LETTERS TO THE EDITOR

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CHILD DENTAL HEALTH

Fuzzy classifications

Sir, as lecturers in the sociology of oral health we endeavour to instil critical awareness about oral health inequalities among our dental students. Published data sources help us to demonstrate the social patterning of oral health and in turn strengthen our claims as to the social determinants of oral health and the persistence of oral health inequalities.

Previous child dental health surveys recorded child oral health according to a variety of social variables, including household composition and socio-economic status (NS-SEC).[1] However, the 2013 Child Dental Health Survey incorporated a change in the reporting of area classifications to include ONS 2011 output area classification (OAC). These OACs are based on the grouping together of 'similar geographic areas according to key characteristics common to the population in that grouping'.[2] The role of the OAC is 'intended to be illustrative of the characteristics of areas in terms of their demographic structure, household composition, housing, socio-economic characteristics and employment patterns'.[3] As a result, according to the 2013 survey, 22% of 'hard pressed living' children at the age of five in England, Wales and Northern Ireland have severe or extensive dental decay, compared with 18% of 'constrained city dwellers' children aged five, 9% 'suburbanites' and 9% 'urbanites' children aged five.[4] While a glossary of each of these groups are included in the technical report[2] we query the empirical utility of these classifications.

The ONS admit that these OAC groups, such as 'constrained urban dweller' and 'urbanites' represent 'the most generic description of the population of the UK'.[3] Nevertheless, how we define and measure health is a political act, influencing public opinion of health and health policy more generally.[5] By using the OAC classifications the distribution of child oral health is recorded not according to social class but rather to these 'fuzzy' descriptive classifications. This change in reporting makes it difficult to compare 2013 data with previous surveys, which relied on the established socio-economic status classification, having a negative impact on our capacity to assess oral health trends over time and across social groups. As a result, the 'clustering of disadvantage' associated with poor oral health becomes obscured, reducing in turn our ability to monitor the 'health gaps'[5] that exist in society. The lack of accurate social/epidemiological data will also detract from recent efforts within the dental profession in the UK on how the profession can work to reduce health inequalities and contribute to a more equal society through their delivery of care.

P. Neville, E. Sutton, Bristol
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ORAL SURGERY

Mandibular fracture risk

Sir, a 28-year-old male patient presented to our maxillofacial department with an iatrogenic mandibular fracture, confirmed by imaging, following removal of an impacted lower right third molar tooth.

The extraction was carried out under local anaesthetic in a general dental practice where upon delivery of the tooth, both dentist and patient heard 'a crack'. Subsequently, the patient's occlusion was deranged and mobility was evident in the right side of the mandible. The following day, open reduction and internal fixation was carried out under general anaesthetic and the patient was discharged two days post-admission.

In light of the recent changes to the law regarding consent, we feel this case highlights the important implications for clinicians. The landmark decision in Montgomery *v* Lanarkshire Health Board,[1] given by the UK Supreme Court on 11 March 2015, means that the 'Bolam test' no longer applies to the issue of consent. This previously-used test asked whether a clinician's conduct would be supported by a responsible body of medical opinion. However, the law now requires doctors to take 'reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment'. The definition of a 'material risk' is one to which a reasonable person would be likely to attach significance.

In this case, the risk of mandibular fracture was not discussed with the patient during the consent process. It can be argued that, due to the low incidence of mandibular fracture associated with the removal of teeth (<0.005%),[2-4] this need not be discussed during routine procedures. We believe this is now a perilous attitude in an increasingly litigious world. In the case of Rogers *v* Whitaker,[5] an Australian court found the ophthalmologist to be negligent for failure to disclose the chance of blindness due to its remote risk (0.007%). Whilst we respect that the loss of vision is a far greater morbidity than a mandibular fracture, we feel the latter would be deemed of significance by the majority of patients. Our advice is that the rare risk of mandibular fracture is discussed with all patients before removal of lower third molar teeth.

S. Basyuni, A. Ferro, M. Cameron
Cambridge
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PROSTHODONTICS

Tenacious lump of calculus

Sir, as the maxillofacial on-call doctor at Gloucester Royal Hospital, I was asked to assist with the removal of both the upper and lower dentures for a lady who was due for an endoscopy. She had a late presentation for suspected gastric cancer.

