LETTERS TO THE EDITOR

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DEFENSIVE DENTISTRY

Not only the young

Sir, I avidly read the editorial *Defensive dentistry* (*BDJ* 2014; **217:** 327) but think that the points you raise are not just a concern of young colleagues.

As quite an experienced GDP I have fully embraced the new concept of minimal intervention dentistry in recent years. In some aspects I have had tremendous results and huge improvements in grass-roots standards of oral hygiene and awareness etc. But within the NHS this has effectively been at my own expense. While prevention is certainly a lauded and admirable approach it can undermine livelihood and be self-sacrificing. As you write, altering this defensive position is very difficult to the point that even when treatment is necessary there is considerable resistance to this and lengthy verbal explanation and coaxing compounds the financial situation. One cannot just 'get on with things' easily anymore.

I have given this much thought and been lobbying here in Northern Ireland for many years. There have been recent threatened cuts imposed and the situation is very tricky indeed within the health service. Whilst one can be defensive one can only be spurred on if one's very livelihood is threatened. One just cannot take that lying down.

I always use the argument that the obvious solution is to be paid for prevention but for some reason they don't trust dentists to do this. Teachers are paid good salaries for doing something that cannot be quantified as such on a daily basis and are trusted to do.

I am getting results with my minimal intervention techniques and should be rewarded for this not getting poorer the more time I spend at work, which is what is happening at the moment. I know I am not alone in this as there was a letter in *The Times* recently commenting on the very issue of increased demands placed on dentists on reduced resources.

W. P. McLaughlin
DOI: 10.1038/sj.bdj.2014.1143

INFECTIOUS DISEASES

Early syphilis

Sir, I would like to present an interesting case recently encountered in the maxillofacial unit, which aims to raise awareness amongst dental professionals of a relevant and re-emerging infectious disease.

A 23-year-old soldier was referred with a one-month history of 'oral ulceration'. At presentation the patient was complaining of soreness in the palate, tongue and retromolar region, along with a 'sore throat'.

The patient gave a history of a nine-month period of 'flu-like' symptoms. He was also concerned for an unexplained loss in weight of two stone over a two-month period.

Intra-oral findings included: nodules in the dorsum of the tongue (Fig. 1), vesicles in the right retromolar region, and a raised erythematous nodule in the palate. Alongside this, there was also bilateral tonsillar enlargement, and left jugulo-diagastric lymphadenopathy.

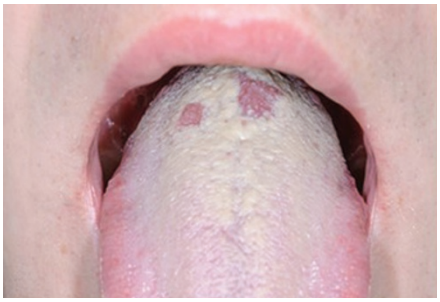

Fig. 1 Patient presenting with nodules in the dorsum of the tongue

The differential diagnoses included: candida infection, secondary syphilis, HIV, herpes simplex infection, tuberculosis, lichenoid reaction, and lichen planus. Blood tests showed a strongly positive result for syphilis total antibody, representing early syphilis (within two years of acquisition).

The patient was urgently referred to the sexual health department, where a confirmatory syphilis screen was carried out, and subsequently treated with one dose of benzathine penicillin G 2.4 million units IM. At this stage contact tracing was carried out by a trained health adviser, to notify all relevant partners of the potential risk of infection.

At a two week follow-up, the patient showed complete resolution of symptoms, and intra-oral lesions were no longer evident.

Further research into this infectious disease demonstrated some alarming statistics. Between 2003-2012, the Health Protection Agency reported a 49% increase in incidence of syphilis in England. As a result, dentists may be faced with patients infected with syphilis yet undiagnosed. Therefore, dentists can be crucial in detecting orofacial manifestations of untreated syphilis. It is important that syphilis is considered in the differential diagnoses by dental professionals for commonly occurring symptoms such as: oral ulceration, cutaneous rashes, lymphadenopathy and un-resolving malaise. Any of these presenting features should raise a high index of suspicion amongst dentists, and consequently the appropriate referral should be made for further testing.

