

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

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

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.

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

impression trays to improve the quality of work for patients as well as saving time and money for dentists.

J. S. Hans, London
DOI: 10.1038/sj.bdj.2016.69

1. Carrotte P V, Winstanley R B, Green J R. A study of the quality of impressions for anterior crowns received at a commercial laboratory. *Br Dent J* 1993; **174**: 235–240.

ENDODONTICS

Gross misinterpretation

Sir, as postgraduate students in endodontics, we have undertaken a review of the paper by Hansrani (*BDJ* 2015; **219**: 481–483) and would like to share some of our observations with your readers.

Given the content of the paper, the use of the word 'overview' in the title is not justified as it is more of a personal, discursive exercise undertaken by the author. The notable omissions in the paper are the myriad of factors that affect radiographic interpretation, ranging from observer bias to the location of the periapical lesion in the arch and involvement, or otherwise, of the bony cortical plate. Newer, three-dimensional imaging, such as cone beam computed tomography, was not mentioned at all.

Many of the author's statements are as a result of misinterpretation of, and based on, dated literature. There is no mention of the causes of 'failure' that may, for example, be due to extra-radicular or intra-radicular infection. There is also a complete absence of reference to apical surgery and extraction as treatment options for 'failure' cases apart from these being used as criteria to denote 'failure'.

The author failed to adequately define the criteria used to determine treatment outcome; instead, he compounded the deficiency by misquoting the European Society of Endodontology guidelines.¹ In fact, these guidelines divided outcome into 'favourable', 'unfavourable' and 'uncertain' as well as an 'exception' category for periapical scars.

Recent outcome studies, for example, Ng *et al.*² reported on factors associated with endodontic 'success' and 'survival'. This seminal research is not referenced by the author and if enlightened, perhaps the author would not have given credence to the outdated and discredited theory of 'anachoresis'.

The relative importance of thorough canal preparation, effective irrigation, complete obturation and a good coronal seal are poorly addressed and mislead the readers into thinking that obturation is of no significance. Both Klevant and Eggink³ and Ray and Trope⁴ were misquoted. Supported by more recent literature (eg Ng

*et al.*²), the evidence points to a combination of high technical quality root canal treatment, as exemplified by good quality obturation, and a good coronal seal, as major contributory factors to 'success'.

In conclusion, we feel that this article grossly misrepresented the topic of radiographic evaluation of 'root fillings'.

S. Jivraj, N. Dollay, P. Shah, N. Louskos, K. Ranshi, by email
DOI: 10.1038/sj.bdj.2016.70

1. European Society of Endodontology. Quality guidelines for endodontic treatment: consensus report of the European Society of Endodontology. *Int Endod J* 2006; **39**: 921–930.
2. Ng Y L, Mann V, Gulabivala K. A prospective study of the factors affecting outcomes of non-surgical root canal treatment; part 1: periapical health. *Int Endod J* 2011; **44**: 583–609.
3. Klevant F J, Eggink C O. The effect of canal preparation on periapical disease. *Int Endod J* 1983; **16**: 68–75.
4. Ray H A, Trope M. Periapical status of endodontically treated teeth in relation to the technical quality of the root filling and the coronal restoration. *Int Endod J* 1995; **28**: 12–18.

Blatant ignorance

Sir, we are compelled to write to express our dismay at the content of the paper by Hansrani on assessing root canal fillings.

Nearly all the views expressed in the paper are personal opinions, not based on sound scientific evidence or supported by careful and critical analysis of the literature. A principal worry is the constant use of unreferenced or indeed inappropriately referenced statements, which are misleading and not evidence-based. We could provide a line-by-line critique and multiple examples of the deficiencies of the paper but we have selected just a few.

The title does not reflect the contents; purporting to be an overview on assessing root fillings on a radiograph, it is one person's philosophical discourse on the science and practice of endodontics. The interchangeable use of the terms 'periradicular periodontitis', 'periapical periodontitis' and 'apical periodontitis' shows ignorance of terminology and is only one of many examples of sloppiness.

In the opening paragraph, it is claimed that the European Society of Endodontology (ESE) guidelines¹ state that 'radiographs should show the root apex with preferably at least 2–3 mm of the periapical region clearly identifiable.' In an act of self-contradiction, the author then included, amongst the 11-year-old reprinted illustrations, a radiograph (Fig. 2) that failed to meet this requirement and of 'unacceptable' quality if rated according to published guidelines;^{2–4} the other two accompanying radiographic images (Figs 1 and 3) are only just about 'diagnostically acceptable'.

Re-stating the ESE's criteria defining an unfavourable outcome,¹ the author is economical with accuracy by conveniently not including the 'Exception: An extensive radiological lesion may heal but leave a locally visible, irregularly mineralised area. This defect may be scar tissue formation rather than a sign of persisting apical periodontitis. The tooth should continue to be assessed.' Compounding the sin of omission, the author listed in the next paragraph the unrecognised criteria defining 'failure', which is not part of the ESE guidelines¹ and not one of the three outcome categories ('favourable', 'uncertain' and 'unfavourable').

The inaccurate claim that 'radiographs of single rooted teeth can be easier to interpret and understand than those of maxillary permanent molar teeth' discounted mandibular molars. The one reference⁵ cited on the microbiota of the root canal system overlooks the more recent, and abundance of, studies using newer, culture-independent techniques.

To trot out Dubrow⁶ as a reference in order to claim that canal obturation is not required is to live in the past as the paper made reference to silver points, an obsolete root filling material already consigned to history. In addition, to further justify this contention Klevant and Eggink⁷ was inappropriately used as in their paper healing was improved in the 'root filled' cohort over the 'dressed' controls.

The statement that the use of NiTi 'leads to improved success rates in endodontics' is unreferenced and presented as fact when, at present, there is a lack of a convincing body of evidence to uphold this claim. The author continuing to live in the past is further exemplified by the claim that 'obturation prevents entry of microorganisms into the root canal system from the oral cavity or via the blood system'. The idea of blood (anachoresis) as a source of infection has been outdated for years.

To claim that 'similar failure rates for teeth with radiographically optimal and suboptimal root fillings suggest RCT is not as technically sensitive as once thought' shows blatant ignorance. Does it mean that the author is happy to receive a suboptimal root filling? Is the author saying that dental schools no longer need to teach and expect, and clinicians do not need to achieve, high technical quality root fillings? Is the author not aware of, for example, the work of Sjogren *et al.*,⁸ Ng *et al.*,⁹ as well as the systematic review by Ng *et al.*?¹⁰ They all highlighted technical factors, as measured by radiographic quality of root fillings, as a principal prognostic factor in healing. A strong association between