

# Other journals in brief

A selection of abstracts of clinically relevant papers from other journals.

The abstracts on this page have been chosen and edited by John R. Radford.

## Post Gillick

Adolescent autonomy revisited: clinicians need clearer guidance

Brierley J, Larcher V. *J Med Ethics* 2016; **42**: 482–485

**In addition to the court, those with parental responsibility have the authority ‘to override the refusal of a Gillick-competent child, if it was in his or her best interests to do so.’**

Invariably, examination candidates cannot be restrained when asked to describe Gillick competence. Alas they, and indeed their examiners, invariably know only of one side of the argument. Yet it was back in 1996, ‘Brazier and Bridge (DOI: 10.1111/j.1748-121X.1996.tb00401) raised the question “is adolescent autonomy truly dead and buried” following judicial decisions which had seemed to reverse the Gillick-inspired trend for greater child autonomy in healthcare.’

Intimately linked with this ruling is the ‘best interests’ test. This has recently been explored in a paper (see *J Med Ethics* 2016; **42**: 542–549) that has been summarised in this section of the *British Dental Journal*. At the heart of the ‘best interests’ test is for whom is that the best interest?

There is a tension. On one hand, there is both the legal and ethical imperative to protect children from the harmful consequences of their actions. Such has been set out by the United Nations Convention on the Rights of the Child, Article 3(1): ‘In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.’ This has been enshrined in the Children Act 1989 with The Welfare Checklist. But then there is autonomy.

As background, it is assumed that a child of 16 years of age can consent to medical treatment as long as they demonstrate capacity to ‘understand (fully) the nature and purpose of the proposed treatment and its consequences for themselves and their family.’ The issue hinges on a child’s right to refuse treatment. It is entirely plausible that ‘refusal of treatment is more likely to be associated with adverse outcomes than consent’; refusals for treatment are considered irrational in contrast to consent that would appear rational. Notwithstanding this, ‘harms of non-evidence-based therapies are increasingly recognised.’

Recent case law [NHS Foundation Trust Hospital v P [2014] EWHC 1650 (Fam)] involved a 17-year-old female with a personality disorder and history of self-harm, requiring treatment for an overdose of paracetamol. P refused consent to this urgent treatment. The Hospital Trust made an urgent out-of-hours application that indeed it would be lawful to treat P, despite her refusal. Although the psychiatrist considered she had capacity despite her mental health history and personality problems, the court ruled against her refusal as it was considered in her best interests to receive treatment.

The authors urge ‘...clarity over the circumstances in which society expects that autonomous choices of adolescents can be overridden.’

DOI: 10.1038/sj.bdj.2016.774

## Smile aesthetics

The impact of occlusal plane cant along with gingival display on smile attractiveness

Kaya B, Uyar R. *Orthod Craniofac Res* 2016; **19**: 93–101

**Inverse relationship between occlusal cant and gingival display.**

The conclusion made in the ‘Structured Abstract’ that heads-up this paper is that the ‘influence of occlusal plane cant becomes less when gingival display increases, whereas the influence of gingival display decreases when occlusal cant increases.’ In this study carried out in Başkent Üniversitesi Turkey, 204 raters (orthodontists, dentists and lay people) assessed the attractiveness of 30 different smiles using the visual analogue scale (VAS). Pictures of smiles, that of note were restricted to the lower half of the face only, had been modified using image processing software such that they showed different occlusal cants and gingival displays. ‘Occlusal plane cants above 2° and gingival display above 0 mm were perceived unattractive.’ Age and gender of the rater did not affect perception of the smile attractiveness. As ‘smile design’ now appears to be the preserve of the cosmetic dentist, it was not surprising that dentists and orthodontists rated the attractiveness of smiles less than lay people.

DOI: 10.1038/sj.bdj.2016.775

## BoTN-A

The efficacy of botulinum toxin for the treatment of trigeminal and postherpetic neuralgia: a systematic review with meta-analyses

Shackleton T, Ram S *et al.* *Oral Surg Oral Med Oral Pathol Oral Radiol* 2016; **122**: 61–71

**There is moderate evidence as to the efficacy of the use of botulinum toxin to treat trigeminal neuralgia and postherpetic neuralgia.**

Pharmacotherapy is the treatment of choice for most ‘neuralgias’ as it is less invasive than surgery. However, such medication is associated with ataxia, dizziness, nausea, fatigue, rash and drowsiness. Botulinum toxin type A (BoTN-A) is a neurotoxin that blocks acetylcholine release from presynaptic nerve endings. It has analgesic effects independent of its action on muscle tone.

In this systematic review and meta-analysis, 179 references were identified. Following exclusion, 19 texts were interrogated resulting in six studies that were included in this qualitative synthesis. All six studies were double-blinded, randomised, placebo-controlled studies. The overall strength of the evidence was moderate because of the small number of studies and risk of bias. ‘Patients treated with BoTN-A were about 2.9 times more likely to have a 50% or more reduction in pain compared with the placebo group (95% CI 1.726–4.848;  $P < 0.001$ ).’ This finding is particularly welcome as all the patients had had a suboptimal response to conventional medical management.

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