

Thousands of new oral health educators

Oral health promotion in the community pharmacy: an evaluation of a pilot oral health promotion intervention

Br Dent J 2017; **223**: 521-525; <http://dx.doi.org/10.1038/sj.bdj.2017.784>

How amazing would it be if we had thousands of new oral health educators on whom to rely? Would they be able to motivate improved oral health, lower caries levels, improve periodontal health and prompt more frequent dental attendance? All sounds too good to be true? Think again, since it seems that community pharmacists are not only hovering in the background they are actively promoting oral health on a daily and regular basis, and as part of their NHS contracts.

This paper, in reporting an initiative in deprived areas of County Durham last autumn, highlights how interdisciplinary collaboration can be of great potential benefit to society in general and dental patients, actual and potential, in particular. For me, one of the key elements of this paper is the fact that people visited and asked questions of their pharmacists precisely

because they are not dentists. That may seem so counterintuitive that it is nonsense and yet with careful thought it makes complete sense. Oftentimes people are wary of asking questions of 'an expert' for a variety of reasons. They may not have access – apparently 90% of the UK population has a community pharmacist 20 or fewer minutes away; they may not want to 'bother' an expert (the dentist) as it seems a small matter, or because the expert is always so very busy – the pharmacist may be rather more approachable in these contexts.

Also, we do have to remember, however reluctantly, that not everybody likes visiting us! It was a point of view often given in the days before clinical dental technicians could legally practice. Patients who attended the then 'denturists' argued that it was a dentist who had extracted

all their teeth and given them the dentures that now didn't fit properly, so what was the point of going back? They attended specifically because the expert was not a dentist.

With these factors in mind it is less surprising that pharmacists can be such a valuable potential source of patient education and could potentially be helped to develop into a more recognised resource of community information on oral health. What adds further positive hope is that in another survey, quoted in this paper, a questionnaire of 354 London pharmacies found that 99.4% of participants recognised oral health promotion as part of their role and 72.5% of participants were willing to incorporate this into their NHS contract. Almost all of us in the UK have one in easy reach – shall we talk to them?

By Stephen Hancocks

Spotting the signs

The impact of bulimia nervosa on oral health: A review of the literature

Br Dent J 2017; **223**: 533-539; <http://dx.doi.org/10.1038/sj.bdj.2017.837>

Sufferers of bulimia nervosa attempt to control their weight by forcing themselves to be vomit, an act often referred to as 'purging'. It is estimated that 8% of women suffer from bulimia at some point, generally beginning at around the age of 18 or 19.¹ People who have bulimia will often keep their eating disorder secret so it is important that healthcare professionals are aware of the signs; particularly dentists, considering the damaging effect of frequent vomiting on the dentition.

In this review, Tim Newton and co-authors focused on the findings of ten papers. These papers demonstrated that bulimics suffered most commonly with dental erosion, dental caries and reduced salivary secretions. However, they do note that bulimics' dietary choices could possibly account for caries and erosion, as previous studies have noted that binge eating often includes sugary foods. The authors note that bulimia is more prevalent amongst women than men (they cite one study which showed that lifetime prevalence of bulimia is 1.1% amongst women and 0.1%

amongst men). They also point out that bulimia causes a reduced salivary flow rate which in turn is detrimental to the maintenance of oral health.

The effect of gastric acid, which has a mean pH of 2.9, on teeth is clearly a major cause of dental erosion amongst bulimics. The authors point out the clear relationship between duration of self-induced vomiting and the number of lesions on the teeth.

The authors identified some cases where patients did not demonstrate a correlation between vomiting and erosion; however, they note that this may be because those patients knew not to brush their teeth immediately after vomiting.

There are conflicting reports on caries levels amongst bulimics. Reduced salivary flow rate and the dietary choices of binge eaters may account for an increase in dental caries, but better oral hygiene and the suggestion that *S. mutans* are unable to metabolise below pH values of 4.2 means that bulimics sometimes demonstrated fewer DMFT than the controls.

Newton *et al.* do stress that *S. mutans* can adapt and remain active at lower pH levels, therefore higher levels of *S. mutans* could increase the risk of caries. Further research is required regarding dental caries risk amongst bulimics as some studies found no difference in DMFT between bulimics and control groups.

The review authors conclude that it is not only vomiting that affects bulimics' teeth, but also medication and dietary habits. They suggest that as dental care professionals are in a prime position to spot signs of bulimia and also to advise on oral hygiene post-vomiting, it is important that this topic is covered in the dental curriculum.

By Jonathan Coe

1. NHS. Bulimia. Available at <http://www.nhs.uk/Conditions/Bulimia/Pages/Introduction.aspx> (accessed September 2017).



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