

# LETTERS TO THE EDITOR

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## ERRATUM

Letter *Br Dent J* 2015; 219: 48

'Case reports: Giant sialolith

In the above letter we stated the author was Sabit Demircan from Istanbul, Turkey. The letter's co-author, Sabri İşler from Istanbul, Turkey, was omitted in error.

We apologise for any inconvenience caused.

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## ETHICS

### Assessing 'material risk' and 'values'

Sir, the authors have drilled into the landmark case of *Montgomery (Appellant) v Lanarkshire Health Board (Respondent)* (Scotland) The Supreme Court. Hilary Term [2015] UKSC 11 On appeal from: [2013] CSIH 3; [2010] CSIH 104), recently heard by their Lordships (*Br Dent J* 2015; 219: 57–59).

As they state, there is agreement between the ethical codes advised by the General Dental Council (in *Standards for the dental team* and in particular the earlier GDC guidance *Principles of patient consent*) and the General Medical Council, and this Supreme Court judgement. But how can a dentist assess 'material risk' and the 'values' a patient ascribes to that particular treatment?

An approach has been described by Shokrollahi (*Ann R Coll Surg Engl* 2010; 92: 93–100), that has been summarised in this Journal's abstracts section (*Br Dent J* DOI: 10.1038/sj.bdj.2010.541). In this, the patient is invited to complete a request for treatment form. In carrying this out 1) the practitioner shares information with the patient as to the benefits and risks of the procedure, 2) the patient is then asked to put down in their own words on the request for treatment form what they have understood by the discussion, 3) the patient is invited to state their decision, and finally, 4) affirms this by the customary 'symbolic signature'. In addition, completing a request for treatment form is a 'soft' method (for the practitioner) of assessing capacity.

The completed request for treatment form is filed in the case-notes as evidence of valid consent.

## TECHNOLOGY

### Generation theory in practice

Sir, I first realised I was looking a little older at a recent dental trade show. A salesman was explaining the function of the app he was promoting. Clearly frustrated by my apparent lack of understanding, he closed the conversation with 'You could always get your kids to download it for you, sir'.

Plangger *et al.*<sup>1</sup> in their recent paper in the *BDJ*, state that 'smart mobile device apps ...are important tools to add to the dental patient experience'. However, my age group, described as baby boomers, have been shown to be slow to take up smartphone technology. Only 40% of us own a smartphone and around 33% of those has never used it to connect to the Internet or download an app<sup>2</sup>. We are

also the heavy metal generation who will be prolific users of dental services over the next few decades.

I do not deny the importance of technological innovation in dental practice management. However, I suggest that the presence of a patient-facing app is unlikely to be the deal sealer for my generation when selecting a dental practice, not least because our children may well be living in Kathmandu or Cape Town.

P. Hellyer, Southsea

1. Plangger K, Bredican J, Mills A J, Armstrong J. Smart dental practice: capitalising on smart mobile technology. *Br Dent J* 2015; 219: 135–138.
2. Deloitte. The state of the global mobile consumer (2013). Available online at [http://www2.deloitte.com/content/dam/Deloitte/global/Documents/Technology-Media-Telecommunications/dttl\\_TMT-GMCS\\_January%202014.pdf](http://www2.deloitte.com/content/dam/Deloitte/global/Documents/Technology-Media-Telecommunications/dttl_TMT-GMCS_January%202014.pdf) (accessed September 2015).

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Request for treatment forms are available for download from [www.rft.org.uk](http://www.rft.org.uk).

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## COCHLEAR IMPLANT UPDATE

Sir, I respond to the Letter *Patient safety: Cochlear implants*.<sup>1</sup> In dentistry monopolar electrosurgery is more often used than bipolar for aesthetic and restorative purposes,<sup>2</sup> but monopolar instruments are contraindicated in patients with cochlear implants.<sup>2–4</sup> If bipolar electrosurgical instruments are used, the tip of the cautery should be at least 3 cm away from the implant location.<sup>4</sup> Monopolar diathermy should not be performed in the head and neck region and bipolar diathermy is contraindicated in sites within 2 cm of the cochlear implant.<sup>5</sup>

Dentists should never use microwave diathermy, shortwave diathermy and ultrasound diathermy on these implant patients.<sup>6</sup> These procedures may irreversibly damage the cochlear implant and neurons of inner ear.<sup>5</sup> Transcutaneous electrical nerve stimulation (TENS) therapy is used as one

modality to treat TMJ pain<sup>7</sup> but should not be used in patients with a cochlear implant.<sup>6</sup> External parts of the implant should be removed when ultrasound tooth cleaning machines are used.<sup>6</sup> Ultrasonic imaging and therapy is contraindicated in these patients.<sup>4</sup> The speech processor of the cochlear implant should be switched off, removed and kept away from the room containing X-ray equipment while taking dental radiographs.<sup>6</sup> Patients with Nucleus 24 cochlear implants can undergo a magnetic resonance imaging (MRI) scan up to 1.5 Tesla by using a splint and head bandage.<sup>8</sup> A recent study observed that an MRI scan can cause pain, magnet displacement, and polarity reversal of the magnet and surgery may be required for removal and reinsertion of the magnet.<sup>9</sup> External components of the implant should be removed during MRI scans, gamma camera and radiotherapy with cobalt units/linear accelerator.<sup>4,6</sup> Patients' cochlear implant teams should be consulted before these procedures. Cone beam computed tomography, computed tomography, electric pulp test, panoramic radiograph and digital radiograph are quite safe in these patients.

V. Kumar,  
India