Letters to the Editor

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LETTERS

FOOTPATH QUACKS

Sir, quacks in India, particularly in Mathura, operate on various footpaths and other public places mostly in the suburbs of the city. Extracting teeth, filling cavities and creating dentures requires a certain level of training and practice, but a number of these itinerants have none.

In the last few months many patients who visited the Department of Public Health Dentistry, KD Dental College, Mathura, presented with an unusual type of abrasion leading to excruciating pain (Fig. 1).

Fig. 1 Abrasion caused by 57% hydrogen peroxide

These patients had used a liquid thrice daily for two months for removal of stains and whitening of teeth after which time the teeth were free of staining but also had exposed pulps. Chemical analysis revealed that the liquid consisted of 57% hydrogen peroxide, a concentration not recommended for dental treatment. Hydrogen peroxide has the potential to affect dental enamel because of its acidic pH.¹ Concentrated (30%) solutions of hydrogen peroxide can reduce the microhardness of enamel dentine and cementum. This reduction can be noted with exposure times as short as 5 minutes for the dentine and 15 minutes for enamel.^{2,3} Studies have shown that histologically

the irritant effects of direct application of 30% hydrogen peroxide to the pulp tissue include obliteration of odontoblasts, haemorrhage, resorption and inflammatory infiltration.¹

It is shocking to see the way these quacks are making a fortune at the expense of innocent people who are likely to have little or no other access to dental treatment. Such issues go unnoticed, especially in rural and slum areas. The matter should be taken seriously by the concerned authorities and appropriate steps should be taken to stop unlawful practices by providing better plans for dental services and making them affordable for all.

A. Chaudhary, India

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SHINY CONCRESCENCE

Sir, a 61-year-old male patient presented with advanced periodontal pocketing associated with the upper right second permanent molar (17). He had previously been prescribed metronidazole by a colleague for an acute infection at this site. After some discussion the patient consented to extraction under local analgesia.

Radiographic examination had revealed the very close proximity of the roots of 17 and those of the adjacent unerupted and impacted third molar (Fig. 1).

While elevating 17 a somewhat greater degree of resistance to movement was encountered than one might

Fig. 1 Radiograph showing the very close proximity of the roots of 17 and those of the adjacent unerupted and impacted third molar

Figs 2–3 The extracted teeth

expect from a tooth with such advanced loss of bone support. The two teeth were carefully removed together along with a small piece of bone overlying the impacted wisdom tooth, the area was sutured and healing was uneventful.

On examination it was clear that the two teeth were conjoined by cementum, the surface of which had a shiny appearance (Figs 2–3). The patient was insistent that he retain this dental curiosity and it was not possible to examine the teeth in section.

Conventional radiographic imaging may not clearly indicate whether the closely approximating roots of adjacent teeth are superimposed, in intimate contact or fused together.¹

However, where there is no clear demarcation between the roots of adjacent teeth, concrescence is a possibility that should be considered during treatment planning, whether extraction, endodontics or periodontal therapy is being considered.²

A. Alshawaf, Canterbury

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ANTICOAGULANT GUIDELINES

Sir, we write further to previous correspondence relating to the dental management of patients who are taking anticoagulant drugs and the lack of relevant guidance for dental practitioners.^{1–3} We offer the following observations based upon arrangements in our region.

In early 2012, it became clear that the drugs rivaroxaban (Xarelto) and dabigatran etexilate (Pradaxa) would be more widely prescribed in Tayside for patients living in the community than had previously been the case. It was also clear that dental practitioners, in both community and hospital settings, would have little prior knowledge of these drugs and their potential impact on the provision of dental care. A guideline for local use within the NHS Tayside Health Board Area was therefore drawn up⁴ to outline the principles of patient management to be adopted for any dental patient who is taking either of the drugs mentioned above. For ease of use by all dental practitioners, the guidance also incorporates information relating to the coumarins and to anti-platelet medications.

The guidance was compiled by a community based senior dental officer who is on the GDC specialist list for special care dentistry, with input from community and hospital-based colleagues on specialist lists in special care dentistry, oral surgery and oral and maxillofacial surgery. Medical expertise and input was provided by locally-based consultant colleagues in cardiology and haematology.

Our guidance suggests that an atraumatic extraction technique, with a limit of 3–4 teeth being extracted at

any one visit, supplemented by local haemostatic measures (sutures, haemostat packs and locally applied pressure) at the time of extraction will allow safe treatment for these patients in a general or community dental practice environment. For coumarin drugs standard advice on pre-operative checking of the INR to ensure a level of <4 is advised. No pre-operative blood testing or dose adjustment is recommended for rivaroxaban or dabigatran.

Advice is also given with regard to the medical conditions which should prompt the dentist to seek advice from a senior dental or medical colleague before a dental procedure likely to cause a haemorrhage is undertaken. These conditions include patients with a recently placed stent, liver or renal impairment, alcohol problems and patients taking cytotoxic drugs or who have any underlying defect of their physiological clotting mechanisms.

In our locality we have been using these drugs (predominantly rivaroxaban) instead of warfarin for selected individuals with atrial fibrillation and for new patients presenting with deep vein thrombosis over the past year and no problems have been reported in relation to the implementation of the principles outlined in the guidance. From our experience, it would seem that those patients with uncomplicated medical histories can be safely treated in general dental practice.

R. Kerr, G. Ogden, Dundee
G. Sime, Perth

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ENGAGING FULLY

Sir, M. Mew's letter *Risking our legitimacy* (*BDJ* 2013; **214**: 143) concerning the aetiology of malocclusion gave views also previously expressed by John Mew. Mike challenges the British Orthodontic Society to engage in a debate on this complex issue, suggesting reluctance on our part to do so.

However:

- In the mid 1990s John Mew was invited to and spoke at a symposium organised by the University of Manchester; his views were listened to and debated
- He also spoke at a seminar at the University of Manchester and his views were debated further. Shortly after this, Professor Kevin O'Brien made an offer to John Mew to provide research support to evaluate the effectiveness of the treatment that John was promoting. Unfortunately, John did not take up that offer
- David DiBiase, Consultant Orthodontist, had a debate with him in Sydney, Australia, at the request of the Australian Orthodontic Society in February 1994
- A further debate took place on 3 November 2005 and was held at Elland Road in Leeds. This debate was entitled 'Traditional orthodontics ruins faces'. The argument was proposed by John Mew and opposed by Simon Littlewood with Professor Bill Shaw as chair. A report of the debate was published in the *BDJ* in 2006 (*BDJ* 2006; **201**: 243–244)
- John and Michael Mew presented for a day at the BOS offices for all the UK orthodontic postgraduates in 2007.

We believe that the British Orthodontic Society has engaged fully in debate on the issues raised, contrary to the opinion of Mike Mew.

S. Rudge
Honorary Secretary,
British Orthodontic Society
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HATCHING A SMILE

Sir, I thought your readers might find this interesting. Whilst visiting a local garden centre, I came across some rather unusual garden decorations (Figs 1–2). I was wondering quite who might want such things in their garden; perhaps these are modern day scarecrows influenced by an experience of dentistry?

Both stones seem to be 'hatching' a smile and perhaps the rudest has been influenced by a Rolling Stones album cover? (Although these stones were still!)