COMMENT

Letters to the editor

Send your letters to the Editor, *British Dental Journal*, 64 Wimpole Street, London, W1G 8YS. Email bdj@bda.org.
Priority will be given to letters less than 500 words long. Authors must sign the letter, which may be edited for reasons of space.

Care for the homeless

Dental services for the homeless

Sir, homelessness is increasing at an unprecedented rate and includes rough sleeping, couch surfing, living in B&Bs, hostels and other forms of temporary accommodation.[1]

In 2017, a staggering 300,000 people were estimated to be homeless in some form in the UK with further increases projected.[2,3]

The prevalence and severity of oral disease and lack of access to dental services amongst this group are just as worrying. In the majority of cases, access to dental care is limited to emergency visits and relief of pain.[4]

In one study, 45% were found to be experiencing ongoing pain or infection as a result of untreated dental disease,[5] whilst 54% have been reported to not have visited a dentist for more than ten years.[6] This is particularly concerning as homeless people fall into the high risk category for oral cancer due to higher rates of smoking and alcohol intake.[4]

On the plus side, many individuals, charities and organisations have made highly significant efforts and contributions to the oral health and quality of life of homeless people.

In terms of dental care, major improvement of services at a national level will only come about via change of policy and regulations, large-scale coordinated planning and investment by the government.

Despite the current availability of community and mobile dental services for homeless people, these are often fragmented and the demand for resources greatly outweighs availability.[4]

General dental practitioners are often limited in the services that they can provide, partly due to lack of adequate support and inadequate remuneration in the current UDA system, which discourages treatment of high-needs patients.

As piloting of the new dental contract has recently been extended to 2020 this remaining time frame would be an ideal opportunity for planning and inclusion of policies to encourage provision of dental care to vulnerable groups within the structure of the new dental contract.

M. Ahmadyar, by email

1. National Audit Office. What's behind the growing number of rough sleepers? 2018. Available at https://www.nao.org.uk/naoblog/growing-number-of-rough-sleepers/ (accessed November 2018).
2. Shelter. More than 300,000 people in Britain homeless today. 2017. Available at https://england.shelter.org.uk/media/press_releases/articles/more_than_300,000_people_in_britain_homeless_today (accessed November 2018).
3. Crisis. Homelessness projections: Core homelessness in Great Britain. Summary Report. 2017. Available at https://www.crisis.org.uk/media/237582/crisis_homelessness_projections_2017.pdf (accessed November 2018).
4. British Dental Association. Dental care for homeless people. 2003. Available at https://bda.org/dentists/policy-campaigns/research/patient-care/Documents/homeless_dec20_2003.pdf (accessed November 2018).
5. Simons D, Pearson N, Movasaghi Z. Developing dental services for homeless people in East London. *Br Dent J* 2012; **213**: E11. DOI: 10.1038/sj.bdj.2012.891.
6. Smile4life. The Oral Health of Homeless People Across Scotland. 2011. Available at https://dentistry.dundee.ac.uk/sites/dentistry.dundee.ac.uk/files/smile4life_report2011.pdf (accessed November 2018).

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Corporate dentistry

Upholding dental standards

Sir, re E. O'Selmo, V. Collin, P. Whitehead. Associates and their working environment: A comparison of corporate and non-corporate associates. *Br Dent J* 2018; **225**: 425-430.

According to the 'Standards for the Dental Team',[1] there are nine core ethical principles a GDC-registered dental professional must keep to at all times.

Given the findings by O'Selmo *et al.* (*BDJ* 2018; **225:** 425-430) that non-corporate associates reported a significantly greater level of autonomy and a greater ability to make workplace and clinical decisions, corporate associates will risk failing to uphold a number of these GDC principles.

For example, to put patients' interests first (Principle 1), to work with colleagues in a way that is in patients' best interests (Principle 6) and to be able to maintain the patients' confidence in the dentist and the dental profession (Principle 9).

Clearly, it is time the business practices and operations of dental corporates deserve further investigation, in depth debate and a wider audience, both dental and the public.

B. S. Chong, A. M. Berman, G. Billis, C. D. Emery, P. K. Shah, A. M. Quinn and A. D. M. Watson, by email

1. General Dental Council. Standards for the Dental Team. 2013. Available at https://standards.gdc-uk.org/ (accessed November 2018).

DOI: 10.1038/sj.bdj.2018.1121

Paediatric dentistry

Child caries and antibiotics

Sir, we have read the recent article on guidelines relevant to paediatric dentistry[1] with interest. Many issues raised by the authors were identified in a small qualitative study we completed at a district general hospital.

We completed clinician-led questionnaires with 110 children and their parents attending for the removal of carious teeth under general anaesthesia. The questionnaires were used to gather information on the percentage of children who were prescribed antibiotics in primary care prior to referral. We also explored the effect

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dental caries had on the quality of life of the children.

Worryingly, 24.5% of the children had missed school for dental-related issues prior to attending their hospital appointment, while 39% of parents felt they were not given advice on the causes or how to prevent dental caries. The absence of adequate preventative regimes at primary care level means that the oral health of children is unlikely to improve.[2]

In addition to the guidelines discussed in the article,[1] we feel it is important to recognise the guidance available for antibiotic prescribing.[3] Forty-one percent of children included in this study were prescribed one or more courses of antibiotics prior to attending their hospital appointment. Of the total number of children prescribed antibiotics, 82% of parents reported that their child's primary complaint had been of pain when seeking emergency dental treatment and that no facial swelling or increased temperature were noted.

