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 education

Screening or discrimination?

Sir, as a colour-blind dentist, who has been in practice for 35 years, I was interested to read the opinion piece on screening dental students for a 'minimal acceptable level of colour vision' (*BDJ* 2016; **221**: 227–228). The article, though carefully written, rang alarm bells about potential, future discrimination. While writing this response, the Paralympics have just ended and those athletes are exemplars of how the spirit can overcome the physical through adaptive behaviour and grim determination.

My colour-blindness is the commonest form (red-green) and I have never encountered any patients with naturally green teeth. The challenges of shade selection, as detailed in the article, are common to all dentists and I always have the patient assess the shade with me, using controlled and standardised lighting conditions. That is simply a matter of good practice while also possibly being an adaptive behaviour to ensure against my own possible confusion of the more subtle colour perceptions.

It is therefore my opinion that the article raises concerns which are unwarranted for any member of our profession who uses proper means of assessing colours. Those concerns can easily lead to discrimination and so I hope that future articles of a similar nature will be refused publication in the *BDJ*.

C. Marks, by email

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Dental sedation

Regional demographics

Sir, I read with interest the article by Wanyonyi *et al.*¹ regarding the provision of sedation services within primary dental care in England. The article suggests that there is a marked socio-economic effect on the uptake

of sedation with the most deprived areas showing the highest uptake.

Using the Index of Multiple Deprivation 2015 data it is possible to calculate the proportion of lower super output areas (LSOAs) within each quintile of deprivation for LSOAs in the North of England (as shown by the infographic in *BDJ* 2016; **220**: 123). What this shows is that in the North of England 29.9% of LSOAs fall within quintile 1, the most deprived, and 15.8% fall within the least deprived quintile. In the North of England, 29.1% of courses of treatment with sedation are provided to those in the most deprived quintile, and 11.9% are provided to those in the least. This correlates with the demographic of the region and is not indicative of a socio-economic effect on the uptake of sedation in the North of England.

Z. Freeman, *Clinical Fellow in Dental Public Health, Newcastle University*

1. Wanyonyi K L, White S, Gallagher J E. Conscious sedation: is this provision equitable? Analysis of sedation services provided within primary dental care in England, 2012–2014. *BDJ Open* 2016; DOI:10.1038/bdjopen.2016.2.

DOI: 10.1038/sj.bdj.2016.750

Dental research

Trigeminal neuralgia

Sir, I refer to your editorial¹ *Read all about it* and to the difficulty of bringing new work to the attention of both the profession and those who could formalise and further the research.

It seems almost impossible to bring serendipitous discoveries into the mainstream of the professional publications. There are by definition no references to other articles or other researchers' work. It would be a useful extra in your journal to have a section for appeals for collaboration in or extension of new work.

In this context I put a personal appeal for assistance with a trial of orally ingested palmitoyl ascorbate as a total suppressor of

the pain of trigeminal neuralgia (TN). This has now been used by enough people to give great hope that it would be universally useful in this distressing condition. It has already been instrumental in being able to avoid surgery for a patient listed for it. Assistance and funding for a formal trial from those better qualified than me would be welcome.

A. Carmichael, by email

1. Hancocks S. Read all about it. *Br Dent J* 2016; **221**: 99.

Editor's note: In response to this suggestion by Dr Carmichael, we are introducing a new space in the Upfront section: 'Calls for collaboration'. See p 441 for further information.

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Oral trauma

Camel bite

Sir, animal bites are usually caused by wild and domestic animals such as lions, bears, dogs, cats, but rarely by camels.¹ The mechanism of camel bite injuries are complex and include penetrating and crushing injuries by the camel jaw and blunt injuries when victims are picked up, lifted and thrown by the camel, resulting in fractures and severe lacerations of skin, muscle, tendons and nerves.

Camel bite injuries vary from avulsion of scalp, skull fractures, brain injuries, traumatic tracheostomy, common carotid artery injury, fracture ramus,² orbital fracture dislocation of the temporomandibular joint, and gas gangrene to fractures with or without neurovascular involvement.³ All soft tissue wounds and fractures should be regarded as contaminated, so all patients should be given tetanus vaccine and broad-spectrum antibiotic coverage.⁴ During closure if there are underlying bone fractures, many authors believe that they should be treated by primary closure following reduction and fixation of the underlying bone.