GREAT ENTHUSIASM

Sir, I read recently with great appreciation the interview with Kathryn Harley (*BDJ* 2013; **214:** 85-87). Her inspiring enthusiasm for providing much needed paediatric dental care was exceptionally motivating. As a Foundation Dentist working in Scarborough I was surprised to find, on seeing families for the first time, how many parents were not aware of the basics required for the oral health needs of their children. It was soon apparent how other sources of information, such as health visitors as Dr Harley comments, or indeed the media, have provided advice which in some cases can be quite detrimental to the developing dentition.

The most notable of these is fruit juice consumption. Parents who strive to improve their child's diet by compliance with the 'five a day' recommendation through providing an ongoing source of fruit juice to drink are often a little put out when the damage this is causing to their child's teeth is explained! The fact that it is a young recently qualified dentist, who clearly has no children of their own, issuing this blow also does not help. I therefore, when such scenario occurs in the future, intend to use Dr Harley's encouraging comment and state that as they are already doing so well in ensuring their child has an excellent diet of fresh fruit and vegetables, no further juices are required and that milk or water will suffice.

The other most enlightening topic discussed within this article is that regarding the cost of carbonated drinks in comparison to less acidic, and sugar-free products. It is indeed very obvious when in supermarkets, how much cheaper high-sugar fizzy drinks can be in comparison to mineral waters, an important issue in today's climate. Tap water does appear to have a stigma attached to it, when certainly having the unappreciated luxury in this country of a good standard of tap water, we really should be taking advantage where possible. If children were encouraged to drink more tap water whilst young, sugar-cravings as they grow may be less extreme, allowing an overall healthier lifestyle.

With regards to providing dental treatment for the child patients I currently see, again having only recently qualified, I would not say that I feel completely comfortable with certain procedures, mainly those which involve the provision of anaesthesia or extraction of teeth. However, from reading Dr Harley's comments, I am even more determined to ensure the correct care is provided at the correct time, as if avoided, radical treatment will certainly be necessary. Although it may be felt that postponing treatment until a later age will reduce the risk of dental anxiety for the patient, unfortunately if left until more extensive care is required, only the opposite will result.

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COMMUNICATION OBSTACLE

Sir, I have been treating a Polish patient in my final year Outreach placement. The patient speaks no English and brings his son as an interpreter. Despite the language barrier, I obtain valid consent for the course of treatment, via his son's translations. The treatment plan comprised of full clearance of all remaining teeth, and provision of immediate complete/complete dentures with a view to construct definitive dentures after a six month period.

Although slightly more time was required than usual per appointment, I was able to successfully communicate through the patient's son. When the patient attended for delivery of the immediate upper denture, there were still three teeth in the upper arch requiring extraction.

As the patient is needle phobic, I had previously used topical anaesthetic prior to infiltrations, if only for psychological purposes. Once anaesthesia was achieved, I began to luxate the first tooth for extraction.

The patient began choking unexpectedly. I sat the patient forward and started back slaps in case he had inhaled something. The patient continued choking and was struggling to breathe. He began to panic and I asked his son to tell him to calm down and encourage him to cough. The patient's son was also worried and was not translating, instead shouting at me to 'do something'. I was unable to speak to the patient to ascertain what had happened. I checked the patient's mouth for airway obstructions or fractured teeth/broken restorations. Nothing was evident.

I called for my supervising clinician and explained the situation. The patient was still choking and struggling to breathe. Due to the communication issues, we could not fully manage the patient or calm him down and the son was too emotionally involved to be of any help to us. As neither the supervising clinician nor I were aware of the cause of choking, it was decided to phone for an ambulance and send the patient to hospital for further investigation.

At the patient's next appointment, his son explained that there was no conclusive reason for the choking and that the most likely cause had been swallowed topical anaesthetic. The lack of sensation to the throat probably panicked the patient. I feel that I could have managed this situation better had there not been such an obstacle to communication. The requirement for a non-biased, independent interpreter is evident to me now and I have learnt not to use family/friends as translators in the future.

It would be encouraging if there were guidelines in place to prevent the use of family members as translators in a dental setting and instead use an independent individual who has experience in working in medical/dental environments.

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BRINGING OUT OUR INNER CHILD

Sir, reframing is one of the strategies used to guide behaviour in children in the dental practice. It is defined as 'taking a situation outside the frame that up to that moment contained the individual in different conditions, and visualise (reframe) it in a way acceptable to the person involved, and with this reframing, both the original threat and the threatened 'solution' can be safely abandoned'.[1] In an informal survey we carried out, 232 of the 352 practising general dentists replied that the main problem they faced while treating children was the management skills and the tolerance level. Patience, tolerance

and communication skills seem to play the major role in behaviour guiding children but who should be reframed first, child or dentist?

We have attempted to explain reframing using Eric Berne's transactional analysis.[2] Personalities are made up of three parts or ego states: the Parent, the Adult and the Child. The child ego state is of two types: the 'free child' and the 'adapted child'. The former can be playful, authentic, expressive, and emotional; the latter is the part of the personality that has learned to comply with the parental messages received while growing up.[2-4] Communication between two people involves six ego states (three for each person) and is called a transaction which is said to be complementary or reciprocal when the ego state addressed is the same as the ego state that responds. In general or in a dental setting, we tone down our voice and try to talk to the child using euphemisms or second language. Baby talk is used to communicate with infants and toddlers. To treat a five-year-old we need to sound like a five-year-old. This helps the child to socialise and identify with us like an equal and not a stranger. It is important for all dentists treating children to realise the child ego state in them. Bringing out the 'free' child in us helps in complementary transaction and better communication with the child. It is the dentist's mind that needs to be reframed first, for s/he needs to learn to own the problem and show a positive attitude in treating children rather than complaining that children are difficult to manage.

S. Asokan, Tiruchengode
S. Nuvvula, Nellore

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STANDARDISED ORTHODONTICS

Sir, adult patients that could possibly benefit from orthodontics commonly present to us with degenerating dentitions, missing teeth, poor aesthetics and compromised periodontal health. This makes it difficult if not impossible to achieve Andrew's six keys of ideal occlusion.[1]

Therefore, all adult orthodontic treatments require an inter-disciplinary approach to facilitate optimal aesthetics, stability and function. Graber[2] recommends the following treatment objectives which can be offered after a thorough assessment:

1. Parallelism of abutment teeth
2. Most favourable distribution of teeth
3. Redistribution of occlusal and incisal forces
4. Adequate embrasure space and proper tooth position
5. Acceptable occlusal plane and potential for incisal guidance at satisfactory vertical dimension
6. Adequate occlusal landmark relationships
7. Better lip competency and support
8. Improved crown to root ratio
9. Improvement of self-correction of mucogingival and osseous defects
10. Improved self-maintenance of periodontal health
11. Aesthetic and functional improvement.

Comprehensive orthodontics will always attempt to fulfil all treatment objectives that are set out above. Short-term orthodontics may fulfil some of the above treatment objectives in the form of a compromised treatment or as an adjunctive treatment.

A standardised approach for record taking, diagnostic procedures and assessment is required for both comprehensive and short term orthodontics. Only then can patients be well informed of possible treatment objectives and the advantages and disadvantages of alternative treatment plans.

The quicker the dental profession work towards a standardised approach, the better it will be for the future of adult orthodontics.

R. Aulakh
By email

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