LETTERS TO THE EDITOR

Send your letters to the Editor, British Dental Journal, 64 Wimpole Street, London, W1G 8YS
Email bdj@bda.org. Priority will be given to letters less than 500 words long. Authors must sign the letter, which may be edited for reasons of space. Readers may now comment on letters via the *BDJ* website (www.bdj.co.uk). A 'Readers' Comments' section appears at the end of the full text of each letter online.

DENTAL GRADUATES

Not all doom and gloom

Sir, I agree with Lewney[1] that it is currently a strange time in dentistry where the younger generations are finding it difficult to secure their dream jobs in general dental practice. When I joined dental school in 2008, job security was almost a guarantee, making one almost exempt from the uncertainty of future employment. Nowadays, with the implementation of national recruitment and only limited dental foundation (DF) training posts, UK graduates are being pushed out by the competition, finding it harder to secure a DF post and subsequent associateships.

I guess after five long years at dental school we expected some remuneration and feel hard done by in the current dental jobs market. For us young dentists, deciding whether to stay in general practice or to specialise can be a tough decision to make. With the contract reform coming along, it seems the general dentist will have to take extra measures, ie postgraduate training, to prove they are capable of carrying out the more complex treatment plans for patients. The days of having just a BDS are diminishing.

However, I do feel it is not all doom and gloom; there are a lot of other professions and jobs with far worse prospects than ours and we need to get out of our bubble and learn to beat the competition to secure that ideal job. We should build our CV by attending courses, undertaking postgraduate training, build a portfolio with high quality clinical photographs, write articles, become a member of the LDC, ask patients to write testimonials and observe local specialists to learn new skills ... the list goes on!

Now is a better time than ever to connect with each other and support one another as a profession and that's why I started www.thedental-network.com. I saw a need for all dental professionals (nurses, dentists, hygienists, specialists and technicians) to come together as one big supporting team by creating a dental directory website. The purpose of this idea was to allow dental professionals to easily seek information about fellow colleagues or dental practices, to open doors and build on a career pathway. I would like to encourage *BDJ* readers to join the network.

A. Patel
By email

1. Lewney J. Are these the good old days? *Br Dent J* 2014; **216:** 221–222.

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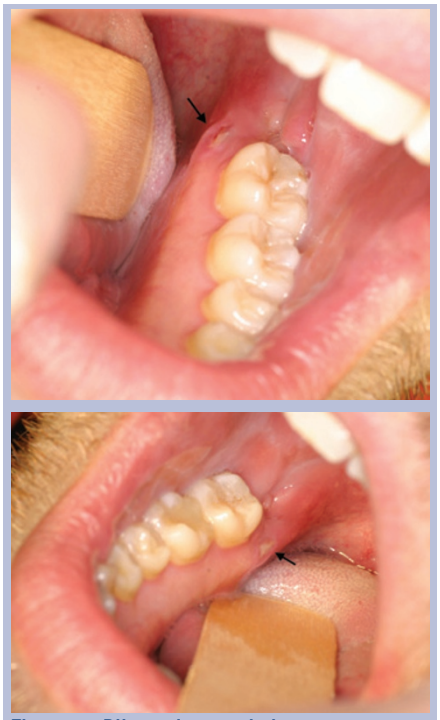
ORAL SURGERY

Prominent bone shelves

Sir, the majority of reported cases of mandibular osteonecrosis and bone exposure have been associated with bisphosphonate use or radiation therapy. However, three publications in the *BDJ* have reported such findings in the posterior and medial aspect of the mandible not being associated with medication or radiation.[1-3] We wish to present another interesting case.

A healthy, non-smoking and non-medicating 31-year-old Caucasian male underwent uncomplicated surgical removal of partially erupted mandibular third molars on both sides. Five weeks post-surgery, the patient presented with discomfort and moderate pain of two days duration from both sides of the posterior and medial aspect of the mandible. Examination revealed bilateral necrotic bone exposure on the medial bone shelves at the level of the removed third molars (Figs 1 and 2), each measuring approximately 2 × 2 mm. The surrounding mucosa was inflamed, but without sign of infection. Radiographic examination revealed no pathology. The patient was prescribed paracetamol for pain control and chlorhexidine oral rinse for the inflamed mucosa. The necrotic and exposed bone parts exfoliated spontaneously seven weeks post-surgery. Healing was confirmed eight weeks post-surgery.

Overall, mandibular tori and the posterior aspect of the medial shelf (at the level of the mylohyoid ridge) are two of the most common locations for osteonecrosis. Prior to surgery, it was noted that the patient had bilaterally prominent mandibular shelves. A standardised lateral approach was used on both sides and there was no perforation of the medial wall during the surgery. Hence, the osteonecrosis was likely secondary to bone remodelling post-surgery.



