LETTERS TO THE EDITOR

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ORAL SURGERY

Suturing in the real world

Sir, the importance of gaining suturing skills at an early stage is invaluable for turning dental students into confident and competent dentists. Commonly this involves students learning suturing on a flat suture pad, unimpeded by environmental constraints. While an effective tool, the main disadvantage is inadequate preparation for suturing when impeded by the environmental restrictions of the oral cavity. It has been shown that a hands-on experience of suturing improves student performance in basic skills assessments¹ and that simulation of a surgical procedure with formal teaching intervention enhances this.²

In Bristol we have devised a method to enhance this experience which we would like to share. It involves cutting an oral-cavity-sized hole out of an iced beverage lid and securing it onto a suture pad. Students are then required to suture through the hole created. The size of the hole can be changed to accommodate student ability or change the level of difficulty of the task (Fig. 1). The method

Fig. 1 Beverage lid used to recreate oral cavity space for 'real world' suturing practice

BETTER SERVED IN A DENTAL PRACTICE

Sir, I read with interest the letter from J. Humphreys (*BDJ* 2015; 218: 266) about patients presenting to the emergency department (ED) with dental complaints. As an Emergency Medicine Specialty Registrar, I have encountered numerous patients presenting to the ED with dental problems.

My experience is that patients perceive there to be limited availability of dental services, in and out of hours. There is also lack of clarity in some geographical areas about how to access these services – for both clinicians and patients. I agree that patients are also not aware of alternative emergency treatment options for dental problems. In addition, I wonder whether there is a financial aspect involved, as it is well known that EDs are free of charge at the point of care.

It should be acknowledged that there are a proportion of patients who will not seek dental care anywhere other than the ED. Could these episodes of attendance be better used as an opportunity to direct their care more appropriately?

The increased number of patients attending EDs and the shortage of beds experienced in many hospitals is well publicised in the national press. There are certainly a number of patients who have attended EDs who could have been better served in a dental practice. The patient journey is improved by collaboration between primary and secondary care, and this should include ED working with general dental practices. Are there ways to create stronger links between the two?

A. Greer, Manchester
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is low technology and will be able to be used in any health setting regardless of resource. It can also be decorated for realism. We propose this as an adjunct to formal surgical teaching in dental school, which can be included in digital multimedia tutorials, student self-directed learning and undergraduate appraisal.

K. French, N. Sonde, R. Perry,
T. W. M. Walker, Bristol

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ORTHODONTICS

24-month braces

I was very interested to see the letter by Dr Pagonis on orthodontosis and orthodontitis in a recent edition of this Journal (*BDJ* 2015; 218: 319–320).

I would like to share information on another dental treatment; this is called orthodontics. This is the correction of problems caused by teeth that are irregular

or out of position. This is called 'malocclusion' and can be corrected by 'orthodontics'. This is a treatment in which sophisticated attachments are glued to the teeth with special adhesive. Then space-age wires are attached to the brackets using special elastics. This puts a force on the teeth and they move.

Unfortunately, the teeth do not recognise the type of brace or wire that is being used and they always move at the same rate regardless of the appliance. Most courses of orthodontic treatment take 24 months, although sometimes this can be longer or shorter depending upon the goals of treatment and wishes of the patient.

I hope that the readers of the journal are interested in this concept and consider it for their patients.

K. O'Brien, Manchester
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Unrelenting diatribe

Sir, in my opinion the recently published correspondence regarding 'orthodontosis and orthodontitis'¹ is little more than a marketing stunt of the lowest calibre.

Although these new 'diseases' sound lovely to the ear and would conceivably resonate with both the public and the profession, the terms themselves are gibberish, both factually and etymologically (*ortho* from *orthos* – meaning 'straight'; *dont* from *odontos* – meaning 'tooth'; *-osis* – meaning 'a state of disease' and *-itis* – meaning 'inflammation').

The position paper on these terms (co-written by the same author as the letter mentioned above) is totally bereft of any evidenced rationale for defining these new 'diseases'.² This is especially pertinent when such 'disease' states (which appear to be nothing more than crooked teeth and hyperplastic gingivae) are common in the majority of the population. Were these 'diseases' relevant then I don't doubt that the world would have an overnight epidemic on its hands of biblical proportions.

