COMMENT

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 trauma

Smartphone hazards

Sir, most teenagers are inseparable from their smartphones and dropping one certainly would be a disaster. A 17-year-old female presented for a second opinion complaining of persistent painful symptoms associated with a traumatised upper central incisor.

Clinical examination revealed a repaired incisal edge to 11 with visible fracture lines to the coronal enamel extending toward the root surface. Sensitivity testing was hyper-responsive to both ethyl chloride and electric pulp testing. Digital pressure to the tooth yielded a painful response to lateral forces. Radiographs showed an oblique root fracture in the mid to apical third of the root. A diagnosis was made of complicated crown and root fracture and irreversible pulpitis. The extent of this injury we found to be surprising given the description of the injury by the patient being the result of her rapidly turning her head to engage in conversation and hitting her tooth against the side of the phone being held by her boyfriend.

The tooth was considered to be of poor long-term prognosis but an initial decision was made to attempt root canal therapy to maintain bone and crucially soft tissues over the medium term. Unfortunately, symptoms did not resolve following pulp extirpation and subsequent redressing of the root canal system on multiple occasions. In view of the complexity of the fracture and ongoing symptoms the patient ultimately requested extraction. An immediate denture has been provided with a view to longer term options in the near future.

With the ever increasing use of smartphones in society with the trend for 'selfies' we wonder whether these devices will become a more prevalent factor to be considered in dental trauma.

V. Wilson, S Stone, G. McCracken, Newcastle

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Accidental ice-burn

Sir, we wish to present a case of an 8-year-old boy who presented with his father following extractions of deciduous teeth in general practice the previous day.

Although the extractions had reportedly been simple and straightforward his parents were keen to avoid pain, discomfort and any swelling that might ensue. His mother had suggested he wrap 'some ice in a clear sandwich bag' and place it over the side of his face where the teeth had been removed. Unfortunately, this resulted in a substantial ice-burn to the lip (Fig. 1). The parents were incredibly upset given their good intentions and the subsequent outcome. Conservative advice was given with regards to managing the traumatised area.

The use of ice is not unusual and the principles of managing many soft-tissue injuries revolve around the stalwarts of RICE (Rest, Ice, Compression, Elevation). Injuries following the application of cold in dentistry or oral and maxillofacial surgery could not be identified in reviewing the literature. It would stand to reason that if advising patients to manage swelling with ice, care is taken to warn the patient of potential risks such as direct contact of soft tissue with ice over prolonged periods.

S. Stagnell, G. Burrows, by email

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Fig. 1 Burn to the lip caused by ice

Medical emergencies

Trivialising the dentist

Sir, I am very concerned at the article in the *BDJ* on 24 June 2016 (Volume 220, issue 12) by Dr Jevon regarding first aid. The advice given in this paper is clear and concise. Surely patients (and others) should expect a level of response to medical emergency above that of first aid to be provided by a dentist in their dental practice. The dentist has after all completed a degree incorporating training and examination in 'medicine for dentistry'. I feel the article would be more applicable to the staff working in roadside service stations (with no disrespect to their level of medical training intended). I could go on but feel that I may be in need of first aid.

R. Kerr, Exeter

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Orthodontics

Allergic to the orthodontist?

Sir, we write to present an unusual case of a 14-year-old child presenting with angioedema with breathing difficulty during orthodontic treatment, resulting in an emergency hospital admission. This was preceded by three other episodes of angioedema during orthodontic treatment. The patient reported 15 episodes of angioedema in the past year; the majority were not associated with dental treatment.

The patient was seen by the immunology team who diagnosed her with non-allergic idiopathic angioedema, after excluding allergy to latex and local anaesthetic and hereditary angioedema. Idiopathic angioedema is defined as at least three episodes of angioedema within 6 to 12 months without clear aetiology.¹

The patient was referred to Bristol Dental Hospital by the local orthodontist due to

concern regarding orthodontic de-bond given the recent episodes. They were seen by the paediatric department and after liaison with the anaesthetic and immunology team, a decision made for the orthodontic de-bond to take place in Bristol Children's Hospital theatre, whilst awake. The benefit of this was that immediate emergency treatment could be administered if required in light of the increasing speed of onset and the severity of episodes. The major concern was of the child's airway given the serious risk due to potential swelling of the tongue, pharynx and larynx.² Oral antihistamines were given pre-operatively and the procedure was completed without complication. The fixed appliances were removed and impressions taken for retainers, which were fitted later in the day.

Idiopathic angioedema may present in a variety of settings, including the dental surgery. Multidisciplinary planning between teams is essential to ensure safe and appropriate care.