Guidelines for antibiotic prescribing emphasise that antibiotics should be prescribed in the presence of systemic factors or in addition to local measures and not as an alternative treatment option.[3] Needless to say, cooperation plays a vital role in providing emergency dental treatment with local anaesthesia to children.

In this sample, only 20% of children were offered alternative treatment options to antibiotic prescription whereas 42% of parents felt their child could cooperate for simple treatment with local anaesthesia. This suggests there is room for improvement in the provision of emergency treatment for children presenting with dental pain. Further audits could help to reveal which areas require change.

As healthcare professionals, we have the responsibility to monitor our prescribing practices. The number of antibiotic prescriptions by general dental practitioners count as almost 10% of all NHS prescriptions in primary care.[4] Further research is needed to assess how systems within primary care can be improved to facilitate better emergency care provision whether it's through re-education or reallocation of resources.

R. Kelly, S. Kidy, P. Allen and G. Sittampalam, by email

1. Brown N, Harford S, Babbar I, Clifford J, Law C, Power R. Guidelines relevant to paediatric dentistry–do foundation dentists and general dental practitioners follow them? Part 1: diagnosis and prevention. *Br Dent J* 2018; **224**: 727–732.
2. Bagramian R A, Garcia-Godoy F, Volpe A R. The global increase in dental caries. A pending public health crisis. *Am J Dent* 2009; **22**: 3–8.
3. Scottish Dental Clinical Effectiveness Programme. Drug Prescribing for Dentistry. 2016. Available at www.sdcep.org.uk/wp-content/uploads/2016/03/SDCEP-Drug-Prescribing-for-Dentistry-3rd-edition.pdf. (accessed November 2018).
4. Faculty of General Dental Practice, UK. Antibiotic Prescribing Standards. 2014.

DOI: 10.1038/sj.bdj.2018.1122

CASE REPORT LETTERS

Dermal fillers

Dermal fillers alert

Sir, a fit and well, middle-aged female presented in practice for a routine dental check-up. She had no presenting complaints, however, on examination unusual cream coloured nodules were noted within her lower vestibular region (Fig. 1). These were firm, non-mobile and painless.

There appeared to be no obvious explanation for these lesions; the adjacent teeth were sound and positive to sensibility tests, and radiographs confirmed there was no dental pathology to explain the presence of the nodules.

A thorough intra- and extra- oral examination revealed no other abnormalities, including no lymphadenopathy. On further questioning, the patient revealed she had had dermal fillers placed four days previously into the nasolabial and Marionette lines at another practice. She confirmed that this was a hyaluronic acid type filler (non-permanent). Based on this, our working diagnosis was intraoral extension of the dermal filler. Given the lack of sinister features to these nodules, the initial line of management taken was conservative.

At her four week follow-up appointment, the lumps had marginally reduced in size but were otherwise unchanged. She was seen again at two months with no changes. Conservative management was continued, and by her eight month review appointment, the nodules had entirely resolved (Fig. 2).

We would like to use this case to highlight that intraoral complications following dermal fillers is possible. The migration of dermal fillers into the oral cavity and presenting as nodules is a recognised phenomenon that has been reported.[1,2]

As well as firm nodules, the intra-oral migration of dermal fillers can result in a granulomatous foreign body reaction, presenting as swellings or yellowish plaques which are usually painless.[3]

A. Ibraheim, Z. Hasan and A. Ujam, by email

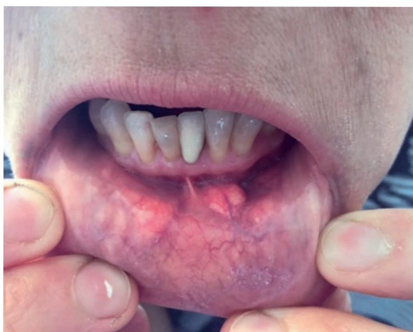

Fig. 1 Lower lip cream coloured nodules

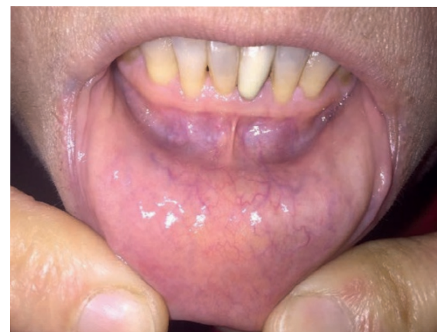

Fig. 2 Lower lip of same patient after eight months

1. Kehily E, Hayes M, McCreary C. Adverse reactions to facial dermal fillers: a case report. *J Ir Dent Assoc* 2015; **61:** 36–39.
2. Feio P S Q, Gouvêa A F, Jorge J M Lopes M A. Oral adverse reactions after injection of cosmetic fillers: report of three cases. *Int J Oral Maxillofac Surg* 2013; **42:** 432–435.
3. Shahrabi-Farahani S, Lerman M A, Noonan V, Kabani S, Woo S B. Granulomatous foreign body reaction to dermal cosmetic fillers with intraoral migration. *Oral Surg Oral Med Oral Pathol Oral Radiol* 2014; **117:** 105–110.

DOI: 10.1038/sj.bdj.2018.1123