Letters to the Editor

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LETTERS

SMALL BUT REAL POSSIBILITY

Sir, the following case highlights the small but real possibility of temporomandibular joint dislocation into the middle cranial fossa.

A 12-year-old boy sustained a fall and injury to his jaw while playing indoor football. He experienced sudden acute left sided facial and jaw pain, and trismus. At examination, there was a significant malocclusion consisting of left sided premature posterior contact and a shifted dental centreline to the left (Figs 1 and 2).

Figs 1–2 Temporomandibular joint dislocation into the middle cranial fossa

Following presentation to the A&E department, he underwent an urgent CT investigation and was seen and admitted under the care of the maxillofacial team.

Open reduction and repair with a temporalis flap was planned under

general anaesthesia, however, subsequent manipulation and relocation under anaesthesia occurred as a closed procedure. He was placed in heavy elastic intermaxillary fixation for a period of approximately two weeks, and then a period of light elastics followed this.

To date, the patient has made an uneventful recovery and has commenced orthodontic therapy which had been planned for a pre-existing malocclusion. Functional and aesthetic outcomes are good.

C. J. Mannion, T. Teemul, R. Clarkson

By email

DOI: 10.1038/sj.bdj.2013.585

FALSE NEGATIVE RESULT

Sir, I have been reading the very interesting ongoing series of articles in the *BDJ* discussing periodontal disease in relation to treatment planning and oral diagnosis.^{1,2} The point is clearly made that absence of bleeding on probing is a very significant indicator for periodontal stability.² Lack of gingival bleeding also suggests stability. Clinical attachment loss (CAL) is stated as a measure of periodontal disease history rather than current activity. Using this measure requires one to establish a baseline measurement and follow up regularly by probing measurements.¹ A detailed outline of smoking as a major risk factor for periodontal disease is outlined and the effect that this habit has on attachment loss and lessened response to periodontal therapy.¹

A senior periodontist colleague pointed out to me of late that smoking may mask periodontal bleeding and, therefore, can of itself be implied to produce a 'false negative' result in terms of scoring for disease activity via use of

this measure alone. The masking effect of smoking has been indicated from the literature.^{3,4} Further, a reduction in clinical signs of gingivitis is seen in smokers due to vasoconstrictor effects of nicotine and heavier keratinisation of the gingivae in smokers.⁴ In summary, as quoted from the literature:⁴ *'It is concluded that the validity of gingival bleeding as a sign and a symptom of inflammatory periodontal disease may be reduced as a consequence of smoking'*. This suggests that the utility of bleeding as a sign and symptom of periodontal disease activity may be masked due to smoking.

In summary, measures of periodontal disease such as bleeding may be different in smokers *vs.* non-smokers. The masking of selected periodontal disease signs/symptoms can be as a result of nicotine's vasoconstrictor effect. My advice now with patients who are smokers is not to directly trust the bleeding measure, rather, assess over time CAL after establishing a baseline, as suggested to me by my senior colleague. It was, therefore, quite surprising to me that the authors of the said articles in the *BDJ*,^{1,2} themselves periodontal specialists, had not indicated this connection between masked bleeding and the smoking risk factor. I feel it is very important for dentists in general practice to be quite aware that smoking may lead to underscoring for periodontal disease activity and, as mentioned, in these patients a thorough follow up of loss of CAL with baseline assessment is certainly a more worthy and reliable assessment of their disease status.

J. A. Loudon, NSW, Australia

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DOI: 10.1038/sj.bdj.2013.586

DIAGNOSTIC DELAY

Sir, we have read with great interest the article by Dave,¹ where the author warns about diagnostic delay in oral cancer and makes patients (patient delay), health-care professionals (doctor delay) and the healthcare system (system delay) responsible for it. The paper also highlights the importance of reducing delayed diagnosis in order to ensure cancer treatment at an early stage. However, when the question 'Why is reducing delayed diagnosis important?' arises, the only answer in the manuscript is that 'the most important prognostic factor in oral cancer is the stage of the tumour at the time of diagnosis', without considering that it has been proved that diagnostic delay is broadly associated with more advanced stage oral cancer (pooled RR: 1.47; 95% CI: 1.09–1.99), particularly when the delay is longer than one month (pooled RR: 1.69; 95% CI: 1.26–2.77).² Moreover, the estimation of the relative risk of mortality for head and neck carcinomas related to any diagnostic delay (either patient or professional delay) is 1.34 (95% CI: 1.12–1.61), and specifically referral delay is associated with a three-fold increase in mortality.³