K. Tidbury
By email
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ORTHODONTICS

Fast and furious

Sir, I have read the recent correspondence about short-term orthodontics (STO) with interest. As usual the battle lines are drawn between the specialists and the practitioners of STO who are perhaps most likely to be non-specialists.

There is no scientific evidence that any one appliance is fundamentally faster than another[1] and the reason for this is simple – the maximum speed of orthodontic tooth movement is determined by biological factors, not appliance type. A simple case well selected for use with an effective appliance and resulting in a full correction of the malocclusion could be described as fast. However, it is likely that many 'fast' or 'short-term' cases are actually under-corrected or partial treatments, with a much higher degree

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of post-orthodontic restorative work than 'complete' orthodontic treatments. This almost routine restorative work is dressed up in the term 'minimally invasive dentistry' on the basis that it is less destructive than it would have been had no orthodontics been done at all. But what if a full orthodontic correction had been made? Would any restorative work be required at all? Written consent should show that the alternative benefits of complete orthodontic treatment should have been explained and the resultant risks and limitations of the shorter treatment accepted. Patients have a right to know. It is not enough to record simply that they did not want to wear braces for two years.

Partial orthodontic treatments may have other serious consequences, especially where fixed retainers are to be used. If the teeth are not fully aligned (paralleled) then access for interdental hygiene will be reduced or impossible. Deep overbites take time to reduce and alignment without full overbite reduction will result in higher rates of bonded retainer failure and relapse. Flexible nickel-titanium wires are more likely to produce proclination of crowded teeth without addressing smile width. Black triangles that commonly result from alignment in adults need full paralleling of the teeth before the contact points can be modified and then space closed to eliminate them. This all takes time.

The undergraduate orthodontic curriculum has been so pared down that GDPs attending one or two day courses may be unable to judge that they are being misled by the claims of a company which has an interest in selling them their appliances. A look at the Fastbraces 'university' www.fastbracesuniversity.com is shocking indeed. Although there are scientific references on the website, none of them directly support the stated and implied claims made that Fastbraces are new, faster, move the teeth in a different way to 'old' braces, are less likely to need extractions and require only 15 minutes of retention per day. It is full of pseudo-science and even a name for a new disease, 'orthodontitis'! Despite this nonsense, Fastbraces is the latest system to be sweeping the UK. I wonder if the rates of litigation will go up or down?

P. Huntley
By email

1. Wong H, Collins J, Tinsley D, Sandler J, Benson P. Does the bracket-ligature combination affect the amount of orthodontic space closure over three months? A randomized controlled trial. *J Orthod* 2013; **40:** 155–162.

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PERIODONTOLOGY

Disease group

Sir, it is somewhat of a relief to peruse your periodontal issue. Not least welcome are the comments on implants, given that our profession, and especially periodontists, are surely mainly concerned with preserving the natural teeth whenever possible.[1] Also welcome is the re-use of the term 'focal infection revisited' although it is, perhaps, best accompanied by the concept in the original of the dentist as physician.[2,3] While one periodontal disease does, indeed, occupy most activity, we really must stop using the term periodontal disease as if there were only one.[4] And it is well past the time when patients need to appreciate that we are physicians as well as surgeons[3] and that periodontal medicine[5] is here to stay. Focal infection, too, has come of age, with ever increasing evidence of the relationships between periodontal and systemic diseases.[6,7]

Not that we should ever forget the roots (no pun intended) of our common chronic inflammatory periodontal disease group, although assessment in ancient populations is undoubtedly best done when one uses, for example, Miles' method of ageing and Darling and Levers' methods of assessing eruption and bone height, which provided the evidence for the widespread nature of both caries and the chronic inflammatory periodontal diseases.[8]

H. N. Newman
London

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2. Newman H N. Guest editorial: Focal infection revisited - the dentist as physician. *J Dent Res* 1992; **71:** 1854.
3. Newman H N. The dentist as physician. *Br Dent J* 1998; **185:** 374.
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6. Newman H N. Focal infection. *J Dent Res* 1996; **75:** 1912–1919.
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8. Newman H N, Levers B G H. Tooth eruption and function in an early Anglo-Saxon population. *J R Soc Med* 1979; **72:** 341–350.

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