Figs 1–2 Bilateral necrotic bone exposure of the medial aspect of the mandible at the mylohyoid ridge

It is important for dental surgeons to be aware that osteonecrosis of the mandible is not always associated with medication or radiation but can occur in healthy patients. The local anatomy of the medial shelf needs to be examined prior to surgery in the posterior aspect of the mandible, and patients with prominent bone shelves should receive preoperative information that there is a small risk for delayed healing. As the complication described in the present case is rare, changing the surgical approach is not advised. However, a medial flap instead of a lateral could be considered in selected cases. This approach will allow the

EROSIVE LICHEN PLANUS

Sir, erosive lichen planus is a painful condition affecting the oral mucosal membranes. It is characterised by recurrent episodes at intervals of a few days to a few months.[1] The management of large symptomatic erosive areas can be troublesome. There are several approaches and may include antimicrobials, steroids, immunomodulatory medication, topical analgesics and anti-inflammatories, barrier agents as well as laser removal.[2] Adcortyl ointment has been used for the symptomatic management of oral mucosal conditions and it has been beneficial to selective patients. Adcortyl in orabase is a paste that contained triamcinolone. Its advantage was due to adhesion to mucosal membranes and forming a protective film. Adcortyl in orabase was discontinued in 2009. Recently in our clinical practice we have used Betnovate cream 0.05% as an alternative. Betnovate cream contains the active ingredient betamethasone. It has been used in mucosal membranes before and in particular 0.05% betamethasone cream has been used as an alternative to circumcision for the treatment of phimosis in boys. In our experience the benefit obtained is worthy of further investigation. It appears that it provided symptomatic relief and was able to provide an effective barrier. Betnovate is not licensed for oral mucosal membranes and it should be used under close clinical supervision. Our clinical experience may be of benefit to several patients. Further research is essential in order to establish a clinical protocol of its use as well as a side effect profile.

A. Kanatas, Leeds
P. Brotherton, Hull

1. O'Neill I D, Scully C. Biologics in oral medicine: ulcerative disorders. *Oral Dis* 2013; **19:** 37-45.
2. Radwan-Oczko M. Topical application of drugs used in treatment of oral lichen planus lesions. *Adv Clin Exp Med* 2013; **22:** 893-898.

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operator to smooth the bony shelf before wound closure.

M. Kharazmi, A-P. Carlsson, P. Hallberg
Sweden

1. Scully C. Oral ulceration: a new and unusual complication. *Br Dent J* 2002; **192:** 139-140.
2. Scully C. Oral ulceration. *Br Dent J* 2002; **192:** 607.
3. Friel P, Macintyre D R. Bone sequestration from lower 3rd molar region. *Br Dent J* 2002; **193:** 366.

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Bolitho not Bolam

Sir, I write in response to the letter published in the *BDJ* by A. Aslam regarding the NICE guidelines for the extraction of lower wisdom teeth. Dr Aslam refers in his letter to the Bolam test[1] which would allow any practitioner to be defended by opposing expert opinion in the event of any accusation of negligence regarding lower wisdom tooth removal.

The Bolam test has been misused and misquoted since its inception in the Bolam *v* Friern case in 1957. For example in the case of De Freitas,[2] only 11 surgeons out of 1,000 supported the defendant's actions. Despite this, the court found that this was a reasonable body of medical opinion. Due to incidents such as this, Bolam has been since modified by the case of Bolitho,[3] which adds a layer of clarification to Bolam and prevents expert opinion which is illogical being used to defend allegations of negligence. It is for the judge in any case to decide what constitutes expert opinion being illogical.

Dr Aslam relies on the belief that the English judiciary does not discriminate between expert opinion from this jurisdiction and outside. This may be the case in theory, but it is likely that opinion from the jurisdiction the case originates from will be accepted over and above that of foreign opinion when the two contrast. This is because foreign opinion is sometimes likely to lack the cultural and legal context that might mean its application to a different jurisdiction is impaired. In the example given of wisdom teeth extraction, one must remember that these extractions will most likely be privately funded in the USA whereas they are funded by the taxpayer in the UK, which is likely to affect the guidelines surrounding their removal. I would argue that the AAOMS guidelines don't have the same authority in England that the NICE guidelines do. With regards to the debate over best practice, I share Dr Aslam's confusion, but until the guidelines are modified to change this, it would be better to heed the NICE guidelines from a point of view of avoiding a negligence claim.

A. C. L. Holden
By email

1. Bolam v Friern Hospital Management Committee [1957] 1 W.L.R. 582
2. De Freitas v O'Brien [1995] P.I.Q.R. P281
3. Bolitho v City and Hackney HA [1993] P.I.Q.R. P334

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