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.

LITIGATION IN DENTISTRY

Troubled by the profession

Sir, I feel obliged to warn all practitioners regarding the knock-on effects of their patient care, and how a third-party, when driven, can 'persuade' patients to take the litigation pathway. When I and my practising partner sold our practice after 23 years, I stayed on as an associate. After some 2-3 years, it became clear that I was being scrutinised and that my abilities were in question. I felt I had no option but to resign, a decision which clearly annoyed the practice owner and his (wife) manager. I was threatened with: 'I am going to destroy you and if you do not give me all the money I want to support (in my view) patient retrospective treatments, I shall report you to the GDC' by the practice owner. His wife was quick to add that they 'would not give up' in chasing me for money.

I had already agreed (under duress) to leave £10,000 to cover retrospective care. This became £17,000 when the owner refused to pay me at all for my last three months' work. The parting words were: 'you can speak English reasonably well so you shouldn't have too much trouble finding a job'. (I let the reader interpret this comment as they see fit.) Some five years later following several (settled) legal claims, patients are still being guided along the litigation route whilst I am facing financial hardship leading to me having to sell my practice, retire from dentistry early (I am 58) and look for alternative sources of income. The sheer cost of indemnity cover rose to a staggering £64,000 making it impossible for me to continue.

I am troubled by a profession which seems to applaud the threatening of one member by another and the fact that the GDC can be used as 'a weapon'.

Patient care is important but there must (hopefully) come a point where practitioners can be seen to be bullying rather than 'representing their patient's best interests'... It is a relief to me that none of my children have chosen dentistry as a profession and that my wife will be able to leave behind the stress and strain of managing our practice. The profession itself has (for

PHARMACOLOGY

Confounders for bleeding

Sir, we read with great interest a review article about exodontia in dual antiplatelet therapy recently published in your Journal.¹ Nathwani *et al.* reviewed studies about the effect of dual anti-platelet therapy on bleeding after dental extraction. As mentioned in its discussion there are many confounders for bleeding after dental extraction. The most important confounders are number of extracted teeth, number of roots, manufacturing company of aspirin and clopidogrel, the indication and duration of dual anti-platelet therapy, dentist's skill, number of cases, and suitable control group. We recently published a paper about the bleeding after one tooth extraction in 64 patients undergoing dual anti-platelet therapy and comparing the bleeding with 50 in a healthy control group.² In this study we aimed to control all abovementioned confounders. We only evaluated patients undergoing one tooth extraction, by a unique dentist, consuming unique dose and brand of aspirin and clopidogrel, and comparing bleedings with a suitable control group, undergoing one tooth extraction by the same dentist. The indication for dual anti-platelet therapy was during the first year after percutaneous coronary

intervention (PCI) with stenting in all of our patients. We also checked the effects of duration of anti-platelet therapy and time of consuming the last dose. We think concluding no significant effect of anti-platelet therapy on bleeding after tooth extraction, needs such studies for each group of patients. All abovementioned confounders should be controlled in future studies. We also suggest repeating this study for patients undergoing two-teeth extraction comparing with a matched control group and in patients taking anti-platelet drugs for other indications. This topic needs more prospective studies and then concluding by a systematic review and meta-analysis.

Also we want to add a sentence to the conclusion of Nathwani *et al.*'s article: one tooth extraction seems to be completely safe in patients taking aspirin and clopidogrel after PCI and stenting.

H. Karimi-Sari, M. Saeid Rezaee-Zavareh,
Tehran

1. Nathwani S, Martin K. Exodontia in dual anti-platelet therapy: the evidence. *Br Dent J* 2016; **220**: 235-238.
2. Sadeghi-Ghahrody M, Yousefi-Malekshah S H, Karimi-Sari H, Yazdanpanah H, Rezaee-Zavareh M S, Yavarahmadi M. Bleeding after tooth extraction in patients taking aspirin and clopidogrel (Plavix®) compared with healthy controls. *Br J Oral Maxillofac Surg* 2016; **54**: 568-572.

