SEVERE BILATERAL CLICK

Sir, a few weeks ago, I examined one of our junior dental nurses who has recently joined the practice.

She has a long history of migraines throughout her late teens and now, aged 20, has a severe bilateral click on opening. As we often hear, her migraines began following the removal of all four first premolars and fixed orthodontics in her mid-teens. Her GP has also been aware of her migraines and has been prescribing her amitriptyline for some years.

On examination, there was indeed a hefty click on opening and non-working side interferences on both upper second molars. Some very simple occlusal adjustments removed the interferences and three weeks later her TMJ click had gone and so had the migraines.

I urge us all to be in closer contact with our patients' GPs in such cases. This poor girl has (I think) been prescribed powerful tricyclic antidepressants needlessly for several years.

J. Critchley
Totnes

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SLIGHTLY ROSE-TINTED

Sir, I write in response to the letters *Ticking time bomb* from J. Webber in the *BDJ* (2013; 214: 274) and *Implants and dementia* by Dr D. Howarth (*BDJ* 2013; 214: 47). As someone involved in the teaching of dental implants to post-graduate students, I have read Dr Webber and Dr Howarth's views with great interest.

Dr Webber's view that 'endodontically treated teeth require no further intervention' is slightly rose-tinted. He states that the 'survival rates' of implants and endodontically treated teeth are the same but implies that only implants suffer complications. Even the most expertly endodontically treated teeth are subject to periodontal disease, loss of retention of restorations and mechanical failure in much the same way as implants. To include these complications in 'implant survival' and to ignore them in 'endodontic survival' is disingenuous. However, I'm never certain why we compare the survival data of a tooth to an implant. Dr Webber

is absolutely correct. Restorable teeth should be retained whenever possible. This applies to periodontal treatment as much as endodontic treatment. Implants should not be considered an alternative to teeth but one treatment option for the replacement of missing teeth. I also suspect that Dr Webber is correct and that all too often endodontic and periodontal treatment is overlooked in favour of implants.

Dr Howarth raises an interesting concern. Well performed implant treatment in an appropriate patient can undoubtedly provide an improved quality of life. Should we withhold this treatment just in case the patient develops dementia? Given the options I personally would choose many years of an improved quality of life over the risk of problems in the last few years of my life should I be unfortunate enough to develop dementia. The real issue here is the responsibility for the provision of long-term care and maintenance of implants.

I have many concerns over 'implantology'. I regularly see the results of poorly planned and delivered implant treatments. If I'm perfectly honest I should hang my head at some of the treatment I have undertaken particularly in my early years, although at the time much of this was considered 'cutting edge'. I worry that increasingly the basic principles of dental treatment planning are losing out to speed, convenience, patient demands and, dare I say it, profit. One example is 'centres' that heavily advertise one specific implant treatment, fixed teeth on the same day. By nature this will attract phobics and poorly motivated patients with neglected dentition. These patients will get a clearance (although I suspect many of these teeth can be restored) and an immediately loaded implant fixed bridge. My concern is that these poorly motivated patients are delivered fixed restorations that can be difficult to clean and require enormous commitment to home and professional maintenance. Is this really in their best interest? I also have concerns over the quality of some of the implant training available and regulation.

Dr Webber may be right. We may be sitting on a time bomb but it is not the fault of the implant or even the implant manufacturers.

R. Adams
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FOOTPATH QUACKS – CORRECTION

The letter *Footpath quacks* published in the *BDJ* on 11 May 2013 (214: 429) only listed one of the authors. The full names of the authors of this letter are as follows:

Dr Alankrita Chaudhary, Dr Navin Anand Ingle, Dr Navpreet Kaur, Dr Ajay Nagpal, Dr Kuldeep Dhanker.

We apologise for any inconvenience caused.

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QUALITY OF EVIDENCE

Sir, Dr Faggion raises a number of important issues regarding the reporting of clinical research findings at oral presentations, which deserve wide discussion.¹ However, we are concerned that the reader may be left with the view that the content of major dental meetings is thus somehow tainted by the presence of industry sponsorship and by speakers' conflicts of interests. As organisers of what we anticipate will be the largest conference on periodontology and implant dentistry ever held in Europe – Europerio 8 London 2015 – we welcome the opportunity to comment on some of the points raised, particularly as related to Europerio, which is featured prominently in the article.

Firstly, as correction of fact, at Europerio 7 2012, all invited speakers received clear guidelines on their presentations that included a requirement for disclosure of any conflicts of interest and the avoidance of bias. These guidelines were not posted on the meeting website (and thus not visible to the author when carrying out his investigation). The guidelines referred to in the article were for 'Research Presentations', which were free papers selected for researchers to present individual research projects, as opposed to the invited speakers on the main scientific programme. Secondly, although many of the Europerio sponsors are entitled to organise their own symposia; these are clearly designated as such