LETTERS TO THE EDITOR

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ORTHODONTICS

The consent dilemma

Sir, I write in response to the opinion article *Truth or consequences: the potential implications of short-term cosmetic orthodontics for general practitioners* (*BDJ* 2013; **215:** 551-553). The author makes some very interesting and relevant points on the clinical benefits and short-comings of 'quick-fix' orthodontics. They also clearly demonstrate the growing market for this type of orthodontic treatment.

I concentrate on the principle of obtaining informed consent. One essential component of obtaining 'valid' informed consent is to provide the patient with all treatment options, risks, their respective advantages and disadvantages and likely long term prognosis. The question I pose is: is the general dental practitioner equipped with enough orthodontic specialist knowledge to make the consent process valid? For example, a patient presents with mild labial crowding of the lower buccal segment. The patient wishes to proceed with orthodontic treatment. Have all the options been explored? Have the advantages and disadvantages of fixed appliances and labial appliances been discussed? Have their benefits and prognosis been discussed; has the patient had the opportunity to compare these to the benefits and prognosis of clear aligners, for example? If the patient has only been given the option of a clear aligner, has the GDP gained 'valid' informed consent? The author highlights the clinical implications of the 'quick-fix' orthodontic appliances as well as the unfavourable tooth movements which may be more amenable to relapse. Are these risks highlighted at the beginning of the treatment plan? Of course if these questions have been addressed then the patient has the choice to go forward with a treatment option which suits them and their circumstances. However, the ethical dilemma presents itself when these issues were not addressed or were not addressed sufficiently due to lack of specialist knowledge. Was the consent process, therefore, legally sufficient?

The success of clear aligner technology is a great orthodontic treatment option for many patients, in particular adults. It most definitely has a place in both general and specialist practice. However, this is only one treatment option and it is imperative for the practitioner to inform patients of all options and relative prognosis for both legal and moral reasons.

M. Basati
By email

DOI: 10.1038/sj.bdj.2014.103

DRUGS

Fraught interactions

Sir, the paper on drug interactions marks a significant contribution to this potentially fraught area relevant to clinical practice.[1] It might be helpful to remind practitioners of the drug (medication) issues relevant to patient age.[2] Not only are older individuals generally more susceptible to drug effects, but there are also potential issues with children – in whom there are the well-recognised dental risks from agents such as tetracyclines – but also the need to avoid aspirin and other non-steroidal analgesics because of the potential to develop potentially lethal liver and brain damage (Reye syndrome), and also the potential hazards from use of codeine.

Since 2012, it has been recognised and flagged up in alerts by the US Food and Drug Administration (FDA) that some children have died post-operatively after being given codeine in amounts within the recommended dose range.[3] Codeine is hepatically converted to morphine by the liver and some children genetically are ultra-rapid metabolisers who convert codeine into potentially fatal amounts of morphine.

Paracetamol (acetaminophen) is an alternate analgesic, very widely used and with a well-established record of safety and efficacy. However, the FDA is now asking doctors to stop prescribing medications that have more than 325 mg of paracetamol/acetaminophen per adult dose, because of its potential hepatotoxicity at larger doses.[4]

Most cases of severe liver damage have been in patients who have taken more than the prescribed dose of a paracetamol-containing product over a 24-hour period or who have taken more than one paracetamol-containing product at once and/or who have drunk alcohol while taking the paracetamol.

C. Scully
London

1. Dawoud B E S, Roberts A, Yates J M. Drug interactions in general dental practice - considerations for the dental practitioner. *Br Dent J* 2014; **216:** 15–23.
2. Scully C. *Medical problems in dentistry*, 6th ed. London: Elsevier, 2010.
3. FDA US Food and Drug Administration. Drugs. Codeine information. Available at: www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm118108.htm (accessed 3 February 2014).
4. FDA US Food and Drug Administration. Acetaminophen toxicity. Available at: www.fda.gov/Drugs/DrugSafety/SafeUseInitiative/ucm230396.htm (accessed 3 February 2014).

DOI: 10.1038/sj.bdj.2014.104

DENTAL EDUCATION

Dentists not dogs

Sir, I was pleased to read the Committee of Postgraduate Deans & Directors' report on dental education[1] and the need for UK dental schools to adopt the principles of 'competencies' and 'proficiencies' rather than the outdated 'aims & objectives' of the past. This has already been established elsewhere in the world for over ten years. It is time we caught up!

Could I also plead, as I have done for 20 years now, that we stop referring to dental education as 'training'. One trains dogs – universities EDUCATE their very capable and carefully selected students, surely.

R. W. Matthews
By email

1. Committee of Postgraduate Dental Deans and Directors. A curriculum for UK Dental Foundation programme training. Available at: www.rcseng.ac.uk/fds/courses/documents/GPT%20Curriculum.pdf (accessed 3 February 2014).

DOI: 10.1038/sj.bdj.2014.105

RESTORATIVE

The naming of parts

Sir, 'If something has no individual descriptive term it has far less chance of clinical acceptance or clinical recognition.