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.

TRIGEMINAL NEURALGIA

Rapidly successful treatment

Sir, I refer to my letter published in April 2012 (*PA and fish oil*; *BDJ* 2014; 212: 356–357) and write to advise that the treatment method mentioned in it has proven rapidly successful in several more otherwise intractable cases.

This inexpensive treatment with a powerful antioxidant should be worthy of further investigation by a clinician within the NHS if possible. It would provide significant savings as well as relief for patients currently suffering long-term pain.

I would be pleased to cooperate with any interested clinical researchers or clinicians with patients in need.

A. Carmichael, by email
DOI: 10.1038/sj.bdj.2014.914

GREEN DENTISTRY

Motivating change

Sir, I read with interest *Greening up the bottom line* in the 11 July issue (*BDJ* 2014; 217: 10–11), where Caroline Holland talks to Bob Bhamra of Jivadental who has 'probably done more than any other UK dentist to operate a carbon neutral practice'.

Could the dental opinion-formers who believe that evidence-based dentistry makes a sustainable approach to business impossible, please make yourself known. A debate is welcome.

I disagree that 'making that first step towards an eco business is costly'. As Holland's piece suggests, training in effective waste segregation can save the practice money, as can efficient heating.

Dentistry is not behind in its drive towards sustainability, nor without leadership. Within NHS Fife, Scotland, working with the NHS Fife Public Dental Service, we believe we were the first to measure the carbon footprint of the dental service.¹ We demonstrated that 36% of the carbon footprint was attributable to procurement, or what we purchase; 18% is attributed to building energy with nearly half of the carbon emissions relating to patient and staff travel. Our pilot developed into work with academic colleagues to analyse how we could reduce our carbon

PROMOTING EXCELLENCE

Sir, ADAPT (Aesthetic Dentistry and Professional Testing) was formed in 1993 as a society dedicated to researching and promoting excellence in aesthetic dentistry. Our group has an ongoing role of clinically evaluating newer and better materials.

At regular study meetings, held in West London, members share experiences as a study club, use dental products and report on our findings.

Since 1993 ADAPT initiatives have been welcomed by the dental industry and also general dentists whom we hope

have benefitted from our impartial role.

Qualified dentists are invited to apply to join ADAPT and anybody interested should provide a CV and send it to: Dr Howard Stean, Chairman ADAPT, 103 Mortlake Road, Kew, TW9 4AA, or send an email to either: adapt@adapt.demon.co.uk or howardstean@ukteeth.com.

There is no charge for membership, but members should expect to attend regular meetings and be willing to participate in the ongoing evaluation programme.

H. Stean, Chairman ADAPT
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footprint by placing services close to patient need (not yet published).

There are challenges in motivating professional behavioural change. I would agree with Bob Bhamra's comment that 'the dental consumables trade still appears to be distinctly ungreen'. In 2012 on behalf of Health Scotland, I attempted to engage the British Dental Trade Association by sending a questionnaire to 117 of its members – approximately seven replies were received, and there were few respondents within that year who wanted to engage. Such engagement is important as without manufacturers and suppliers actively seeking to reduce their carbon emissions it makes significant reduction problematic.

It's quite possible within the next few years that practices will be required to report on sustainability within dentistry. The UK is obligated to reduce its carbon footprint by 80% by the year 2050. The Sustainable Development Unit recently published a draft metric paper, which considers possible ways that dental practices could measure and monitor sustainable practice. I believe it is not out of the question for NHS Commissioners to consider such metrics when commissioning dental services. I would urge all interested colleagues to view the consultation: www.sduhealth.org.uk/areas-of-focus/metrics.aspx.

It is possible that an online tool may be developed to enable dentists to measure and monitor their carbon emissions as part

of their approach to sustainability. Views on this would be welcome. Please contact me directly at brettduane@nhs.net

I would like to congratulate Bob Bhamra on his approach to sustainable dentistry. I urge my colleagues to follow his approach.

B. Duane, Consultant in
Dental Public Health

1. Duane B, Hyland J, Rowan J S, Archibald B. Taking a bite out of Scotland's dental carbon emissions in the transition to a low carbon future. *Public Health* 2012; 126: 770–777.

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GUIDELINES

An alternative viewpoint

Sir, I read with interest the correspondence from Professor Richards and Dr A. C. L. Holden (*BDJ* 2014; 217: 106) about ethical dilemmas arising from published professional guidelines from, for example, the Faculty of General Dental Practice and the British Society of Periodontology. I would like to present here an alternative viewpoint from my position as a specialist in periodontics and a trained dental expert witness with well over 15 years' experience.

