ARF HIKE

You cannot be serious

Sir, I just received my Annual Retention Fee (ARF) renewal communication from the GDC with its most helpful attached Q&A section. I must express my amazed opinion that something designed to justify the large hike in the ARF, managed to do precisely the opposite.

Stating that the major cause of the fee rise is the large increase in 'fitness to practise' hearings it then later says that the number of those found lacking as a result of these hearings was so very small that they could not possibly make up any financial shortfall; this is having your cake and eating it on a *Great British Bake Off* scale. It goes on to state that these wrongdoers amounted to 'only 0.001%' of the dentists on the register, revealing top down failure and mathematical incompetence to match the arrogant hypocrisy of earlier. By my rough calculation this percentage would equate to about 40% of one single dentist; this based on a figure of 40,000 dentists on the Register obtained by phone just now (be warned this figure could be incorrect!).

I believe that the GDC approach to the regulation of our profession is the source of many woes: for the many dentists who are caught up in the many unwieldy, deeply unpleasant and expensive hearings that seem to come to nothing; for patients with genuine grievances (rather than the unpleasant, bonkers or just plain vindictive ones); for the profession asked to pay hard earned money to the unfit incompetent organisation that is charged with policing it.

Presumably this year's ARF communication was written with the difficult dento-political environment in mind – maybe with the aim of restoring some confidence in the Council prior to its day in court? That this must all have been examined and given clearance from the very top of the organisation seems to provide ample reason for a head or two to roll.

J. J. Sellers, by email
DOI: 10.1038/sj.bdj.2015.106

Get off our backs

Sir, Peter Ward's recent editorial (*The entrepreneurs at the GDC; BDJ* 2014; **217**: 549) is a gloriously dispassionate view on the workings of the current GDC and it may be interesting for all concerned to listen to this year's *Reith Lectures*, on BBC Radio 4, by Dr Atul Gawande.

In his lectures, Dr Gawande talks about the increasing complexity of medicine and the human fallibility of doctors, suggesting that preventing avoidable mistakes is a key challenge for the future of medicine. He also cautions against the 'council of perfection' by regulators as being unrealistic and as a means for setting up the medical professionals for failure: you are damned if you do and damned if you don't!

Peter Ward concludes with the GDC's admission about having 'done very little work on looking into the "why" of complaints but has ploughed on in ignorance to build its empire'. What is also worth noting is how the GDC, both staff and members, justify its behaviour by stating that they are only doing what the regulations allow them to do. This is the Nuremberg Defence, ie 'I was only following orders'. It is surely time for the GDC to come to terms with the realities of life in the medical/dental world and to get off our backs so that we can care for our patients without looking over our shoulder to see if the GDC is coming to damn us.

C. Marks, Southampton
(sent December 2014)
DOI: 10.1038/sj.bdj.2015.107

The dental police force

Sir, I applaud the BDA's stance on the recent ARF price hike and am, of course, disappointed that the increase went ahead despite the efforts.

Dentists always regarded themselves as a self-regulating profession but, since the changes to the make-up of the Council, should we still regard ourselves as such? The Council is made up of six lay members and six members of our profession, the Chairman being a lay member and presumably having the traditional 'casting vote'.

I would, therefore, suggest that we are no longer a self-regulating profession, as a result of the potential distortion of influence in Council decisions by the make-up of the Council.

In consequence, why are dentists expected to pay the whole costs of what is, in effect, an external governing body?

The public purse pays for the police force etc so why should only dentists pay for the dental 'police force'?

J. S. Pairman, Bearsden
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BODY ART

Intraoral tattoos

Sir, inner lip inking is on the rise as a latest trend in body art with the lower labial mucosa being tattooed. Popular on blogs, this tattoo is considered unique as it is not readily visible. It is an extremely painful procedure and can be expensive too. Figure 1 shows a 31-year-old male who had such a tattoo done by a tattoo artist because he thought it was trendy. Figure 2 shows a 35-year-old male who had the tattoo completed for devotional reasons by a temple worker.

