EDUCATING PATIENTS

Sir, we recently conducted a survey, the aim of which was to assess patient awareness of tooth wear and its risk factors. Fifty consecutive adult patients were seen in two general practices in south-east London. After examination tooth wear grade was determined by a simple method where upper anterior tooth surfaces (buccal, palatal and incisal) were checked for wear and the highest grade recorded; 0 = no wear, 1 = mild wear exposing enamel only, 2 = moderate wear exposing dentine and 3 = severe wear where pulp or secondary dentine is exposed.¹ Questions and discussion then followed to determine patients' knowledge of tooth wear, its risk factors and whether their dentists had discussed this.

The patients (mean age 41 years; 66% female), all with some degree of tooth wear, were from diverse ethnic backgrounds; 44% African and Afrocaribbean origin, 24% White British, 18% Asian origin, 10% Continental Europeans and 2% Irish. The percentages with grades of tooth wear were: grade 1 – 16%, 2 – 74% and 3 – 10%; 40% indicated grinding their teeth at night, 50% brushed their teeth aggressively, 52% consumed large amounts of acidic drinks, fruits and carbonated drinks, 20%

crushed bones in their diet, and 24% suffered from heart burn.

Tooth wear and its risk factors were known about by 56% but only 20% indicated that their dentist had discussed this with them.

The prevalence of tooth wear and its severity is increasing and dentists should play an important role in educating patients on it and its prevention. Questions about tooth wear and its causes as well as advice on prevention should be part of each dental visit. Patients eventually present with tooth wear symptoms, such as sensitivity or an aesthetic problem, and that is usually too late.² Complex tooth wear indices are used in research and laboratory work but are not suitable for basic screening in a general practice setting. Simple tooth wear indices such as the basic erosive wear examination index would help GPs detect and grade tooth wear easily and effectively.³

D. Nasser, S. Dunne, London

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Fig. 1 Lateral view of tongue with spherical bead *in situ*

revealed a spherical bead embedded in the body of the tongue (Fig. 1).

The patient was admitted for intravenous antibiotics. Soon after admission, he had incision and drainage of the tongue with removal of the embedded bead under local anaesthetic.

There are a variety of complications associated with tongue piercings including pain, swelling, prolonged bleeding, chipped, fractured or abraded teeth, gingival recession and mucosal trauma.¹⁻³ There is also a reported case

of a Ludwig's angina that developed secondary to a tongue piercing.⁴ The case we present demonstrates the risks that a dormant foreign body can pose in the tongue. As dental professionals we have an important role in educating patients about the risks of tongue piercings. If a patient discloses that they have an unwanted part of a piercing embedded in the oral cavity, referral to a local maxillofacial unit should be instigated promptly so that removal can be arranged and future complications avoided.

S. Bryan, J. Lim, N. MacKenzie
Portsmouth

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