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.

DENTAL RADIOGRAPHY

Use of beading wax

Sir, I was delighted to read the letter *Beard protection* published in *BDJ* Volume 217 No. 11, that demonstrated how patient care can be improved with a simple stroke of genius. This inspired me to share a 'trick' that I devised years ago to facilitate radiographic film placement for the purposes of taking bitewings or periapicals.

Bitewings radiographs are invaluable at initial examination to aid detection of proximal caries in children.[1] Lateral obliques are alternatives in children who are less tolerable of intra-oral radiographs, though arguably less diagnostic. In addition, not all clinics may be equipped with the extra-oral radiographs for lateral obliques.

However, one reason, among others, that some patients could not tolerate intra-oral radiographs might be that they do not enjoy the sharp edges of the protective sleeves of radiographic films pressing against the floor of the mouth or palate.

Soft beading wax is commonly used for extending the periphery of impression trays. It can be used to line the periphery of radiographs (Figs 1-2) to blunt and 'cushion' the sharp edges and improve comfort for patients. Therefore, this technique might be useful in children, especially those with coagulopathies where careful use of radiographic films is encouraged to reduce risk of iatrogenic accidental trauma to sublingual tissues.[2] It might also be useful in children/adults with mandibular tori and lower palatal arch.

This technique may not guarantee that the patient will cooperate with an intra-oral radiograph. In addition, perhaps not all brands of radiographic sleeves have sharp edges. Nevertheless, with its simplicity and low cost involved, it is definitely worth a try in order to improve patient comfort and increase diagnostic yield.

R. Yee, by email

Figs 1-2 Beading (Utility) wax used to line radiographic film

1. FGDP(UK). Selection criteria for dental radiography, 3rd ed. London: Faculty of General Dental Practice (UK), 2013.
2. Brewer A, Correa M E. Guidelines for dental treatment of patients with inherited bleeding disorders. 2006.

DOI: 10.1038/sj.bdj.2015.200

TEMPERED PLEASURE

Sir, I noted with mixed feelings and some surprise that my email dated 26 November 2014 appeared in the letters column in *BDJ* Volume 218 No. 4 on 26 February. The pleasure that I had managed to get something published in your reputable journal was somewhat tempered by the delay 'twixt sending the email and its publication: some **three** months.

This delay, between me suffering the attack of Sudden Onset GDC-Induced Apoplexy (SOGIA – soon to be recognised by the WHO as a new clinical dental condition) which motivated me to email the Journal, and that email's appearance on the letters page, seems rather worryingly excessive. Presumably, my email lay on an electronic spike somewhere, slowly losing its cutting edge relevance, as it was overtaken by Ebola, Barry Cockcroft and other more important stuff.

Now, writing to the *BDJ* is not something I would normally do while enjoying good mental health. But this time, I would like to use your letters column to inform any of the very few people in the dental world who have ever heard of me, that I long ago (about three months, in fact) stopped worrying about the clowns at the GDC. A thrilling New Year is well under way – I can recommend gluten free, organic Ashtanga yoga to all your readers.

I can also recommend, with apologies to Groucho Marx, that, as a UK dentist, in my opinion it is best only to be a member of those organisations who legally insist you join them, which is why I am still GDC-registered but may well have let my BDA membership lapse at some point.

J. J. Sellers, by email

Rec. 4 March 2015
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ARF HIKE

Call for resignation

Sir, the General Dental Council has been found to have acted unlawfully in its consultation on the increase to dentists' registration fees. In addition the Professional Standards Authority has found the GDC to be unfit for purpose, a position that was found to have improved little in a recent review.

I recently received email notifications from both the Chair of Council and Chief Executive of the GDC attempting to explain and justify their actions in the light of the damning court judgement. Nowhere in these messages was there an apology or attempt to show remorse for the unlawful actions.

If the GDC were to find a dentist to have acted unlawfully and their practice unfit for purpose that dentist would have been immediately suspended and in all probability struck off the register by the GDC.

Those responsible at the GDC for this unlawful action must be held to account and suffer consequences. If they are not prepared to take the decent course of action then the profession should act as a whole and call for their resignations. The profession can best do this through its professional association, the BDA, and I

am pleased to see that the executive officers of the BDA are actively attempting to hold the GDC to account.

