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

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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).

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DENTAL EDUCATION

Dentists not dogs

Sir, I was pleased to read the Committee of Postgraduate Deans & Directors' report on dental education¹ 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).

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RESTORATIVE

The naming of parts

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

TAKING ACCOUNTABILITY

Sir, Paul Hood was a dental classmate of mine in Queen's University and I was very saddened to hear of his death (*Dentist suicides*; *BDJ* 2013; 215: 593–594).

There were 26 people in our year at Queen's University Dental School. Paul was one who committed suicide in December and two months ago another colleague, also our year, committed suicide. Both have pointed to pressures from the dental boards and, in N. Ireland, pressures from the RQIA and Dental Probity. This, I think you would agree, is

quite a high proportion, two out of 26.

Over the last ten years in N. Ireland there have been a number of dental suicides. As yet, I am not aware of any 'minister of state for health opening any enquiry into the dental board, BSO or probity department here in N. Ireland' and starting to make them take accountability for their actions.

Perhaps the BDA could take action on this here in Northern Ireland.

M. Haran

By email

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[...] There seems no doubt that this condition exists, yet, because it has no name, it has no official existence.'

So said the great medical philosopher Richard Asher when introducing his newly christened symptom, Texidor's Twinge, to the Medical Society of London in 1959.¹

2014 marks the anniversary of a new epidemic in the UK of middle aged adults with untreated part-erupted mesioangular impacted lower third molars associated with unrestorable distal cervical caries in the adjacent second molar.^{2–5} We all recognise this symptom complex but so far it lacks a name and hence it has limited clinical acceptance. It is high time we put this right, and I propose it is named the Shepherd Brickley Syndrome in tribute to the two protagonists of non-prophylactic wisdom tooth management who introduced this epidemic to British dentistry 20 years ago.⁶

J. Townend
Chichester

1. Asher R. Making sense. In *Talking sense*. London: Pitman Medical, 1972.
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3. Allen R T, Witherow H, Collyer J, Roper-Hall R, Nazir M A, Mathew G. The mesioangular third molar – to extract or not to extract? Analysis of 726 consecutive third molars. *Br Dent J* 2009; **206**: 586–587.
4. Saund D, Dietrich T. The effects of NICE guidelines on the management of third molar teeth. *Br Dent J* 2012; **213**: 230–231.
5. Mansoor J, Jowett A, Coulthard P. NICE or not so NICE? *Br Dent J* 2013; **215**: 209–212.
6. Shepherd J P, Brickley M. Surgical removal of third molars. *Br Med J* 1994; **309**: 620–621.

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EBD

Squirting sockets

Sir, I was a little disturbed to see the suggestion that 'there is some evidence that rinsing with chlorhexidine or placing chlorhexidine gel in the sockets of extracted teeth provides a benefit in

preventing dry socket' in the *Evidence Based Dentistry* 'toolbox'.¹ I have some misgivings about this advice.

If chlorhexidine gel is placed in all extraction sockets, what is the likelihood of seeing serious adverse side effects such as anaphylaxis, especially since the use of chlorhexidine (and consequent sensitisation) has become so widespread?

Is this a licensed and safe use of chlorhexidine gel?

Is it wise to use gel from a toothpaste tube parenterally?

If a serious adverse reaction occurred, would our treatment be defensible in court?

I note that some of the papers² reviewed by the Cochrane team mention using gelatine sponges. I haven't used these since the 1970s as I have doubts about sterility and the advisability of using bovine-based materials in some religious and other groups, to say nothing of BSE.

I would draw readers' attention to the last line of the Cochrane Review,³ not included in the toolbox, namely that 'it is recommended that all members of the dental team prescribing chlorhexidine products are aware of the potential for both minor and serious adverse side effects'.

All things considered it's probably not a good idea to squirt chlorhexidine gel into fresh tooth sockets.

D. Howarth
London

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2. Haraji A, Rakhshan V, Khamverdi N, Alishahi H K. Effects of intra-alveolar placement of 0.2% chlorhexidine bioadhesive gel on dry socket incidence and postsurgical pain: a double-blind split-mouth randomized controlled clinical trial. *J Orofac Pain* 2013; **27**: 256–262.
3. Daly B, Sharif M O, Newton T, Jones K, Worthington H V. Local interventions for the management of alveolar osteitis (dry socket). *Cochrane Database Syst Rev* 2012; CD006968. doi: 10.1002/14651858.

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