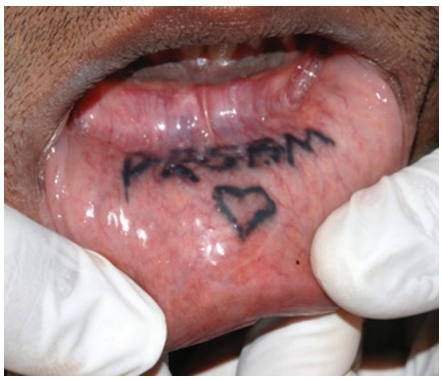

Fig. 1 A 31-year-old male with a lip tattoo

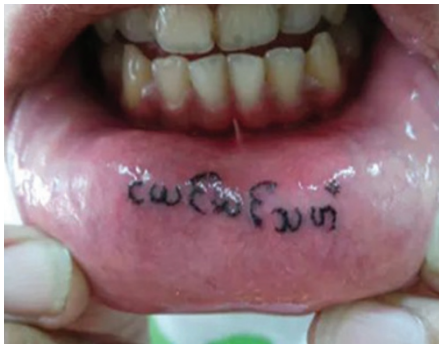

Fig. 2 A 35-year-old male who had a lip tattoo completed for devotional reasons

Tattoos play an important role in many religions as ritual tools and part of tradition; in particular Buddhism and Hinduism use them extensively for protection and devotion. Ramnaamis are a sect of Hindus in North India who devoutly and uniformly tattoo their entire body including the tongue and inside of the lips, believing that it protects them from harm. Tattooing rituals are also common to tribes of South East Asia and sacred Buddhist texts are commonly tattooed by Thai people. These texts are believed to possess powers and magical potency.[1] The trend of tattooing the inner surface of the lip with these sacred texts as part of ritual is now on the rise.

Due to the action of saliva most of these tattoos may fade away within a few months but some may stay up to five years;[2] however, they pose serious health risks such as: infection, swelling, granuloma formation and scarring.[3] Intraoral tattoos may have an additional risk of gingival recession around the lower anteriors that are in contact with the tattoo.[2]

Tattoo inks contain many components including metallic salts, carbon, aluminium, oxygen, azo pigments and polycyclic

RESIDUAL NECK LUMP

Sir, I am writing regarding a case seen in the maxillofacial department, where I am currently working as a core trainee. A 68-year-old female patient presented initially to the ENT department with a painful neck 'lump' of a few weeks' duration which had decreased in size with antibiotics prescribed by her GP. A nasendoscopic examination was completed, revealing no abnormalities. Clinical examination revealed a level II lymph node on the right side which was shown by ultrasound examination to be reactive in nature. The patient was reassured and discharged.

Two months later the patient was referred to our department with the same problem. Apart from a slight increase in size, the 'lump' was asymptomatic. Clinical examination revealed a 1.5 cm hard lump in the right submandibular region, with firmness extending to the lingual aspect of the mandible. Intra-oral examination showed a lone standing, heavily restored wisdom tooth in the lower right quadrant. Further investigation with an orthopantogram (OPG) revealed a periapical radiolucency associated with this tooth and led to a provisional diagnosis of a chronic sinus arising from this periapical infection. An MRI scan confirmed a chronic sinus tract extending from the lingual aspect of the mandible to the neck, almost certainly arising from the chronically infected lower right wisdom tooth. This tooth was removed and the sinus tract excised under local anaesthetic. The residual neck lump resolved soon after the procedure.

This case, and its history, is not uncommon on our clinics. It is of relevance to our ENT colleagues to consider chronic dental infection as a differential diagnosis for neck swelling. Although simple, it can be easily overlooked and lead to an unnecessary delay of treatment for the patient.

J. Harrild, V. Santhanam, by email

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compounds.[4] The local and systemic carcinogenic potential of tattoos remain unclear, being described in literature as purely coincidental.[4] There are reported cases of malignancy arising from cosmetic tattoos of the lips, but none from the oral mucous membrane.[5,6] The US Food and Drug Administration has not approved any tattoo pigments for injection into the skin and many pigments used in tattoo inks are industrial-grade colours suitable for printers' ink or automobile paint.[2] Despite this, faith and fashion seems to be driving popularity. While a counterargument is that tattoos have been practised for a long time, the issue is how they will behave in the oral mucosa and we need to keep a close watch on these cases while also educating our patient about their potential risks.

L. A. Telang, Penang, Malaysia

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PHARMACEUTICALS

Tetracyclines and periodontal disease

Sir, I write with regard to the paper *Drugs, medications and periodontal disease* (*BDJ* 2014; **217:** 411–419) and would like to make some additional points.

Tetracycline antibiotics are one of the oldest classes of broad spectrum antibiotics used. Tetracycline, doxycycline and minocycline are some of the examples of this class of antibiotic. The levels of tetracyclines are found to be higher in gingiva and gingival crevicular fluid than in the serum. In addition to their antibacterial activity, tetracyclines appear to possess anti-inflammatory, anti-collagenase, wound-healing properties and also reduce bone loss. Tetracycline inhibits matrix metalloproteinases (MMPs) such as collagenases which have a role in breakdown of connective tissue. Low dose doxycycline also improves periodontal parameters such as clinical attachment levels and probing pocket depths. Doxycycline is more potent than tetracycline in inhibiting MMPs and is found to be safe for administration for three months at 20 mg dose twice a day. Minocycline, in addition to having immunomodulatory properties, stimulates osteoblasts and has a role in enhancing periodontal healing.

Vagish Kumar LS, by email

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