

Letters to the editor

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Multidisciplinary teamwork Collaborating on diabetes

Sir, diabetes mellitus afflicts 3.3 million people in the UK with perhaps a further one million as yet undiagnosed.¹ As HbA1c rises, the risk of periodontal disease increases dramatically.² The combination of increased inflammatory mediators, advanced glycation end products and impaired immunity in diabetes may all play a role.³ But this is by no means a one-way street. Indeed, the bidirectional relationship between poor glycaemic control and periodontal disease is long established.³ One would assume therefore that, between dentists and physicians, information regarding these diseases is both easily accessible and eagerly sought...

As doctors, we are fortunate to know several practising dentists from whom we can seek insight into current practices. 'We just ask how well controlled it is... and some do a BM' was the first response we garnered after asking a dental colleague. Another explained, 'dentists don't really talk to GPs or diabetic specialists. We just tell patients with periodontal disease to make sure they get their glucose tested and make sure it's well controlled with [medications] and diet'. A third colleague reported, 'it's usually a case of taking the patient's word for it'. Indeed, more often than not we can trust that our patients will give us a truthful insight into the control of their condition. However, both denial and lack of insight are certainly not devoid in such patient groups.^{4,5} Needless to say, as doctors we are guilty of much of the same. I cannot recall a single instance where I, or one of my peers, had thought to consult a patient's dental records!

We would like to invite our dental colleagues to work more closely with us to increase awareness and curb the incidence of diabetic periodontal disease. Awareness of poor oral health amongst doctors may prompt early investigation for diabetes, whilst awareness of

poor glycaemic control amongst dentists may encourage targeted dental assessment and aid diagnosis. Just as the once estranged medical specialties have irrevocably come to realise, multidisciplinary teamwork may well be the key in breaking such vicious cycles.

S. Dhesi, J. Ellenbogen, by email

1. Diabetes UK. Diabetes prevalence 2014 (June 2015). Available at <https://www.diabetes.org.uk/Professionals/Position-statements-reports/Statistics/Diabetes-prevalence-2014/> (accessed 9 February 2017).
2. Taylor G W, Borgnakke W S. Periodontal disease: associations with diabetes, glycemic control and complications. *Oral Dis* 2008; **14**: 191–203.
3. Mealey B L. Periodontal disease and diabetes. A two-way street. *J Am Dent Assoc* 2006; **137**: 26–31.
4. Broom D, Whittaker A. Controlling diabetes, controlling diabetics: moral language in the management of diabetes type 2. *Soc Sci Med* 2004; **58**: 2371–2382.
5. Garay-Sevilla M E, Malacara J M, Gutiérrez-Roa A, González E. Denial of disease in type 2 diabetes mellitus: its influence on metabolic control and associated factors. *Diabet Med* 1999; **16**: 238–244.

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Oral health

Welcome progress

Sir, for oral health to be included as a key indicator in the Royal College of Paediatrics and Child Health report¹ published in February is welcome progress. At last the mouth is considered to be integral to well-being. A number of factors seem to have brought us to this point including a Chief Dental Officer whose rallying cry is that the mouth needs to be put back into the body. Other factors are the growing awareness that the state of children's oral health is unacceptable in a first world country and an acceptance that children's teeth are not simply the responsibility of parents or dentists. As a society, we all have a part to play whether it's a willingness to embrace a sugar tax, to support tooth-brushing in nurseries or to adopt fluoridation where it's warranted.

BSPD welcomes the movement towards greater collaboration among all those working with children. This was one of the key aims

from the stakeholders meeting we held last year. We are grateful that the Child Oral Health Improvement Programme Board is driving that collaboration.

It's now understood that in these straitened times we are spending millions of pounds carrying out extractions under general anaesthetic in hospital. By working together we can dramatically reduce the burden on the public purse and the impact on children and their families, suffering from a disease which, let's remember, is almost always preventable.

C. Stevens, Vice-President of the British Society of Paediatric Dentistry

1. Royal College of Paediatrics and Child Health. State of Child Health Report 2017. Available at: <http://www.rcpch.ac.uk/state-of-child-health> (accessed March 2017).

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Child dental health

Forty year overview

Sir, in our overview of 40 years of surveys of Children's Dental Health,¹ we reported that 33% of 15-year-old children had permanent teeth extracted because of decay in 1973, reducing to 24% in 1983, and then to 7% in 1993. It has remained near to that figure for the last 20 years.

The proportion of 15-year-olds undergoing extractions as part of orthodontic treatment ranged from 21–26% between 1973 and 2003.^{2,3} We examined the raw data, recently made available, of 2,415 15-year-old children from the 2013 survey of England, Wales and Northern Ireland.⁴ Fifteen percent of 15-year-olds in England had had at least one tooth extracted as part of orthodontic treatment, compared with 16% in Wales and 21% in Northern Ireland. The teeth most commonly extracted were: upper first premolars (8.9%), lower first premolars (4.1%), and upper and lower second premolars (3.8%). Less than 1% of first permanent molars were extracted for orthodontic reasons. In

England and Wales, 7% of 15-year-olds had four teeth extracted, 6% had two teeth extracted and 2–3% had one tooth extracted.

