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.

DIABETES

Multi-disciplinary approaches

Sir, diabetes is becoming an increasingly common condition, with 3 million sufferers in the UK, and 850,000 thought to be undiagnosed.¹ The World Health Organisation (WHO), projects diabetes to become the seventh most common cause of death by 2030.² The condition impacts on quality of life, longevity and is increasingly imparting a burden on healthcare resources. Despite this, diabetes incidence can be delayed or even prevented.³

Recently the American Academy of Periodontology (AAP) and the European Federation of Periodontology (EFP) conducted a review of current literature, finding emerging evidence to support a 'bi-directional' link between diabetes and periodontitis.⁴ Epidemiological studies suggest that patients with poor periodontal health are at greater risk of developing frank diabetes than those with good periodontal health.⁵

At present UK National Screening Guidelines recommend screening for diabetes amongst high-risk populations, in which periodontitis patients are not generally considered. This represents a population of patients where diabetes may remain undiagnosed.

With the EFP Manifesto recommendations for diabetic screening amongst periodontal patients with co-founding risk factors for diabetes, and the recent awareness campaign by Diabetes UK, it is timely that we as a profession look into multi-disciplinary approaches for the detection of susceptible patients with our medical colleagues.

One such method could exploit the use of gingival crevice blood, measuring glycaemic levels from periodontitis patients as a diabetic screening method carried out at dental appointments. This could be followed up by referrals to physicians for further testing if necessary. There is some evidence to suggest the viability of such a method mainly amongst Indian^{6,7} and Middle Eastern⁸ populations. Promising comments from patients in clinical trials include 'easier', 'less invasive' and 'convenient' in

comparison to the standard finger prick blood collection method.⁹

There is a need for research to be conducted to support this technique amongst UK populations. If found to be reliable and practical, it has the potential to invite new ways of patient and professional interaction and viewing the dental visit in the context of general health.

H. Halai, London

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2. World Health Organisation. Diabetes factsheet No. 312. 2013. Online factsheet available at www.who.int/mediacentre/factsheets/fs312/en/index.html (accessed November 2013).
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4. Borgnakke W S, Taylor G W, Genco R J *et al*. Effect of periodontal disease on diabetes: systematic review of epidemiologic observational evidence. *J Clin Periodontol* 2013; **40** (Suppl 14): S135–S152.
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6. Suneetha K, Rambabu T. Gingival crevicular blood glucose assessment as a chairside test for diabetic patients with chronic periodontitis: a clinical study. *Indian J Endocrinol Metab* 2012; **16**: 665–666.
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PROSTHETICS

Galvanic effect

Sir, a patient arrived complaining of a metallic taste whenever he was wearing his partial upper chrome cobalt denture. The notes showed I had provided this some three months earlier which had replaced an ill-fitting acrylic prosthesis. He had complained of the taste ever since.

On examination, I was particularly pleased with the retention, fit, occlusion and aesthetics of the denture but I could

see no part of the chrome in contact with amalgam and the circumferential clasp was round a porcelain bonded crown 27 which had been made abroad previously – I saw no reason for the galvanic effect. Closer examination revealed a small area of exposed metal mesially which was in contact with the clasp arm – surely not, I thought.

I took a deep breath and drilled into the metal through to the dentine and removed all visible metal. Incidentally the metal was very hard to remove and I suspected a cheap non-precious material. I filled the defect with reinforced glass ionomer having first primed the dentine, polished up and replaced the denture. The effect was instant and very satisfying especially as it was very early on a Monday morning (not my best time) and the galvanic effect had instantly disappeared.

I guess that is a good reason to use a suitable good quality metal in our crown and bridge work.

P. Williams, Lowestoft
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NHS DENTISTRY

A serious shift

Sir, the opinion piece by Len D'Cruz makes fascinating reading. I was particularly interested in the compulsory subjects for postgraduate education and the drivers for patient focused care.

