not concerned with their health' needs to be approached with due care and appropriate understanding of human physiology – I'm sure we may all have come across obese or overweight individuals who may not necessarily agree with such generalised statements.

As your keen readers would have spotted in issue 10 (214: 489), the British Society of Periodontology is embarking upon a large campaign to raise awareness of periodontal diseases for both clinicians and patients, with particular emphasis on the systemic links. A recent joint workshop between leading world-renowned clinicians and researchers of the European Federation of Periodontology and the American Academy of Periodontology evaluated the entire evidence base in a systematic way (see www.efp.org for a comprehensive summary).

The *association* is indeed modest, with an Odds Ratio of 1.81,¹ but the biological plausibility is valid – obese patients are at a heightened constant state of systemic inflammation as well as at a high risk of insulin resistance, both of which we know can impact host immune responses hence its association with periodontal disease.²

When researchers started noticing a link between smoking and periodontal diseases,³ the association was put down to the assumption of poor oral hygiene, just as suggested here by C. Marks. Well-conducted research by Bergström⁴ finally proved smoking as its own risk factor, and the rest, as they say, is history.

Therefore, may we suggest to our colleagues living in this world of evidence-based medicine and dentistry, that we allow our dedicated researchers to do what they do best, and await for further definitive research to give clinicians the fully-informed guidance we need on the management of periodontitis in overweight and obese patients.

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BIZARRE METAL SPLINT

Sir, I recently saw a 64-year-old male patient who presented with pain from the lower left quadrant and requested an extraction of a retained root in this region.

On intraoral examination, to my amazement there was a bizarre metal splint covering all the teeth in both the upper and lower arches (Figs 1–2). This had been in place for over a year, as confirmed by the patient and judging by the amount of calculus visible.

The splints were constructed by the

Figs 1–2 An engineer's home-made 'precious splint'

patient, a 'former engineer who was quite good with his hands'. He claimed the splints had helped to stabilise his mobile teeth, enabling him to chew food much better.

The retained root was not visible in the oral cavity, but an OPG X-ray revealed a retained root in the region of the 36 and the splints firmly secured in place (Fig. 3).

The irony of it all was that the patient

Fig. 3 The OPG revealed a retained root and the splints firmly secured in place

wanted the retained root removed, but his 'precious splint' kept intact at all times. The patient also failed to mention if he had attempted an extraction himself leaving a retained root behind.

We agreed that a hospital referral was in the patient's best interest, in case of any other underlying pathology.

Hopefully the hospital may have persuaded the patient to have the splints removed, which may have resulted in the removal of the underlying teeth, as the splints seemed firmly secured with some sort of strong cement.

The end result may be the provision of a denture after the extraction of the mobile teeth, unless the patient decides to construct a DIY implant himself!

Though homemade devices are rare in the UK this is an example of one such rare case.

V. Egemonye
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NOT AN IANB

Sir, I have been successfully using a local anaesthetic (LA) technique introduced to me by Professor Brian Millar (King's Dental Institute, London) which is reliable, predictable and gives far greater patient comfort than inferior alveolar nerve blocks (IANBs). Painless IANBs are not always achievable, quick in onset or capable of achieving profound anaesthesia.¹ There is also the potential for nerve damage independent of the LA used but especially associated with the use of articaine.^{2,3}

Initially, I apply topical anaesthetic gel and give a buccal infiltration alongside the tooth I intend to anaesthetise. After waiting for onset of anaesthesia from the infiltration, I administer 0.1 ml articaine 4% with 1:100,000 adrenaline (Septanest), both mesially and distally of the tooth to be treated,

placing the needle at the periosteum level, approximately 5 mm below the papilla. The 30G, 9 mm length needle is short, sharp, and strong (Septoject Evolution, Septodont). Occasionally the needle will penetrate the cortical plate, but this is not necessary, or desirable.