In our previous paper,¹ we did note the problems with analysing trends due to changing methodologies in the surveys but that for 12- and 15-year-olds, the impact was likely to be minimal. It does therefore appear that the proportion of 15-year-olds who have had extractions for orthodontic treatment has decreased over the last ten years, despite a relatively constant number of 12-year-olds undergoing orthodontic treatment at the time of the survey (8–9%) and an increase in the number of 15-year-olds under treatment from 14% to 18%.^{3,4}

C. R. Vernazza, J. J. Murray, Newcastle

1. Murray J J, Vernazza C R, Holmes R D. Forty years of national surveys: an overview of children's dental health from 1973-2013. *Br Dent J* 2015; **219**: 281-285.
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Dental radiography

Vanishing implant

Sir, having undergone successful treatment for a squamous cell carcinoma of the anterior mandible and lower lip, a patient was now ready for the restorative phase of treatment. The surgery left her edentulous in the lower jaw and in need of some form of prosthesis. She was given a number of options for her treatment and upon discussion with the team, decided to have an implant retained lower complete denture.

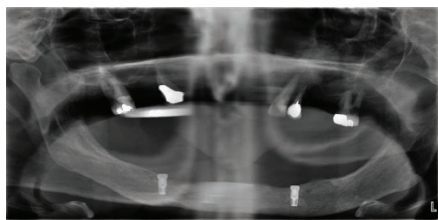


Fig. 1 Only two implant fixtures are seen



Fig. 2 The third implant magically reappears

Subsequently, she had three implant fixtures placed into her lower jaw under general anaesthetic and this was completed without complications. Having returned for a follow up appointment, a dental pantomogram (DPT) was taken to review the position of the implant fixtures (Fig. 1). The image shows the presence of only two implant fixtures, with the central fixture missing, which led to questions as to what had happened to it. The patient explained that she was completely oblivious to it all and had not noticed anything drop out of her mouth. One month later, she returned for a further follow up to review her implant fixtures, as well as her oral candidiasis. A new DPT was taken (Fig. 2) now with the middle implant fixture clearly visible!

This acts as a reminder of a number of key areas with regards to dental radiography. Firstly, ensuring the radiograph is taken appropriately, including the preparation of the patient and the machine and the appropriate positioning of the patient. Secondly, taking care when combining what is known clinically with what can be seen radiographically to form an overall impression. Finally, it raises the question as to whether periapical views should be taken in addition to DPTs in such instances.

(With thanks to Mr Neil Macmillan and Mr Nick Lewis.)

Y. Twaij, by email

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Dental education

Oral biology teaching

Sir, the recent spring meeting of the Association of Basic Science Teachers in Dentistry (ABSTD) brought together oral biology teachers including professors emeritus and heads of school, module leads and lecturers involved in front-line teaching, and was themed around a conversation on the current status of oral biology teaching. Despite a diversity of opinion, each speaker, independently and in their own distinctive way, raised two concerns. Firstly, the loss of scientific rigor in many contemporary oral biology courses and secondly, the lack of engagement and low levels of curiosity amongst students often associated with this topic area. The causes are complex, but may involve shortage of faculty with appropriate expertise, increased competition for teaching time, the eclipsing of basic sciences by clinical topics in contemporary, integrated curricula and inadequate guidance in documentation from regulatory bodies.

Basic science, and oral biology in particular, provide a foundation for clinical studies. If lost, much of the understanding which underpins dentistry will be damaged which will, in turn, impact on the ability of new graduates to deal with complex situations, to respond to change and technical advance, and ultimately on the quality of dental care. Therefore, we must extend this conversation to the whole profession and campaign for a reassessment of the scientific rigor of many dental courses to ensure that the dental degree continues to retain its status as a widely respected, scientifically based professional qualification.

J. Bennett, President, Association of Basic Science Teachers in Dentistry, Plymouth

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Outreach teachers essential

Sir, the recent research paper by Parrot, Lee and Markless (*BDJ* 2017; **222**: 101–106) demonstrates yet again the need for, and special skills required to be, a clinical teacher in a dental outreach setting and the authors are to be congratulated on highlighting this issue.¹

The essential requirement of being 'clinically competent' in a clinical teacher is clear to all parties. However, it is also clear from their paper that students think that a teacher's characteristic of being 'available, receptive and supportive' is of greater importance than the teachers themselves do.¹ Our own research at the University of Portsmouth Dental Academy (UPDA) indicates that students are empowered to be independent practitioners in an environment which treats them as colleagues to be supported, rather than simply recipients of the teachers' expertise.² The need for clinical teachers to be aware of the difference between the academic teaching of the dental school and the realities of primary care/outreach teaching should form an essential part of the training and preparation for their role in outreach education.

However, we have previously highlighted the logistical difficulties and financial costs of providing such preparation and training for part time clinical teachers in an outreach setting.^{3,4} Part-time teachers frequently have other regular commitments, meaning not all teachers can attend on one training or induction day. The training then has to be repeated until all have attended. Time off from their teaching commitment for training involves the costs of providing staff cover. UPDA is exceptionally well supported by both its parent universities (University of