DOI: 10.1038/sj.bdj.2016.431

me, at least) become a disappointment. Practitioners, please be aware that you are vulnerable and that your colleague may not always be what they appear to be.

Name and address supplied
DOI: 10.1038/sj.bdj.2016.432

DENTAL EDUCATION

Admission troubles

Sir, dental school admissions have certainly improved since I went to dental school in 1993. Back then, many students in my year were not interviewed and found out a couple of years in that they were lacking either the communication skills or manual dexterity.

They had been accepted purely on their academic success, GCSE and A-level results.

Fast forward to today, the students have to prove that they are manually dexterous and their communication skills are assessed at the interview stage. Without three As they don't even get a look in.

As a dentist passionate about my career, with a father who is a dentist too, it was no wonder that my daughter was also interested in a career in this field, or medicine as her school thought best. She is highly intelligent, far more than I was at this stage, a real all-rounder and has all the necessary credentials. Sadly, she obtained 2 As and a B in chemistry, in which she missed an A by four UMS marks, out of 600, which works

out at 0.67% away from an A.

The part she fell down on was the ISA, the practical chemistry exam marked by the school, the results of which vary enormously between schools and unfortunately, are not the best at her school. These are very subjective, with some students reporting that the ISA raised everyone's grades at their schools and others with opposite experiences.

She took a gap year and therefore did not apply with predicted grades. Before sending the UCAS forms she rang around to see if any of them would consider her, but was disappointed to find that this was not to be. She is manually dexterous, making intricate cakes for all family birthdays, among other arty creations. She has excellent communication skills, has been a youth leader for years and does regular volunteer work. There must be so many other able students to create such competition!

I am struggling to make sense of this and wondering if there are others around with similar situations?! Would ringing around on clearing day help?

Any advice would be appreciated!

Rant over...

I. Pine, by email

DOI: 10.1038/sj.bdj.2016.433

DENTAL ARCHAEPARASITOLOGY

Rigorous analysis

Sir, the identification of structures recovered from dental calculus deposits (DCD) is complex. Such structures result from either mastication during life or taphonomic agents arriving after death. The complexity of identifying structures from DCD supplants for convincing differential diagnoses. Most often, masticated structures recovered from DCD are vegetal or mineral in origin.¹⁻³ A convincing report of parasite eggs recovered from DCD begins with eliminating the possibility that the eggs in question are not actually fragments of plant tissues, phytoliths, starches, or sand grains.¹⁻³ These structures might look like parasite eggs to the untrained eye.⁴

Once a solid case has been made to the contrary regarding vegetal or mineral origins, then it is appropriate to consider animal origins for the structure(s) in question. Next, length-width measurements and morphological features of structures should be used to form a differential diagnosis. When a structure is suspected of being a parasite, it is critical for researchers to examine the structure in light of the natural history of the suspected organism. It is also important for researchers to question whether the structure(s) arose from in-life mastication or

from decomposer organisms comprising the necrobiome.⁵ Such strategies avoid misdiagnoses leading to inaccurate conclusions regarding the recovery of parasite evidence from DCD.

In a previous letter to this Journal, a case for the recovery of a *Schistosoma mansoni* egg from the DCD of a ninth century AD individual buried in France was reported.⁶ Justification of the diagnosis is necessary because the discovery of an egg in the mouth is counterintuitive, considering that the eggs are disseminated through superior mesenteric to large intestine and into faeces. This report gave no indications as to how the authors determined that the structure reported as an egg was not of plant or mineral origin. The authors provided only a single (length) measurement and pointed out only a single morphological feature (lateral spine) regarding the structure in question. There was no differential diagnosis and no discussion of whether the structure originated via in-life mastication or via taphonomic processes. There were no photomicrographs to support the claim that this egg was that of *S. mansoni*. Only a single egg was reported from this individual's DCD. Single-egg reports are not sufficient for the establishment of a parasite's existence as a disease agent among a historic population.^{4,5} The authors' claim that this case constitutes 'the oldest evidence of the parasite in Europe' is implausible at best.

