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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), healthcare 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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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

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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]