The patient had not removed her upper and lower chrome dentures for 15 years! She had irregularly cleaned her teeth with her denture *in situ* with a toothbrush. During this time she had not needed to attend a dentist, as had no episodes of dental pain, and she explained the dentures had 'attached to her over time'!

I eased the upper denture out and was shocked to see the tenacious lump of calculus lingering on the flange as shown in Figs 1–2 – this is after a good scrub with a toothbrush.

The lower was attached to the soft tissue in the floor of the mouth and would have required surgical excision under local anaesthesia, which the patient declined.

I. Midwood, by email

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Figs 1–2 Upper denture with calculus lingering on the flange

PHARMACOLOGY

Dual therapy guidance

Sir, dental practitioners face an increasing number of medically compromised patients who are on prolonged use of new types of medications for coronary diseases combined with antiplatelet drugs. The invention of new (direct or target) oral anticoagulants (NOACs), including dabigatran, apixaban, and rivaroxaban, which have more favourable pharmacokinetics, as well as a higher safety level, has renewed interest in combination polytherapy.

There is no doubt that dual anticoagulant therapy may have a significant impact on perioperative and postoperative dental care, particularly involving a more complex dental procedure such as oral or periodontal surgery. According to available data, the addition of NOACs to antiplatelet therapy results in a substantial increase in bleeding, most pronounced when NOACs are combined with dual antiplatelet therapy (eg aspirin/clipodogrel and dabigatran/rivaroxaban).[1] Clinical trials elucidated a dose-dependent increase in major bleeding events, including internal (eg intracranial), with apixaban and rivaroxaban when combined with dual antiplatelet therapy.[2]

Since August 2015 recommendations by the Scottish Dental Clinical Effectiveness Programme (SDCEP) in relation to combined antiplatelet and NOACs dual therapy do not advise a specific course of action and they only indicate a need for consultation with a general medical practitioner or specialist.[3] Consultation with an anticoagulation clinic or clinical haematologist is always necessary prior to dental surgery for patients in combined dual anticoagulant therapy due to considerably higher risk of bleeding. Due to the more stable and predictable effects, temporary discontinuation and restarting the NOACs causes less risk than warfarin. When restarting the NOACs, a desirable anticoagulant effect reaches its targeted level within a few hours following administration.[4]

International dental guidelines for the new oral anticoagulants are based on a comparison of their bleeding risks with warfarin or low-molecular-weight heparins. Unfortunately, there are no evidence-based guidelines for the dental management of patients receiving these agents. Manufacturers' specifications for NOACs suggest an interruption to anticoagulation therapy prior to only general surgery,[5] but unlike those for warfarin, do not provide separate recommendations for dental and general surgery. For dabigatran a reversal agent was approved in 2015 for use in the setting of urgent procedures or life-threatening bleeding.[6] Hypothetically, it can also potentially be used in emergency cases of severe excessive bleeding following major oral surgery. For rivaroxaban, apixaban, and edoxaban there are no specific antagonist agents reversing the effect of this class of new anticoagulants.

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Statins and oral ulceration

Sir, statins are inhibitors of 3-hydroxy-3-methylglutarylcoenzyme A (HMG-CoA) reductase that have revolutionised the treatment of hypercholesterolemia. Their beneficial effects have been well documented. According to the British Heart Foundation, over 66 million statins prescriptions were written last year: a figure which has trebled in the past ten years.[1]

Adverse drug reactions (ADRs) to cardiovascular medication were outlined recently in the literature.[2,3] The prevalence of oral manifestations of ADRs is not fully known, and the pathophysiological mechanisms for which these occur have yet to be fully elucidated; there have been reports in the literature associating oral ADRs to simvastatin use.

A 62-year-old gentleman recently presented to our clinic with a 12-month history of a recurrent keratotic lesion with areas of small ulceration on the right lateral border of tongue, which became symptomatic when exposed to acidic or spicy foods. He took regular atorvastatin for hypercholesterolemia; he was a non-smoker and recorded very occasional alcohol intake.

Histopathological analysis through an incisional biopsy suggested candidiasis with focal ulceration. A two week course of systemic fluconazole and topical