As an individual dentist who has lost all confidence in the GDC and is disgusted by recent events, I call for the Chief Executive, the Chair of Council and those responsible for approving the unlawful action to resign.

J. Wilson, Cardiff

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ORTHODONTICS

Causes of malocclusion

Sir, in response to the letter from S. Rudge[1] (representative of the British Orthodontic Society – BOS), my concerns are that:

1. The orthodontic profession does not yet know the causes of the malocclusion
2. Whilst the profession provides orthodontic therapy for approximately 30% of the population, including in some cases major surgery, and many with long-term retention consequences, certain orthodontic therapies may not be evidence-based
3. In not doing everything we can to further the debate on the aetiology which underlies the work we undertake for our patients, we fail to honour our patients and our privileged, self-governing status of the profession.

S. Rudge helpfully notes five events in recent times at which the BOS has supported discussion on other subjects. I commend it for this, its continued support for these exchanges and evidence-based medicine, and experience which should be made available to the general dental profession; those practitioners who in good faith refer their patients to our specialism.

The GDC describes its role as *inter alia* '...to regulate in the interests of patient protection, not to review scientific evidence or bodies of scientific opinion outside the context of a specific complaint of the kind set out above'. Whilst it is appropriate that a regulatory body does not become involved with clinical arguments, the GDC did sponsor a debate on the aetiology of malocclusion in 1936. Therefore, it may be apposite to debate the subject again through their auspices. We could then reflect on the considerable experience, research and advancement in our profession and test whether these give new light to our current, relatively limited, understanding. To support this I make available copies of this and other discussions through an open forum (www.orthotropics.com\debate). I hope that this is considered a constructive contribution to the debate and would welcome contributions from all.

Given the gravity of this situation, could the GDC give an opinion as to whether a debate on this issue would be in the interests of the profession and public at large?

M. Mew, by email

1. Rudge S. Engaging fully. *Br Dent J* 2013; **214:** 430.

DOI: 10.1038/sj.bdj.2015.203

Orthodontosis and orthodontitis

Sir, there is now a significant body of literature that questions the basis of current orthodontic diagnosis and treatment goals and I propose the diagnostic terms of 'orthodontosis' and 'orthodontitis' to address these deficiencies. Emerging literature exposes the lack of evidence for the Angle's classification of Class I (ideal), II or III since there is no verifiable scientific validity that ideal occlusion provides significant benefits in oral or general health.[1-4]

Clinical observations after two decades of orthodontics practice lead to proposing the establishment of a new classification for malpositioned teeth based on the clinical morphology and appearance of the alveolar bone and ridge.[5] Orthodontosis, defined as the non-inflammatory deficiency of the alveolar bone caused by the displaced root(s) of the tooth resulting in marginal chronic soft tissue inflammation called orthodontitis. This classification is diseased-based and follows accepted diagnostic criteria found, for example, in periodontics. Our proposed classification is consistent with differences in the microbial composition of subgingival plaque of malpositioned *vs.* non-malpostioned teeth.

If orthodontic disease presents as a deficiency of alveolar bone around malpositioned roots, treatment should mimic the continuation of natural eruption thereby restoring the architecture of alveolar bone and eliminating soft tissue inflammation. This new technology of orthodontic tooth movement (Fastbraces) contemplates that light forces may possibly stimulate bone remodelling around the area of displaced roots. Consequently, non-extraction therapy is almost always achieved through this bone 'growth' remodelling as the alveolar bone reacts to a tooth erupting in its correct place in the arch and follows accordingly.

Furthermore, orthodontic diagnosis based on the morphology of the alveolar bone accepts the patient's natural dentition within its own hard tissue and soft tissue substrate. Therefore, patients are diagnosed and treated accordingly based on their own individual genetic and morphologic appearance and not based on arbitrary ideals. As a result of the proposed new concept, people's faces are accepted *de facto* and would not be subject to alteration from extractions that would mutilate the natural facial and alveolar morphology.

T. C. Pagonis, Boston, MA

1. Rinchuse D J, Rinchuse D J. Ambiguities of Angle's classification. *Angle Orthod* 1989; **59:** 295–298.
2. Gravely J F, Johnson D B. Angle's classification of malocclusion: an assessment of reliability. *Br J Orthod* 1974; **1:** 79–86.
3. Siegel N A. A matter of class: interpreting subdivision in a malocclusion. *Am J Orthod Dentofacial*