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.

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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.

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