The writers seem to be saying that failing to follow established clinical guidelines has no causative effect, and the initiative is stifled by so doing. I must disagree. The guidelines of such bodies as these are based on sound evidence and good practice so a clinician needs a good reason for departing from them. In particular,

Dr Holden contends that not recording full pocket charting in BPE code 3 & 4 sextants does not constitute a breach of duty. I would argue that without more detailed data than the BPE can provide the clinician simply does not know what is happening to his or her patient. S/he cannot tell whether the treatment s/he has provided has had any effect, beneficial or otherwise. Therefore s/he cannot tell the patient if they are getting better or worse, nor can s/he make informed decisions about future management, whether that be in his/her own practice or by referral for specialist help. Can that be considered good professional practice? Would any responsible body of dentists recommend it?

The BPE is inadequate for periodontal monitoring; it is like telling the time with a calendar. Its purpose is, and has always been, to screen patients for periodontal diseases. It is inadequate, when periodontal diseases are revealed, for effective treatment of individual patients because the clinician is unable to provide the patient with information relevant to their long-term dental health including options for further treatment, or referral to a specialist.

I consider that a patient is entitled to expect a reasonably competent dentist to recognise the presence of a periodontal disease, diagnose it correctly and fully, and provide appropriate treatment or referral. I believe it is within the competence of every GDP to make an accurate BPE and, in appropriate cases, make more detailed measurements (recession, pocket depths greater than 3 mm, bleeding points and mobility are the minimum requirements) and sequential X-rays, so that s/he can monitor progress and advise accordingly. This is the duty of care.

Of course the GDP is entitled to make his/her own judgement about how to manage each individual, but s/he must understand that if the patient starts treatment with good bone support and 15

or 20 years later has little or none, and has loose teeth, the patient is going to want to know why. And if the patient can truly say they had no idea that they had periodontitis, then the responsibility for the failure of communication is, on the balance of probabilities, likely to lie with the dentist rather than the patient.

It is suggested by the previous writers that a dentist is right to withhold referral when a patient is compromised in their ability or willingness to control plaque. I would argue that lack of ability, due to, say, a physical impairment, strongly justifies referral; and that lack of willingness can, in most cases of my experience, be overcome by the additional skills developed by specialist units and practices. The downhill patient is entitled to, at the least in my view, the offer of referral based on full information that the clinician has gleaned from detailed periodontal data collection and radiographs. The wise dentist records this fully in his/her notes and puts it in writing to the patient.

You can call this 'defensive' if you like, but it would have kept the dentists in the case described by Professor Richards out of trouble and saved their indemnifiers a lot of money.

P. R. Greene, Manchester
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OMFS

Extraordinary polyp

Sir, a 31-year-old male was urgently referred to our Oral and Maxillofacial Surgery Department on account of a suspicious lesion presenting on his right buccal mucosa.

The patient was allegedly assaulted with a glass bottle approximately eight years prior to presentation where he sustained multiple orofacial injuries. Following initial healing a small fibroepithelial polyp had developed. Arrangements were made for excision, however, the patient failed to

Fig. 1 40 mm firm ovoid pedunculated lesion to the right buccal mucosa opposite the occlusal line

attend for this procedure and was lost to follow-up. This lesion had subsequently painlessly progressed over the intervening six years and grew considerably in size. Its expansive dimensions meant it constantly interfered with oral function.

This patient's medical history was non-contributory. He denied any tobacco history and reported alcohol consumption within 21 units per week. Extraoral examination demonstrated no significant abnormality and there was no palpable lymphadenopathy.

Intraorally hygiene was poor and there was a 40 mm firm ovoid pedunculated lesion to the right buccal mucosa opposite the occlusal line (Fig. 1).

Our clinical impression was a fibroepithelial polyp reactive to trauma. Although benign in appearance other inflammatory and neoplastic causes were considered in differential diagnosis. This patient underwent carbon dioxide laser excisional biopsy under local anaesthesia. The procedure was uneventful and histopathology confirmed the clinical diagnosis of a fibroepithelial polyp.

Fibroepithelial polyps are a very common presentation, however, lesions reaching this size are extraordinary. Thorough assessment and a confirmed tissue diagnosis are essential.

J. Bowman, N. Frazer, V. Cook, Dunfermline
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