M. Patel, R. Power, S. Dewhurst, Bristol

1. Shroba J, Hanson J, Portnoy J. Current treatment options for idiopathic angioedema. *Ann Allergy Asthma Immunol* 2015; **115**: 429–433.
2. Kaplan A. Angioedema. *WAO Journal* 2008; **1**: 103–113.

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Dental education

Admission troubles

Sir, I was sorry to read that I. Pine's daughter had been unsuccessful with dental school applications (*BDJ* 2016; **220**: 611–612). Having recently given career talks to students who are going to apply for dentistry courses starting next year, I believe there are three options that she should consider. Firstly, it is always worth contacting admission tutors of dental schools where your daughter has applied between the results day and the start of course, to keep checking for vacancies. Although most successful dental applicants achieve the necessary exam grades to be accepted, occasionally places do become available in various circumstances. This includes where applicants with an offer fail to achieve the required grades.

The second option is to enrol into another healthcare-related undergraduate course through clearing, and then apply to dental schools as a graduate. As a graduate, you can apply again for standard five-year undergraduate courses; in addition you can also apply for graduate entry programmes which are currently available at four universities.¹ These

courses allow a dental degree to be completed one year shorter (four years), although this benefit means they are much more oversubscribed and competitive to get into.

The third option would be to apply to study at a dental school in another European country where A-levels are accepted. Currently, the General Dental Council (GDC) allows direct registration for dentists qualified from countries within the European Economic Area (EEA) to work within the UK.² With the result of the recent European Union (EU) referendum, however, it is not known how labour regulations will affect the dental industry in the UK.³ It is possible that when the UK officially leaves the EU, dental qualifications obtained within the EEA countries may no longer be recognised by the GDC, and there may be an additional requirement to sit the ORE (Overseas Registration Examination) before being eligible for registration. In addition, it is important to be aware that the tuition fees are significantly higher and a student loan is unavailable.

O. Kwon, Reading

1. UCAS. UCAS Course Search Tool. Available at: <http://search.ucas.com> (accessed 30 June 2016).
2. General Dental Council. Dentists qualified in the EEA. Available at: <http://www.gdc-uk.org/Dentalprofessionals/Applyforregistration/Pages/Overseas-EEA-Dentist-Page.aspx> (accessed 30 June 2016).
3. Sinclair E, Stagnell S, Shah S. Brexit and dentistry. *Br Dent J* 2016; **220**: 509–512.

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A highly competitive environment

Sir, in his letter of 24 June, Dr Pine highlights his daughter's difficulty in gaining a place to study dentistry. It is very disappointing that someone who wishes to enter the profession fails to gain a place but this is, indeed, a highly competitive environment.

The number of UK undergraduate training places in dentistry is set by government to prevent 'oversupply' of dentists (and it should be noted that undergraduate numbers in the UK were reduced by over 10% in 2013/14). Demand therefore considerably exceeds capacity at every dental school and, due to capped numbers, dentistry is one of the few remaining professions where entry to university depends upon 'selection' rather than 'recruitment'. There is, approximately, a 15:1 ratio of applicants to places in most undergraduate dental schools in the UK and, because of their smaller capacity and the need for one to one teaching in many areas of the course, it can be more difficult to gain a place

in dentistry than in medicine (medicine has approximately 4-5 times more places and there are twice as many undergraduate medical schools as dental schools).

As these posts are sought after very competitively it is important to make the process as fair (based solely on merit) and transparent as possible. First considerations are based objectively on academic performance to ensure that those selected can cope with the very challenging academic elements. There are then subsequent assessments of vocation and motivation, mapping of applicants against 'values' as well as consideration of practical capabilities and communication skills. At each stage school's admissions processes are subject to scrutiny by a variety of sources and so are designed carefully.

In the end we admit highly talented and capable students into a challenging course and we work to enable them to meet the outcomes required for registration. At each hurdle there are, unfortunately, some individuals who do not quite make it. Dr Pine is right when he states: 'There must be so many other able students to create such competition.' There are, and whilst some good candidates are regrettably unsuccessful, those who make it are intelligent, practically capable, carers who are the future leaders of the profession and who are, very deservedly, our colleagues.

C. Youngson, Chair, Dental Schools Council

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The last of my kind?

Sir, I am a recent product of a shortened graduate entry BDS programme. I am the last of my kind, as my school changed from graduate entry to a standard undergraduate degree to conform with a current EU ruling that all dental degrees should be five years' duration. I feel that this is lamentable, for I believe my contemporaries in my cohort brought a rich and eclectic mix of life experience, skills and knowledge from previous degrees and careers and that the old funding structure of NHS bursaries and subsidised places helped many (myself included) to take the plunge and go for this exciting change of career. Given the referendum on EU membership on 23 June voted for our severance from the EU, one wonders whether the Government and the dental education community in the free UK will consider offering this option again?

M. Dyson, Plymouth

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