COMMENT

Letters to the editor

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Patient management

Ask about habits

Sir, pain from the temporomandibular joint (TMJ) is a common reason for referral to the secondary care setting by general medical and dental practitioners alike.

I had the pleasure of meeting a 19-year-old gentleman who presented with a two-year history of pain from his left TMJ which was not subsiding. The patient denied clenching or grinding his teeth; however, when asked about habits he revealed the specimen shown in Figure 1.

Further questioning revealed the patient was chewing this pen lid for up to 12 hours a day. He further mentioned chewing his headphone wires when he misplaced his pen lid (Fig. 2).

Fig. 1 Extensively chewed pen lid

Fig. 2 Patient demonstrating headphone wire in between his teeth

Needless to say, the cause of his pain was obvious and part of his care plan involved elimination of these detrimental habits. He was surprised to hear that persistent chewing of pen lids was likely contributing to his pain, which reaffirms to all clinicians: when there is pain from the TMJ, make it a habit of asking about habits.

M. Dungarwalla, London

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Appealing to five senses

Sir, I recently had the pleasure of treating a blind patient with periodontal disease in general practice. Without the use of the gentleman's sight, it was necessary for me to adapt my usual tooth-brushing and oral hygiene instruction to convey the disease process and teach my patient how to effectively remove plaque from his teeth. Since his periodontal treatment, I have changed the way I practise.

I believe effective oral hygiene instruction to any patient should appeal to all five senses:

SIGHT – The use of disclosing tablets, demonstration on teeth models, flip charts

FEEL – Let the patient feel how a toothbrush and interdental brush is meant to engage with the teeth physically, particularly at the gingival margin and in-between the teeth

SOUND – The clinician must listen to the patient, and *vice versa*. Find out what aspects of oral hygiene they are having difficulty with and support them as necessary

TASTE – Let them taste what a clean mouth and fresh breath tastes like; over time they often report this change

SMELL – We all know perio-breath and would rather have less of that around!

I hope other clinicians find this useful.

I. Midwood, by email

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Oral cancer

A point to chew upon

Sir, we read with interest the letter *Oral cancer: Indian pandemic* where the authors have drawn attention to this deadly disease in India.[1] As dental professionals we are participating in the development of an atlas of cancer in Haryana state in North India that focuses on the reporting of each cancer case reported in Haryana state from each medical institution. The smokeless tobacco (SLT) or chewable tobacco market in India is the world's largest market (70.7 million people) with an exponential growth.[2] Nearly 80% of global SLT users live in the South Asia region, which has myriad varieties of SLT products (betel quid with tobacco, khaini, gutkha, paan masala ,mawa, bajjar, gudakhu and snuff).[3] The biggest drawback we have encountered in this registry is the complete lack of awareness of the public perception of the harmful effects of SLT as compared to smoking.

Within rural parts of North India smoking is a taboo for women but conversely it leads to them using SLT as it is easy to hide from others who might disapprove. Women in this area also have a misconstrued belief that chewing tobacco increases energy for daily labour in the face of limited food intake and to suppress hunger.[4] Easy availability, poor socio-economic status, illiteracy and the low cost of the SLT are other key factors that promotes SLT use by women.[4] Moreover, the use of tobacco-based dentifrices (mishri, gul and lal dant manjan) further aggravates the problem. The quit ratio for SLT is notoriously low (5%) as compared to smoking.[2]

Dental professionals should be more aware and enquire more specifically about SLT use by their rural female patients. Social marketing campaigns are essential but they will have to focus more on SLT-related health risks in females also. Though there is research

on dual usage of smoking and SLT in India among men, there is negligible research as yet on SLT usage and on the patterns and predictors of Indian females' SLT use with its health consequences to explore patterns of usage, especially during pregnancy. The first step in winning the war against tobacco is to acknowledge the unique challenge posed by the usage of SLT in females, which needs to be addressed through social/behavioural and policy level approaches. Eventually, the success of the campaign will depend on women's willingness to be open about their SLT behaviours.

G. Sharma, A. Nagpal, Haryana, India

1. Gupta B, Johnson N W. Oral cancer: Indian pandemic. *Br Dent J* 2017; **222:** 497.
2. Global Adult Tobacco Survey 2009-2010. Available from: https://www.mohfw.nic.in.
3. Indian Council for Medical Research. Three-Year Report of Population Based cancer Registries 2012–2014. Bengaluru, India: National Centre for Disease Informatics and Research-National Cancer Registry Programme, 2016. Available at: http://www.ncrpindia.org.
4. Nair S, Schensul J J, Begum S et al. Use of smokeless tobacco by Indian women aged 18-40 years during pregnancy and reproductive years. *PLoS One* 2015; **10:** e0119814.