Isn't it marvellous then that the product that the author coincidentally promotes for monetary gain (Fastbraces) is the only product that can 'cure' this 'disease'.³ Should millions of patients be convinced they have either of these new 'diseases' and then seek remedy from only those trained to provide Fastbrace treatment, how very rewarding this would be for all involved.

This letter is no more worthy of publication that the unrelenting diatribe emerging regarding the debilitating condition of 'craniofacial dystrophy' and the wonders of orthotropics as a panacea for everything from back pain to sinusitis.^{1,4,5} As a frustrated reader of the *BDJ*, I ask that when letters that appear to express a somewhat 'unique' point of view are considered for publication, that an opinion be sought from relevant dentists on the editorial staff that are knowledgeable in the field. In this case, just because an endodontist writes from his position at the Harvard School for Dental Medicine, does not make his opinion regarding orthodontic diagnosis worth publishing.

N. Stanford, Liverpool

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CASE REPORTS

Misdiagnosed herpes zoster

Sir, following a recent letter (*BDJ* 2015; **218**: 213) we would like to share a similar case.¹ A 47-year-old male patient presented complaining of an inability to open his mouth and pain in its lower right posterior region. Examination revealed an inflamed pericoronal flap over tooth 48. The area was cleaned with chlorhexidine and analgesics were prescribed for 5 days. Extraction was advised to prevent further recurrence.

The patient returned after 5 days and agreed to the extraction. Although the inflammation had subsided his mouth opening was still restricted and the extraction was postponed to await improvement. After a month the mouth opening was still restricted although improved. During the extraction the patient suffered a few lacerations at the corner of the mouth and lower lip due to the restricted access to the third molar area.

The patient was advised to return after 5 days but did not attend until a month later. He told us that the delay was because he had developed a herpes zoster infection. He reported developing ulcers in the area of the lower right lip and corner of mouth. His family physician had referred him to a dermatologist. His ulcers were limited to the lower right lip area, which suggested that they had occurred due to the extraction trauma. The patient had discussed his dental appointment with the dermatologist, but it appears that the dermatologist did not consider the chances of the lower lip being traumatised during the third molar surgery and misdiagnosed it as herpes zoster infection.

We wish to highlight that traumatic ulceration is a differential diagnosis when considering herpes infection, especially when the patient has had a recent dental appointment.

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Oral vitiligo

Sir, as with the skin, the oral mucosa exhibits pigmentation. The normal mucosal colour is described as coral pink but, as with the gingiva, it exhibits an array of colours ranging from pale pink to coral pink in Caucasians and blue to brown-black in Asians and Africans.¹ Dark skinned individuals are very likely to have dark melanin pigmentation.²

Loss of normal pigmentation from the skin or the oral mucosa is a cause for

Fig. 1 36-year-old male with depigmentation of the lower vermilion

psychological and social problems. One common cause for depigmentation is vitiligo, which is an acquired, non-contagious, auto-immune disorder of the skin. Oral manifestations are far less recognised with occurrence most common in the lip followed by palate, buccal mucosa, gingiva and labial mucosa.³ Although the prevalence of skin vitiligo around the world is 1%, in India it ranges up to 8.8%. The prevalence of oral vitiligo is not known.

Figure 1 shows a 36-year-old male with depigmentation of the lower vermilion as the only manifestation of vitiligo. Most often vitiligo affects the young and is a rarity after age 50. The aetio-pathogenesis is not precisely known but autoimmunity is suggested which results in loss of functional melanocytes from the skin and the mucosa.^{4,5} While there is no effective treatment for this condition, corticosteroid therapy is found to be quite good. Mini pulse therapy using dexamethasone has been utilised to control developing and progressing skin vitiligo effectively.⁶

When initial lesions of vitiligo are encountered in routine dental practice, it is obligatory that patients are informed and management is instituted at the earliest as there are high chances of progression. Further, counselling might be an additional option to avoid psychosocial stigma.

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