As new microscopy techniques are applied to archaeoparasitological studies, it is imperative that researchers employ adequate protocols for the differential diagnosis of microstructures recovered from DCD. It is similarly imperative that reports of parasite structures recovered from DCD are held up to scrutiny and are not haphazardly interpreted. The authors of the above-mentioned letter should include a full differential diagnosis, at least one photomicrograph, discussion of potential presence of organisms constituting the necrobiome, and a more conservative interpretation of their results, to address the scepticism of archaeoparasitologists with regard to the information presented in the letter.

J. J. Morrow, K. J. Reinhard,
Lincoln, Nebraska

1. Henry A G, Brooks A S, Piperno D R. Microfossils in calculus demonstrate consumption of plants and cooked foods in Neanderthal diets (Shanidar III, Iraq; Spy I and II, Belgium). *Proc Natl Acad Sci USA* 2011; **108**: 486–491.
2. Power R C, Salazar-Garcia D C, Wittig R M, Freiberg M, Henry A G. Dental calculus evidence of Tai Forest Chimpanzee plant consumption and life history transitions. *Sci Rep* 2015; **5**: 15161.
3. Wesolowski V, Mendonça de Souza S M F, Reinhard K, Ceccantini G. Evaluating microfossil content of dental calculus from Brazilian sambaquis. *J Archaeol Sci* 2010; **37**: 1326–1338.
4. Reinhard K J. Reestablishing rigor in archaeologi-

cal parasitology. *Int J Paleopathol* 2016; in press.

5. Morrow J J, Newby J, Piombino-Mascoli D, Reinhard K J. Taphonomic considerations for the analysis of parasites in archaeological materials. *Int J Paleopathol* 2016; **13**: 56–64.
6. Charlier P, Abadie I, Cavard S, Brun L. Ancient calculus egg. *Br Dent J* 2013; **215**: 489–490.

Dr Philippe Charlier responds on behalf of his co-authors: We have read with high interest the response by J. J. Morrow and K. J. Reinhard discussing our examination of an egg of Schistosoma mansoni in the dental calculus deposit (DCD) of a ninth century AD male individual from France. The decision not to publish the photomicrograph of the parasite was originally made by the Editor-in-Chief for space reasons.

From all aspect (length-width measurements and morphological features), and considering slight deformation due to the acid-treatment of dental calculus,¹ the presented egg (Fig. 1) corresponds to one of Schistosoma mansoni.² It is therefore possible to eliminate all differential diagnoses (fragments of plant elements, phytoliths, starches, sand grains, pollens, etc). No parasite has been found in the control samples from the periphery of the cadaver.

Fig. 1 General view of the *Schistosoma mansoni* egg (HES, ×200 magnification)

We have discussed the possibility of dissemination of this egg out of the superior mesenteric to large intestine tract: vomiting is a relatively common cause of such superior dissemination of the parasite (whatever the presence of any neurological complication of the disease), that may led to ectopic localisations, including oral ones.^{3,4}

Archaeology has given the opportunity of enhancing tools and methods for retrospective diagnoses process in the context of forensic anthropology. The same rigour is systematically given for any samples and procedures, whatever its date and origin.

1. Charlier P, Huynh-Charlier I, Munoz O, Billard M, Brun L, de la Grandmaison G L. The microscopic (optical and SEM) examination of dental calculus deposits (DCD). Potential interest in forensic anthropology of a bio-archaeological method. *Leg Med (Tokyo)* 2010; **12**: 163–171.
2. Lapiere J. *Maladies exotiques et parasitoses autochtones*. Paris: Fournier, 1975.
3. Ripert C. *Schistosomiase intestinale à S. mansoni*. *Presse Med* 2000; **29**: 1577–1579.
4. Carod-Artal F J. Neurological complications of *Schistosoma* infection. *Trans R Soc Trop Med Hyg* 2008; **102**: 107–116.

DOI: 10.1038/sj.bdj.2016.434