Conversely, several research groups have studied the concept of delay in diagnosis of oral cancer but using heterogeneous criteria such as different types of data collected (eg continuous variables versus categorical), or diverse sources of information on patient delay (standard questionnaires, interviews, hospital records, etc) that may – along with variations in tumour biology – explain the absence of a consistent relationship between diagnosis delay and stage at diagnosis in the literature. Despite these shortcomings, diagnostic delay has recently been related to a poorer survival rate in head and neck carcinomas.³

However, The Aarhus Statement has been proposed to improve the design and reporting of studies on early cancer diagnosis.⁴ This guideline recommends the substitution of the term 'delay' (eg 'patient delay') for 'intervals' or 'time intervals'. The aforementioned statement also suggests key time points (dates of first symptom; first presentation, referral and diagnosis) and time intervals.

Particularly relevant for GDPs are the date of first presentation and the date of referral. This time period could be shortened, as Dave accurately suggests, by using training as part of CPD for all members of the dental team, and a variety of additional approaches.

J. M. Seoane-Romero, P. Varela-Centelles,
J. Seoane, Spain

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DOI: 10.1038/sj.bdj.2013.587

WHITENING ADVOCATE

Sir, as most readers will be aware, the law regarding tooth whitening products containing more than 0.1% hydrogen peroxide changed on 1/10/12 making the use of such products illegal in anyone under 18 years.

I had orthodontic treatment from an early age and the appearance of my teeth clearly improved, however, I was still extremely dissatisfied with opacities present on the central incisors. I would never smile exposing my teeth; I was extremely self-conscious and embarrassed if they were noticed. After talking to my dentist about this I was referred to the Charles Clifford Dental Hospital at 15 years of age.

During the teenage years appearance is crucially important. Secondary school can be a cruel place if you do not fit into the 'norm'. Teenage years are a time of growth in confidence and of building self-esteem and the impact

of the appearance of the teeth can be grossly underestimated unless you have experienced having a cosmetic defect.

I was very fortunate in that the staff of the Paediatric Dentistry Department, Charles Clifford Dental Hospital had a keen understanding of the personal impact on me. We discussed the possibility of tooth whitening and assessing the results before we seriously considered the more invasive treatment options. From my perspective, it was the ideal solution, being non-invasive with the potential for excellent results that could be easily maintained. I was able to undertake the whitening at home over a two-week period. The results were astonishing; the opacities were no longer visible and I encountered no side effects. The boost to my confidence cannot be underestimated. The results from the whitening treatment definitely had the greatest positive impact out of all the treatment I'd had carried out over the years.

I have recently undertaken another brief course of whitening treatment as the opacities were becoming visible again but this has resolved successfully after treatment. Now aged 20 and studying dentistry at Sheffield myself, I understand fully the impact that both cosmetic and pathological defects of the teeth have on an individual and this is partly the reason why I have chosen to train in the profession.

I am a strong advocate of this treatment in the type of circumstances I have described and find it difficult to believe that if I were in the same situation now it would not be possible to have this treatment. I cannot see any viable reason why a fully qualified dental professional could not carry out whitening treatment for patients with cosmetic defects that are clearly affecting their mental wellbeing.

A. Coulby
By email

DOI: 10.1038/sj.bdj.2013.588

LONG IN THE TOOTH TECHNIQUE

Sir, with reference to osteo-odonto keratoprosthesis (*Tooth in eye surgery*; *BDJ* 2013; **214**: 373), this technique was reported in this journal as long ago as 1966.¹