COMMENT

Letters to the editor

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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

DOI: 10.1038/sj.bdj.2016.749

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 editorial[1] *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.*

DOI: 10.1038/sj.bdj.2016.751

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.

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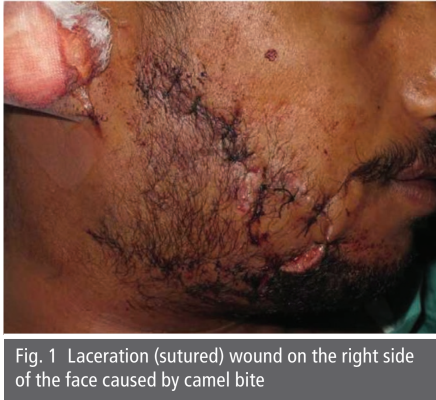

Fig. 1 Laceration (sutured) wound on the right side of the face caused by camel bite

We report a case of a 29-year-old male patient who was bitten by a camel when giving it an injection for scabies. He bled profusely after the bite, receiving first aid care and vaccination at a nearby hospital. On examination the patient was fully conscious, all vitals were stable and there was a 5 cm lacerated wound on the right side of his face (Fig. 1). There was bleeding from the right ear and three separate wounds in the scalp on the left side representing the size of camel teeth. His mouth opening was slightly restricted because of pain, deviation of the mandible on the right side, with weakness of the marginal mandibular and buccal branch of the facial nerve.

Intraorally the patient had disturbed occlusion with premature molar contact on the right side. A CT scan of the facial bones revealed a fracture of the right subcondyle. The fracture site was exposed, reduced and fixed using two, four-holed titanium mini plates of 2 mm diameter. The patient received antibiotics and analgesics postoperatively, and regular follow-up for five years was satisfactory. We consider this to be a rare case because of the uncommon mechanism of injury with compression of the right side of the mandible and left side of skull vault between the two big jaws of the camel without causing injury to the external pinna. As the condyle is the weak point in the mandible it was easily fractured preventing transmission of forces to the cranium.

S. Sanadi, S. Abid, Y. Thobaiti, Saudi Arabia

1. Stucker F J, Shaw G Y, Boyd S, Shockely W W. Management of animal and human bites in the head and neck. *Arch Otolaryngol Head Neck Surg* 1990; **116:** 789–793.
2. Khatana S, Bhagol A. Camel bite injury to the maxillofacial region: unusual cause and uncommon location. *J Craniofac Surg* 2013; **24:** 1957–1959.
3. Ogunbodede E O, Arotiba J T. Camel bite injuries of the orofacial region: report of a case. *J Oral Maxillofac Surg* 1997: **55:** 1174–1176.
4. Ugboko V I, Olasoji H O, Ajike S O, Amole A O, Ogundipe O T. Facial injuries caused by animals in northern Nigeria. *Br J Oral Maxillofac* Surg 2002; **40:** 433–437.

DOI: 10.1038/sj.bdj.2016.752

Oral surgery

Too much information

Sir, 'If there wasn't blood everywhere ... gums flapping, bones bleeding, the root's disappeared!' These thoughts are probably quite common in the minds of dental surgeons conducting apicectomies. However, it is somewhat unusual in twenty-first century dentistry to actually voice them to a patient. Nonetheless, these were the very words spoken to my wife recently at a well-known Glasgow practice. She was understandably alarmed to hear such a detailed description of the carnage in her oral cavity.

While it is important to keep parents fully informed during dental surgery,[1] there is such a thing as too much information – and, indeed, too much contemporaneity. Such running commentary hardly instils in the patient a sense of the dentist's professionalism;[2] in fact, it paints a vulgar picture of the dentist's competence, given that it was the dentist who started the bleeding, the flapping, and the disappearing. My wife might have said something to this effect had she been able to answer back. Fortunately, the surgery seems to have had a good outcome despite the dentist's low score in terms of (over-)communication skills. Hopefully any of your readers with a similar penchant for gory imagery will alter their manner accordingly.

D. Shaw, by email

1. Shaw D. Continuous consent and dignity in dentistry. *Br Dent J* 2007; **203**: 569–571.
2. Shaw D. Ethics, professionalism and fitness to practise: three Concepts, not one. *Br Dent J* 2009; **207:** 59–62.

DOI: 10.1038/sj.bdj.2016.753

Antibiotic prophylaxis

Questions about NICE

Sir, the article by Thornhill *et al.* (A change in the NICE guidelines on antibiotic prophylaxis *BDJ* 2016; **221:** 112–114) raises some fundamental questions about NICE.

While NICE guidelines should always be precisely that – guidelines rather than protocols – and clinicians should exercise clinical judgement in the context of an informed discussion with patients and their close ones where appropriate (what is new?), the purpose of NICE is surely to provide unambiguous, evidence-based recommendations. Patients should have a reasonable expectation that they are managed in a way that is consistent across the profession. Whatever one's position might be in the 'cover', 'no cover', or 'cover sometimes' debate (which still remains largely opinion based), at least the 2008 iteration of CG64 achieved clarity and unambiguity (it also directed attention to what in my mind is the most important issue in all of this – namely high standards of oral hygiene and rapid management of sepsis). The July 2016 iteration does anything but; in fact it dangerously re-focusses the debate on prophylaxis rather than on those crucial preventive factors and leaves the clinician wondering 'who is right?' We do not even have a current UK antibiotic prophylaxis regime should we decide to cover (although Thornhill *et al.* provide guidance in their article). To add insult to injury, if not for the opinion piece in this Journal, most practitioners would probably not even be aware of this important development. This really is not good enough.

Thornhill *et al.* are to be congratulated for their thoughtful and thought-provoking piece; NICE should look to its laurels.

R. S. Moore, Liverpool

DOI: 10.1038/sj.bdj.2016.754

Paediatric dentistry

No added sugar

Sir, currently as a dentist treating only children I am struck by the confusion over 'no added sugar' drinks amongst parents and carers. On a daily basis, on questioning of drinks consumption, I find time and time again I am having the conversation over sugar free or no added sugar drinks. The clever marketing campaigns appeal to families with a most recent advert including the slogan 'drink more water' for a popular squash brand! This specific commercial shows a handy pocket size cordial that can be added to a water bottle while on the go. This leads to parents and carers very easily giving their children highly cariogenic drinks, in increased frequency, whilst believing they are tooth safe. As we all in the profession are only too aware this can cause rapid tooth destruction, especially to the primary dentition through both caries and tooth surface loss.[1]

The state of children's teeth in the UK has already been brought to the general public's attention through various documentaries focussing on paediatric dentistry and also the 'sugar tax' debate.[2] However, there is still a general lack of understanding with regard

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