214:** 47. Dr Howarth's experiences are evidence of the increasing problems that lie ahead for some patients with implants and those who care for them. He confirms what many of us have feared, that implants are indeed a ticking time bomb.

Managing the consent process with a patient who has a compromised tooth isn't simple. There are costs and drawbacks to any solution. In an age where the implant companies market themselves with great force and allure, I suspect that endodontic treatment and re-treatment are occasionally overlooked as options.

The literature on the survival of implant supported restorations compared to restored endodontically treated teeth is pretty unequivocal. Whilst they both have the same survival rates,[1] there are some overlooked facts to consider. When treatment planning for restored endodontically treated teeth it must be stated that once treatment is completed to a high standard no further intervention is necessary. Implant supported restorations on the other hand need continued intervention throughout the life of the patient such as prosthetic repairs, loose screws, lost implants and more.[2] This is not very desirable for an ageing and sick population. Furthermore, patients who have had endodontics completed to a high standard report an improved quality of life after treatment.[3]

It was my concern to encourage patients to understand more about their choices when they have a decayed or infected tooth that inspired the saving teeth awareness campaign (www.savingteeth.co.uk).

I enjoyed Dr Howarth's decision to retain his premolar gaps. When I'm on the London Underground, I often think that the 'mind the gap' mantra could translate well into the dental world, a reminder that the advanced solution today could become a problem for those of advanced age tomorrow.

J. Webber, London

1. Iqbal M K, Kim S. For teeth requiring endodontic treatment, what are the differences in outcomes of restored endodontically treated teeth compared to implant-supported restorations? *Int J Oral Maxillofac Implants* 2007; **22 Suppl:** 96–116.
2. Doyle S L, Hodges J S, Pesun I J, Law A S, Bowles W R. Retrospective cross sectional comparison of initial non surgical endodontic treatment and single-tooth implants. *J Endod* 2006; **32:** 822–827.
3. Dugas N N, Lawrence H P, Teplitsky P, Friedman S. Quality of life and satisfaction outcomes of endodontic treatment. *J Endod* 2002; **28:** 819–827.

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LOCAL OPERATIVE MEASURES

Sir, we read with interest the letter by Dr P. R. Williams entitled *Fat faces and swellings*[1] that recently appeared in your publication. We agree with Dr Williams that the importance of local, operative measures in the treatment of odontogenic infections cannot be overstated. Whilst we are presently undertaking a Cochrane Systematic Review regarding the effects of systemic antibiotics on symptomatic apical periodontitis and acute apical abscess in adults,[2] current clinical guidelines published by the Scottish Dental Clinical Effectiveness Programme (SDCEP) state that 'dental abscesses should be treated by local measures in the first