Maybe the syllabus has changed since I qualified from King's in 1985 or maybe students are skipping the lectures on professional ethics and struggling to make the connection between the aetiology of dental caries, periodontal disease and prevention.

I suspect I am one of many who reluctantly walked away from NHS dentistry. It is good to see that those remaining who have been awarded pilot schemes are now realising the benefits of this way of working. I would like to assure any dentists concerned about deskilling that it is exactly the opposite. Apart from the enjoyment of working as part of a well-motivated and professional team, my working day is

TEACHING STRESS MANAGEMENT

Sir, the article titled *Dentist suicides*¹ is highly thought provoking and we thank Paul Hood's widow for allowing it to be published. As dental education in primary care outreach settings becomes increasingly common, clinical training is often framed by a live PDS+ NHS contract dealing with UDAs and KPIs.²

Final year dental students are already having to cope with the stress of the National Assessment for Foundation Training and the possibility of a low national ranking (and consequently no foundation training place available), all their various online computer assessments and those hurdles which others will only too readily remember of finals case presentations, OSCEs and traditional written and viva examinations. One of our roles as educators is to ease the transition into foundation training, handing over these exceptionally personable, bright and talented young professionals to vocational trainers. In support of this, we give our student colleagues (dental, hygiene/therapy and dental nursing) formal sessions on stress awareness and management.

There is an interesting contrast with the editorial in the same issue³ focusing on the profession taking a more holistic approach to our patients' health and wellbeing and being an integrated part of the healthcare team. However, if additional screening, such as blood pressure checks, are to be an extra burden to already over stretched dentists, realistic funding has to be put in place to provide for the additional members of the dental teams to achieve these important diagnostic and preventive general health measures.

Privately, we do worry about the environment in which our young colleagues will have to work and how they will cope with all the competing pressures of modern dental practice.

D. R. Radford, J. M. Colley, P. Hellyer
Portsmouth

1. Renshaw J. Dentist suicides. *Br Dent J* 2013; **215**: 593–594.
2. Radford D R. A personal perspective: breaking new ground in Portsmouth in the integrated dental education and professional care. *HERN-J* 2011; **2**: 67–71.
3. Hancocks S. The hole and the whole. *Br Dent J* 2013; **215**: 541.

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geared towards the mentally stimulating challenges of consultation, diagnosis and treatment planning. Treatment is at the more complex end of the restorative scale as my therapists undertake the more routine work.

If we want this style of working and a viable business I suspect we need to educate our patients to value and ask for it whether under NHS or private contract. Politicians listen to their voters; more cost effective dental care is good for everybody.

The sorry state of NHS dental care is a complex issue. I sincerely hope that the result of the trials is a serious shift towards preventative, patient-centred dentistry, enshrined in a constructive and appropriate contract.

S. Elworthy née Wilks, Cranbrook
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FLUORIDATION

Advocating public health measures

Sir, I am writing to thank you for your thought-provoking editorial: *Do we really care about caries?* (*BDJ* 2013; **215**: 313).

Since its formation in 1969, the British Fluoridation Society has been working to promote the implementation of water fluoridation schemes. Our aim is to improve oral health and address inequalities, in particular to prevent

childhood caries and avoidable extractions under general anaesthetic. While there is a clear link between deprivation and caries, the figures from the National Dental Epidemiological Programme for England also show that when a deprived area has a fluoridated water supply it can achieve better caries rates than other more affluent areas. Fluoridated Birmingham, for example, ranks higher in the index of multiple deprivation than non-fluoridated Leicester but has a lower dmft>0 score (32.7% and 53.2% respectively).

We fully endorse your view that dental professionals have a crucial role to play in advocating for public health measures such as water fluoridation. Since April 2013, local authorities are responsible for consulting with the public and deciding if new schemes should go ahead. They can also consult on the termination of existing schemes. The anti-fluoridation lobby is small but extremely vocal and not afraid to put pressure on local authorities. In areas where this is an issue, to write to your local councillor and encourage your patients to do the same would be invaluable. For more information go to www.bfsweb.org.

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