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.

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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

instance' and only if 'local measures have proved ineffective or there is evidence of cellulitis, spreading infection or systemic involvement' should an antibiotic be prescribed.[3] Indeed, in the majority of cases of dentoalveolar abscesses, drainage and removal of the source of infection are the only treatments required.[4]

Failing to attempt a surgical procedure (be it extraction, endodontic treatment or soft tissue incision and drainage) when a patient presents with a dentoalveolar abscesses represents a missed opportunity to deal with the cause of the infection. Furthermore, prescribing antibiotics and delaying dental extraction risks the patient developing a potentially serious head and neck infection. Inappropriate use of antibiotics also contributes to the emergence of antibiotic resistant bacterial colonies within the worldwide community, which has become one of the most pressing public health threats of our time. When you consider that dentists in England and Wales are responsible for the prescription of 9% of all primary care antibiotics,[5,6] it becomes clear that we as dental practitioners have an important role to play in the responsible use of these drugs.

We therefore applaud Dr Williams' attitude to the management of this and other patients and would encourage other colleagues to do the same: always attempt local, operative measures when faced with odontogenic infections.

A. Cope, I. G. Chestnutt, N. Francis, Cardiff

1. Williams P R. Fat faces and swellings. *Br Dent J* 2013; **214:** 48.
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4. Ellison S J. The role of phenoxymethylpenicillin, amoxicillin, metronidazole and clindamycin in the management of acute dentoalveolar abscesses – a review. *Br Dent J* 2009; **206:** 357–362.
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MONETARY METAPHOR

Sir, 'Purse with teeth', eh? (*BDJ* cover, volume 214 issue 2). I think we can do better than that! As soon as she saw the artwork on the cover our dental nurse immediately came up with an alternative: snappy, memorable, a metaphor for our times: 'Ah,' she exclaimed. 'Money talks!'

Well done, Jenny!

J. Le Couteur, Featherstone

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COSMETIC TONGUE SPLIT

Sir, a 30-year-old male attended the A&E department at Whipps Cross Hospital complaining of temperature, severe pain, swelling and difficulty eating, swallowing and bad taste following the cosmetic split of his tongue by a tattooist. Examination revealed a bifid tongue (Fig. 1). The cut edges were approximated with a cotton thread-like material, swollen, erythematous and tender to touch. The patient was pyrexic with elevated blood pressure. Local anaesthesia was infiltrated into the tongue; the 'sutures' were removed, the tongue cleaned with betadine and the edges re-approximated using absorbable sutures. The patient was admitted overnight for intravenous antibiotics and steroids and discharged the following day.

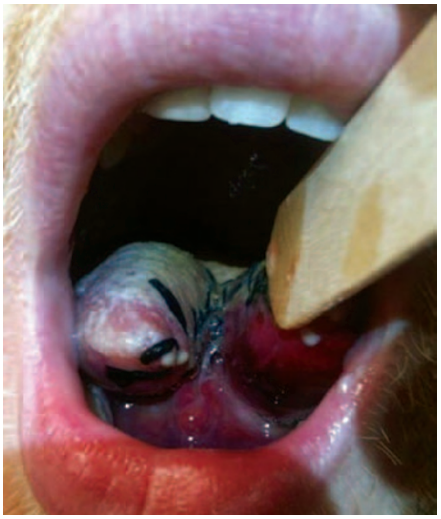

Fig. 1 Bifid tongue on presentation

All surgery carries risks but in the case of tongue surgery, specific risks include bleeding, swelling, lingual nerve damage, infection, scarring and speech distortion.[1] Failure to assess medical history prior to performing such surgery could have morbid consequences. Sterilisation of equipment in an autoclave and disposable gloves are necessary to avoid transmission of infections such as hepatitis and HIV.[2] Psychological evaluation of patients wishing to undergo body modification or mutilation procedures is also an important part of pre-operative assessment to identify disorders such as body dysmorphic disorder.

When a random sample of tattooists in the East London area were telephoned and asked if they carried out tongue splitting, none of them alleged that they were licensed to perform it. We contacted the General Medical Council, who advised that the procedure carried out by the tattooist was not classed as 'surgery' as it was carried out for 'cosmetic rather than health reasons'. They stated that they are solely responsible for regulating registered medical professionals and had no jurisdiction over tattooists.

There is no minimum formal training requirement for tattooists, and no clear laws preventing a tattooist from carrying out a cosmetic tongue splitting procedure. Consumers have protection under general consumer law if they are dissatisfied, and may report tattooists to local authority enforcement officers.[3]

Healthcare professionals should consider petitioning the government to introduce regulation and registration for tattoo artists and banning procedures that involve cutting or stitching by non-medical professionals.

F. Aga, R. Harris
By email

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2. Fleming P S, Flood T R. Bifid tongue – a complication of tongue piercing. *Br Dent J* 2005; **198:** 265–266.
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