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Occupational health

An underestimation

Sir, we read the *BDJ* article by Brown *et al.* with interest.[1] As occupational physicians (OP), it was disheartening to read that 92% of respondents who did not receive occupational health (OH) input would have liked to have been offered this service. Furthermore, only 28% of respondents were offered OH advice before ill health retirement, despite over 90% of respondents feeling that their ill health was work-related. Considering the high proportion of work-related ill-health (WRIH) reported in the paper, we wish to share some information regarding OH.

The Occupational Physicians Reporting Activity (OPRA) Network is the only UK-wide OP diagnosed data source of individual incident case reports of all WRIH.[2] Between 2001–2014, 15,822 cases of WRIH were reported to OPRA, out of which 33 were in dentists. After taking into account sampling, a total of 253 estimated cases were reported in dentists, 174 cases (69%) of which were work-related mental ill-health (WRMIH). Occupational stress with high risks of burnout is widely acknowledged amongst dental practitioners, especially in those who work in the NHS.[3-5]

Although musculoskeletal diseases were the most commonly reported cause of ill-health retirement in the paper,[1] only 12% of cases (n = 30) were so related within the OPRA dataset. Interestingly, 37 cases (15%) that were reported by OPs were cases related to either dermatological or respiratory causes, suggesting different risks leading to a wide range of WRIH conditions. Since not all dental practitioners will readily have access to OH services these findings are likely to be an underestimation of the true extent of WRIH amongst them. While there is a higher OP coverage in the NHS compared to other industries,[6] many dental practitioners, even those who are involved in NHS work, may not be employed by the NHS[7] and therefore may not be entitled to OH services. Those in private practice may choose to forego OH services due to costs.

The recognition of WRIH and timely preventative steps could not only improve well-being in dental practitioners but could also reduce the risk of premature ill-health retirement.

A. Y. Zhou, R. Agius, M. Carder, by email

1. Brown J, Burke F J, Macdonald E B *et al.* Dental practitioners and ill health retirement: causes, outcomes and re-employment. *Br Dent J* 2010; **209:** E7.
2. The Occupational Physicians Reporting Activity (OPRA) Network. 2016. Available at: http://research.bmh.manchester.ac.uk/epidemiology/COEH/research/thor/schemes/opra/ (accessed 19 April 2017).
3. Denton D A, Newton J T, Bower E J. Occupational burnout and work engagement: a national survey of dentists in the United Kingdom. *Br Dent J* 2008; **205:** E13.
4. Bretherton R, Chapman H R, Chipchase S. A study to explore specific stressors and coping strategies in primary dental care practice. *Br Dent J* 2016; **220:** 471–478.
5. Hill K B, Burke F J, Brown J *et al.* Dental practitioners and ill health retirement: a qualitative investigation into the causes and effects. *Br Dent J* 2010; **209:** E8.
6. Carder M, Money A, Turner S, Agius R M. Workforce coverage by GB occupational physicians and disease incidence rates. *Occupational Med (London)* 2014; **64:** 271–278.
7. Glickman M. NHS dentistry: A lack of help. *Br Dent J* 2017; **222:** 496.

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Greek refugee camps

One year on

Sir, further to our article one year ago regarding the first dental aid unit in a Greek refugee camp,[1] we are pleased to report that the charity has gone from strength to strength and is now known as 'Health Point Foundation'.

The unit has moved to Thessaloniki in northern Greece, where it is most in demand. We operate from a base camp and run outreach programmes to over 16 camps and are currently the only providers of dental aid to the refugees in Thessaloniki (Fig. 1). We have had over 300 international volunteers including dentists, therapists, nurses, translators, ground co-ordinators and administration staff. Last year we were working in a makeshift tent using massage tables as dental chairs. I am pleased to report the base camp has now moved into a donated container. Equipment has advanced and we have two dental chairs, portable hand pieces and much more.

The service runs six days a week. A typical working day would include packing equipment from the base camp and setting off for outreach. Work normally starts by 10 am. With the situation being incredibly fluid, it is not uncommon to arrive at the camp and face an obstacle. This may include the military not allowing you access to the camp, another NGO is using your room, or the refugees have all left the camp to new accommodation. It is important to be flexible and keep an open mind. Once the patients start flowing, the satisfaction and gratitude makes any obstacles seem trivial. Currently, treatment is emergency based only, carrying out mostly extirpations and extractions. We run dental education programmes in the camps.

The refugees in Thessaloniki have moved into tents within containers. They are basic but it is a vast improvement from when thousands were sleeping outside. The housing is provided by the UNHCR but most of the amenities are volunteer-led. Like the dental aid, there are NGOs who set up playgroups, ladies activities and education programmes. The focus is towards stabilisation and allowing the refugees to build a life here.

We are grateful for the support from so many people in the profession. If anyone would like more information please visit our website at http://healthpointfoundation.org/ or email dental@healpointfoundation.org.

N. Siddiqui, by email

1. Siddiqui N. Personal account: 'These patients were the fortunate ones'. *Br Dent J* 2016; 2**20:** 502-503.

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Fig. 1 Nausheen Siddiqui (third from right) with the team at Thessaloniki

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