LETTERS TO THE EDITOR

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GUIDELINES

Sound principles

Sir, I thank Mr Greene for his letter (*BDJ* 2014; **217:** 388–389). If all patients behaved in the same way, ie like compliant robots, I would agree with him.

I also agree that using the BPE to monitor periodontal disease, from the dentist's perspective, is like telling the time with a calendar. However, from the patient's perspective the micro view may be counter-productive in the early stage of the pathway to periodontal health. What is needed initially to assess an individual is an overview and not the specifics.

A behavioural approach to treating patients requires skilled application of principles to have the best outcomes in terms of patient compliance. I think we'd all agree that responsible biofilm control is key to periodontal health and that can only reasonably be achieved by the individual patient. Dentists and particularly GDPs have the responsibility to interact with patients in a way that demonstrates the application of sound principles.

W. Richards, by email
DOI: 10.1038/sj.bdj.2015.2

Inform and clarify

Sir, I write to further the current discussion regarding the use of clinical guidelines in assessing negligence. I was delighted to see that Dr Greene had responded to my previous correspondence (initially in response to Professor Richard's letter outlining a case he had come across) as I believe that often there is a great deal of uncertainty and confusion over how legal claims are assessed for merit. I hope that our letters and the resultant dialogue inform and clarify rather than muddy the waters.

The difference in opinion between Dr Greene and myself is a public example of often what happens behind closed doors in a dental negligence case. Like Dr Greene, I act as an expert in legal cases, but do so in my capacity as a dentist rather than as a specialist. Quite often experts will disagree and they are required to come together and discuss the issues at hand. Whilst I have every respect for Dr Greene, I come at this case from the slightly different viewpoint of a non-specialist GDP. As GDPs we have to balance the pressures of NHS general practice with the desire to provide efficacious and appropriate treatment. This is in line with the spirit of the Bolam test.

In this case of the pertinence of 6 point pocket charting for the assessment of periodontitis, I have no particular issue (although I do not class this to be so myself) with Dr Greene's opinion that failure to carry these out strictly speaking could be classed as a breach of duty. However, as many will be aware, a breach of duty does not automatically lead to a finding of negligence if causation cannot be established. In the case Professor Richards previously described whereby the only deficiency is purported to be a lack of 6 point charting, I still fail to see how, even if this is defined as a breach of duty, this may be responsible for causing a patient's periodontitis to worsen if treated appropriately in every other way.

Dr Greene's approach is of course appropriate, desirable and probably what many would term the 'Gold Standard' with regards to treating periodontitis. However, when faced with the multi-faceted pressures of general practice, one can perhaps be excused for not expecting dentists to always provide 'Gold Standard' treatment that rigidly follows idealised guidelines; after all, patients are not entitled to expect perfect treatment. Providing that any treatment given is found to be acceptable by a reasonable body of professional opinion which has logical basis, no legal claim should succeed.

A. C. L. Holden, by email
DOI: 10.1038/sj.bdj.2015.3

FOREIGN OBJECTS

Rubber damn!

Sir, a 24-year-old man presented to the Oral and Maxillofacial Radiology Clinic with a trauma from a rubber bullet which had occurred two weeks previously.

The patient had paraesthesia of the mucosa and the cheek in the left molar region. The teeth in the area were vital to electric pulp tests. Intraoral and extraoral examination revealed lumps detected in the vestibular sulcus area and a panoramic radiograph revealed a radioopaque mass in the region of teeth 33–36 (Fig. 1).

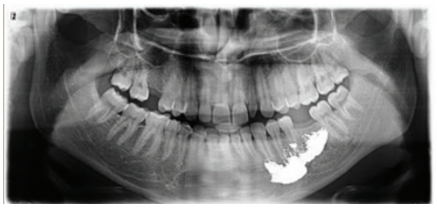

Fig. 1 Panoramic radiograph of the patient

It was understood that the rubber bullet fragmented in the tissues because of the impact on the mandibular bone. The plastic & reconstructive surgery department performed an operation to remove as many particles as possible from the tissues but some of them remain. The patient has a paraesthesia in the related region and will be called for routine follow-up.

T. Emre Köse, A. Burak Cankaya, Istanbul
DOI: 10.1038/sj.bdj.2015.4

PROSTHODONTICS

Enigmatic dental appliance

Sir, I was about to undertake a routine examination of a new patient and as the patient sat in the chair they removed this device from their mouth (Fig. 1). The device appeared to be made of cobalt-chromium, fitting onto the maxillary dentition, covering the occlusal and also palatal surfaces of the maxillary teeth (Fig. 2). I had not seen anything like it before and on further questioning, the patient reported that she had this device fitted in her teens, on the advice of her treating dentist at the time '*to help correct her bite*' and she had worn the device ever since! The patient presented with a moderate/severe Class II skeletal relationship and once the device was fitted, it appeared to cause a very mild anterior open bite which helped to decrease the otherwise traumatic anterior overbite. I have not encountered such an appliance before and discussions with my colleagues left us all wondering about the origins of this dental appliance.