

Letters to the editor

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Oral cancer

Early/delayed diagnosis

Sir, during the last 75 years different definitions and criteria for diagnostic delay have been used when studying early/delayed oral cancer diagnosis, unveiling a remarkable lack of methodological and terminological consistence.¹

The Aarhus guidelines,² issued to overcome these limitations, have proposed standardised time-intervals within a conceptual framework and the abandonment of the term 'diagnostic delay'. The mileposts in this model define the patient interval (first symptom to first presentation to a healthcare professional [HCP]), the primary care interval (first presentation to HCP to first referral to secondary care level), the diagnostic interval (first presentation to diagnosis), and the pretreatment interval (from diagnosis to the start of treatment). This approach gives consistent definitions and a methodological guide for improving the design of studies on this topic,³ which in turn has permitted the demonstration of an association between longer time intervals to diagnosis and treatment of symptomatic oral cancers with poorer outcomes.

In this context, the role of the HCP (GDPs) is particularly relevant to achieve shorter patient and primary care intervals. Bearing in mind the existent 'alarming lack of public awareness', particularly in vulnerable subpopulations, strategies for increasing public awareness of this neoplasms should be prioritised, focusing on its most frequent signs and symptoms – persistent lump or swelling, and white or red patch – especially on those with a higher predictive positive value, such as a non-healing ulceration. Patients should avoid reinterpreting these symptoms as minor oral conditions.

GDPs should undertake specific continuous professional development programmes, as lack of knowledge at the primary care level has been shown to contribute to delay in referral and

treatment. Moreover, and despite the lack of evidence for interventions to reduce the primary care delay in cancer referral, the NICE guidelines have proved useful for reducing the diagnostic interval in cancer, particularly in head and neck carcinomas.

In any case, GDPs should consider that the use of inadequate terminology for describing the period since the onset of signs/symptoms to the definitive diagnosis of oral cancer, like 'early/late', 'prompt/delayed', 'prompt/non-prompt', 'timely/untimely' may have negative connotations,² apart from being imprecise. Contrarily, the use of more descriptive terms [eg: short(er)/long(er)] to describe the different time intervals may help to improve terminological consistence in this field² and to ease scientific communication.

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2. Weller D, Vedsted P, Rubin G *et al*. The Aarhus statement: improving design and reporting of studies on early cancer diagnosis. *Br J Cancer* 2012; **106**: 1262–1267.
3. Varela-Centelles P, López-Cedrún J L, Fernández-Sanromán J *et al*. Key points and time intervals for early diagnosis in symptomatic oral cancer: a systematic review. *Int J Oral Maxillofac Surg* 2017; **46**: 1–10.

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Dental practice

Loyal and caring staff

Sir, I applaud P. Williams' longevity¹ as I have only achieved 36 years at Cotteswold House Dental Care. I do however have a nurse who will on 4 July celebrate 40 years at the practice and a receptionist who has 38 years of service.

While running and owning a successful caring business is to be applauded, I am so

proud that my staff are the most loyal and caring imaginable. To work for one business, dental or other, for 40 years is, I imagine, extremely rare and Dawn Smith will get the big celebration she deserves.

S. Waters, Gloucester

1. Williams P. Dental practice: Longevity record? *Br Dent J* 2017; **222**: 323.

DOI: 10.1038/10.1038/sj.bdj.2017.381

OMFS

Dental fitness prior to cardiac surgery

Sir, I work in the oral and maxillofacial surgery unit of a district general hospital. In the past years we have seen an increasing number of patients due to undergo planned cardiac surgery referred to us by their general dental practitioners (GDPs) for removal of any poor prognosis teeth. Dental fitness is essential to reduce the risks associated with cardiac surgery and prevent post-operative infections related to dental causes.¹

It has recently come to my attention that a number of these patients have brought with them a form requesting the oral surgeons to sign it. This form is a declaration of dental fitness and is issued by their cardiac surgeons. It has been highlighted that it needs to be signed prior to proceeding with their cardiac surgery. It is concerning that a couple of patients reported that they have not been given a date for the operation until this form is returned signed.

In this day and age most patients aim to retain their natural dentition for as long as possible. Our department as well as most oral and maxillofacial surgery departments non-affiliated with a dental hospital offer secondary surgical services but they are unable to provide routine dentistry. Upon completion of their oral surgery treatment, it is likely that further dental issues need to be addressed, including periodontal treatment, restorations and oral hygiene improvement. It is imperative that

the GDPs ensure that the oral cavity is in good health prior to planned cardiac surgery. It may therefore be more appropriate that similar forms are signed at the completion of dental treatment by their GDP. The above may not apply to emergency cardiac surgery when patients are unable to attend their dentist.

It is understandable that in certain cases the decision to declare dental fitness beyond any doubt can be difficult and overwhelming for the dentist. The lack of clear guidance, the patient's compliance with everyday oral care and the shift to maintaining the natural dentition is contributing further to the uncertainty.

