LETTERS TO THE EDITOR

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SPECIAL CARE DENTISTRY

Treating autistic children

Sir, I read the recent interview with Wendy Bellis with great interest (*BDJ* 2015; 219: 315–316). As a trainee working as part of the specialist paediatric dental team in the salaried dental services I have been given great insight into the challenges that a dentist can face when assessing and treating autistic children. I couldn't agree more with Wendy in that each child is completely unique and potentially has something different to teach us all as clinicians – no matter what our level of experience. It is therefore of great importance that we all as dentists acknowledge this and make the effort to better understand appropriate management of these children.

I absolutely agree that in most cases a busy general dental practice setting is not ideal for treating a child with a diagnosis of autism. It follows that the salaried dental services undoubtedly have an important role in the care pathways for these children.

However, what I have witnessed in my current post is the potential for primary and secondary services to work together to make these patients' experience of dental care as positive as possible. It is invaluable when GPs see these patients for short 'easy' visits along with the rest of the family. Not only can this work towards acclimatisation to the dental environment, but it is a way to keep the child in question included in a very routine part of family life. This inclusion can be as positive for the parents and immediate family as it is for the patient themselves. Simple, short visits can really make a difference – these could include setting goals such as trying to have the patient happy, sitting in the dental chair. Visits also act as an opportunity to provide realistic preventive goals as early as possible for this potentially high caries risk group and to support parents through the process and allow questions to be asked and concerns to be eased.

Ultimately a holistic and supportive approach to the care of these children with appropriate input from specialist practitioners and those working on the front line can only serve to improve their experience and

EMERGENCY DENTISTRY

Three primary reasons

Sir, having read the article by Nayee *et al.*¹ I wish to add my experience as a provider of out of hours emergency dentistry. The article gives various reasons patients attend emergency clinics but omits a significant source of patients to our clinics. Our unpublished audits show that many patients have seen a dentist recently prior to attendance at an emergency clinic. Whilst some of these patients have unavoidable post-operative pain, many have had sub-standard care or been sent away without treatment. I believe there are three primary reasons for this:

1. The NHS GDS does not fund emergency care correctly and furthermore there have been attempts to clawback large sums of money from practices who submit an urgent course of treatment followed by a banded course

2. The patient can be at fault as they do not always follow our advice or attend appointments
3. Sub-standard dentistry such as inappropriate prescribing of antibiotics for inflammatory conditions, treatment provided in the absence of a diagnosis (eg simple fillings in a tooth which has a necrotic pulp) and inappropriate referral to secondary care for simple extractions.

Our audits have shown that far more patients of some dentists and clinics attend than others with the similar demographics. It would be interesting to know how many emergency dental problems fall in each category and we are in the process of investigating this.

S. Aaron, London

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1. Nayee S, Kutty S, Akintola D. Patient attendance at a UK dental hospital emergency clinic. *Br Dent J* 2015; 219: 485–488.

the quality of care provided – and isn't that something always worth striving for?

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DENTAL IMPRESSIONS

Metal rim lock trays

Sir, I have recently had my eyes re-opened to the use of metal rim lock trays in everyday practice. With good management and communication with labs, these can be routinely used on the NHS as it is important to have an impression tray which will allow for more accurate impressions at the first time of asking. This should in turn reduce the need for unnecessary custom-made trays.

The use of plastic trays can be a false economy as the cheapness in cost is outweighed by the clinical loss of time and increased lab fees. The major flaw in these trays lies in their lack of rigidity meaning

there is a risk of inaccuracies occurring both on seating and removal of the tray.

Material choice and impression techniques are also important aspects to consider. As the majority of denture impressions are taken in alginate it is even more important to use a rigid tray system as the material is inaccurate and has poor elastic properties. Two-stage wash impressions are at most risk of deformation as the putty induces excess stresses, which the plastic tray cannot handle effectively.

With the added retention present in rim lock trays it means we don't have to routinely use tray adhesives. Adhesives cause a huge number of inaccuracies as it is difficult to get an even spread and they are rarely given enough time to work, not to mention ruining clinical work tops. The presence of an integral metal handle also allows for added pressure to be applied towards the impression taking surface allowing for more accuracy. As metal trays are easily sterilised and if they are labelled correctly, I feel they should be routinely used as primary