As well as being conservative of LA solution, the area of tissue anaesthetised is relatively localised and the tongue is left un-anaesthetised, enabling restorative procedures in the same appointment on both lower quadrants, without bilateral IANBs. The patient can immediately assess the smoothness of a recently placed restoration with their tongue. An advantage over, say, the Stabident system,⁴ or a computer-controlled LA delivery system such as The Wand, is that it does not involve the purchase of any special equipment. I have used this technique for all routine restorative procedures: restorations, root canal treatments, and even extractions in the posterior mandible (administering an adjunctive lingual infiltration of articaine 4%).

A disadvantage is the potential for increased frequency of administration of the LA solution into the circulatory system but this has happened surprisingly infrequently. A retrospective audit of this technique in my practice involved 110 administrations with only one failure to gain satisfactory anaesthesia, in a patient with an irreversible pulpitis requiring root treatment on a lower molar. There was one incident of inadvertent administration of anaesthetic solution into the circulatory system.

This technique has proved an important addition to my skill set and has not only saved time and given much more predictable anaesthetic results; it has also been greatly welcomed by my patients.

D. Miller
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TOGETHER WE ARE STRONGER

Sir, I write regarding the recent letter from N. Knott (*BDJ* 2013; 215: 607).

In his letter Dr Knott says he was a member of a small minority opposed to the BDA being a trade union in 1975 when he was a member of the Representative Board.

I would suggest that minority may even be smaller in the profession now.

The trade union activity of the profession is incredibly important to preserve the ethical position of the profession as it comes under more and more influence from outside agencies and politicians; indeed the role of the new PEC is to ensure that these changes are vigorously challenged when they impinge on the professional and ethical manner in ways colleagues practise.

Now is a time when that strength of membership is needed more than ever to ensure that colleagues are supported through all aspects of their career to provide quality ethical treatment for our patients. It is very evident that with recent scandals about CQC, Mid Staffs and others that the restructuring of the NHS allows political leaders to shift blame to others, and the Francis report has been extensively discussed within the BDA to ensure we drive the profession in clinical standards and oppose things that impinge on that.

With the advance of a new NHS contract, and the implications of care pathways, best practice and levels of competency of the profession in proposed three tier levels of skills, it is imperative to be part of a solid and robust trade union to ensure our professional ethics and our ability to provide a wide range of treatments are defended. These changes will have impact across the whole profession and not just those working within the NHS.

If you have not joined the BDA for its trade union function, do so please to ensure that together we are stronger.

E. Crouch
PEC Member

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ENTERTAINMENT VS. EDUCATION

Sir, the influence of media on public health is significant and has great potential for the positive. Unfortunately, I feel this is not always used to the utmost benefit. In a recent episode

(28 May 2013) of *Embarrassing Bodies: Live from the Clinic*, I was left disappointed with the lack of attention paid to periodontal disease, the leading cause of tooth loss worldwide.¹

Simone, a 44-year-old female patient, presented via webcam with the complaint of 'receding gums' and being unable to tolerate her current denture for longer than an hour, due to swelling of the gums. She had a history of recent trauma causing greater tooth loss. The patient's primary concern was a possible allergy to the denture.

Following this, the advice provided focussed on the possibility of an ill-fitting denture or allergy. The options of dental implants were even suggested. I felt there was an undue concentration on the more 'sexy' aspects of the case, providing television entertainment rather than informative education. The crux of Simone's problems stemmed from her 'receding gums', indicating periodontitis, of which she appeared unaware and naive. There was no acknowledgement of this, or that simple measures such as good oral hygiene, healthy life choices, and regular dental visits are crucial in the management of this common condition.

Addressing patient concerns is, rightly so, a fundamental issue in dentistry and in the case of Simone the denture did need to be carefully assessed. However, I would have liked to have seen this show, which has had viewer ratings as high as 3.5 million² and is ostensibly considered a more authoritative medical-based television production, taking a more responsible attitude towards public health awareness. The provision of accurate, up-to-date and simple advice about some of the most common issues in dentistry is vital in raising awareness of problems seen daily in practice.

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