A. Pantiora, by email

1. Chambers J B, Dayer M, Prendergast B D *et al*. British Heart Valve Society Beyond the antibiotic prophylaxis of infective endocarditis: the problem of dental surveillance. *Heart* 2013; **99**: 363–364.

DOI: 10.1038/sj.bdj.2017.382

Water fluoridation

It really is this simple

Sir, thank you for printing Dr Connett's letter regarding fluoride.¹

Recent publicity around unacceptable levels of child GA exodontia and the development of the (welcomed) Starting Well Programme, targeting prevention at the 13 areas in England with the worst child dental health, make the letter highly relevant.

There is simply no credible evidence that fluoride is neurotoxic at the concentrations used in community water fluoridation or those occurring naturally in areas like Hartlepool of between 0.7 and 1 ppm. There is, however, an

international consensus that fluoridation at this level is safe and effective. It really is this simple.

The language used by Dr Connett is typical of the anti-fluoridation lobby. Words such as neurotoxic, toxic, fearful, chemophobia are designed to elicit an emotional response and to intimidate – even when there is zero evidence to support the points made. To an extent this approach has worked, successfully intimidating dentists and politicians even in the face of the scientific evidence that fluoridation can make a difference and is safe. There are signs that this is changing with the realisation that, in spite of the improved evidence-based prevention being delivered by GDPs in primary care, problems remain and fluoridation could help to change this.

It really is time that science and evidence is allowed to make the case for and against fluoridation. Recent reports^{2–4} from New Zealand, Australia and here in the UK state resoundingly that fluoridation is safe and reduces dental disease. As dentists, we need to demonstrate leadership, talk to our patients and local politicians and advocate fluoridation, particularly in communities where the dental health burden is high and where dental health inequalities are wide. It is time that the facts around fluoridation are allowed to speak for themselves – to use Dr Connett's own words – to protect the health of citizens.

Hull and the East Riding of Yorkshire LDC

1. Connett P. Water fluoridation: Is fluoride chemophobia? *Br Dent J* 2017; **222**: 323–324.
2. The Royal Society of New Zealand. Health effects of water fluoridation: A review of the scientific evidence. A report on behalf of the Royal Society of New Zealand and the Office of the Prime Minister's Chief Science Advisor. August 2014.

Available at: <http://royalsociety.org.nz/assets/documents/Health-effects-of-water-fluoridation-Aug-2014-corrected-Jan-2015.pdf> (accessed April 2017).

3. NHMRC. Draft Information Paper: Effects of water fluoridation on dental and other outcomes. September 2016. Available at: <https://consultations.nhmrc.gov.au/files/consultations/drafts/nhmrc-fluoride-information.pdf> (accessed April 2017).
4. Public Health England. Water fluoridation. Health monitoring report for England 2014. Executive summary. March 2014. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/300201/Water_fluoridation_health_monitor_for_England_2014_executive_summary_1Apr2014.pdf (accessed April 2017).

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Mystery object

Denture drop

Sir, I acquired but sadly disposed of an identical 'mystery object' to that pictured in the *BDJ*¹ (Fig. 1) when I took over a retirement practice in Woodford Green in 1978. It was designed to be held by the dentist or nurse, just above the chin, allowing discreet removal of dentures directly into the small bowl. Patients would use their hands to briefly 'hide' the dentures as they slipped out of the mouth.

C. Wallis, by email

1. News. Can you identify this mystery object? *Br Dent J* 2017; **222**: 325.

DOI: 10.1038/sj.bdj.2017.384



Fig. 1 Mysterious porcelain dish at the BDA Museum

CASE REPORT LETTERS

TMJ pain

Giant cell arteritis warning

Sir, in August of 2016 a very fit and healthy 73-year-old female patient of mine developed intermittent severe pains in the occipital area bilaterally. Following a series of tests, a consultant rheumatologist prescribed prednisalone 25 mg per day but admitted to not having a definitive diagnosis.

In December 2016 the patient suddenly developed severe TMJ pain and although no occlusal disharmony in two intact arches was identified a soft-bite raising splint was

provided. This gave some slight relief and the symptoms slowly subsided. The prednisalone was then at 10 mg per day.

In January 2017 she noticed that blood vessels in her temple were becoming prominent (but not painful) and then she experienced pain in her muscles of mastication on chewing (claudication) and was unable to finish a meal where meat required chewing.

An urgent appointment with the rheumatologist was sought. He diagnosed giant cell arteritis (GCA) and the prednisalone was increased to 60 mg. A significant number of patients with GCA (up to 20%) suffer problems

with occlusion of the ophthalmic artery and permanent blindness. Strokes are also more likely. It is therefore essential that high doses of prednisalone are given as soon as GCA is suspected as this massively decreases the incidence of eye problems.

As general dental practitioners we should be more aware of GCA and that pain on eating or other undiagnosed 'jaw pain', is a symptom. Also, an oral surgeon advised me that any instance of rapid onset TMJ pain in an older patient should be referred urgently and that a biopsy of the temporal artery would probably be carried out. It seems there