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.

OMFS

Instant relief

Sir, may I congratulate Jaspreet Virdee at such an early stage in her career on delivering such a thought-provoking Opinion article[1] and review of current management issues in TMD stimulated by, and following, her personal poor experience when visiting her local 'teeth focussed' GDP. I would like to make gentle comment on two areas of this paper.

The section 'Management in primary care' focuses on the administration of paracetamol, NSAIDs (such as ibuprofen) and sometimes the addition of benzodiazepines (diazepam) to alleviate the acute and iatrogenic trauma to the TMJ structures that often ensues following prolonged sessions of dental treatment. This therapy regime is quoted in the paper, and from other sources, to be likely to take sometimes as long as three weeks to take maximum effect.

TMDs must be the most common musculoskeletal disorder in the causology of facial pain. In my practice following a long session of multiple quadrant preparations, in spite of the patient being seemingly relaxed, with 'rest periods' given, often with mouth prop and rubber dam in place – and even sometimes having fallen asleep – it was certainly the sort of situation that accounted for easily the majority of patients that often experienced this complicating acute TMJ discomfort and significant pain postoperatively.

The most effective and reliable method I found of treating this scenario when correctly diagnosed and with a dramatic effect in dealing with the acute pain, hypo-mobility, associated inflammation, and of course the inevitable distraught patient, was the administration of oral dexamethasone, a glucocorticoid, in a tapering dose orally over five days beginning at a total of 6 mg on the first day.[2] The almost instant relief experienced by affected patients is best illustrated by the effusive early morning calls received following the day of prescription expressing thanks for the pain relief and 'the best night's sleep for some time'.

Jaspreet Virdee references the advice of NICE and also the Special Interest Group in TMD but not the potential of the above regime in producing the effective removal of the patient distress and discomfort associated with the traumatised TMJ apparatus in such circumstances which is evidence based.

One other comment if I may, in regard to the statement that 'botulinum toxin (BT) injections may be considered as an alternative for masticatory myofascial pain if conservative methods have failed'. This is not offered here as a guaranteed solution in resolving such pain but in that it may improve the severity of symptoms, in that significant reductions in pain scores were achieved. The pathway for this seems to be that BT administration has a proven effect on depression[3] and the associated mood lift effect may well serve to diminish the perceived pain.

Hopefully this paper will encourage other younger colleagues to publish in the *BDJ*!

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1. Virdee J. The headache of temporomandibular disorders. *Br Dent J* 2018; **224:** 132–135.
2. Zandi M. The role of corticosteroids in today's oral and maxillofacial surgery. *In Glucocorticoids - new recognition of our familiar friend.* InTech Publications, 2012.
3. Chung S, Chhabria A, Jung S, Kruger T H C, Wollmer M A. Botulinim toxin as a treatment for depression in a real world setting. *J Psychiatr Pract* 2018; **24**: 15–20.

DOI: 10.1038/sj.bdj.2018.273

Maxillary position

Sir, I would like the opportunity of commenting on Dr Jaspreet Virdee's interesting opinion on TMD.[1] Currently there seems to be little consensus on either the cause or cure for TMD, or the most appropriate treatment. One constant feature is a retruded maxilla, but this is rarely mentioned and to my surprise many dentists are not aware of it and even specialists often seem unable to assess it.

These days dentistry is considered to be an evidence-based subject but evidence faces a problem when there are a large number of variables. It gets progressively more difficult to design studies that can consider more than five or six factors simultaneously. Each study tends to consider a number of relationships in specific situations, but many fail to establish whether the factors are causative, associated or resultant, meaning that in this situation we may be left with no more than a long list of possible factors.

In a sense the research has blighted TMD treatment rather than provide us with a set of answers. Here I believe that logic may do better than research. The condyle is a very small part of the body and yet it is blamed for many aspects of dysfunction and pain. Mammals have been around for more than 60,000,000 years and evolution has ensured that we now function quite well. In this case reason would suggest it is unlikely that more than one or maybe two things have gone wrong rather than 20 or 30 often suggested.

I am sure that many clinicians have suggestions to make, but my money is on maxillary position.

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1. Virdee J. The headache of temporomandibular disorders. *Br Dent J* 2018; **224:** 132–135.

DOI: 10.1038/sj.bdj.2018.274

Healthcare provision

Registration and retention of dentists

Sir, Professor Batchelor's paper, *Registration and retention of dentists on the General Dental Council register between 2006 and 2016* (*BDJ* 2018; **224:** 105–109) highlights important issues to be considered by those tasked with the challenge of dental workforce planning. This challenge is confounded by, amongst other factors, lack of information on the number of General Dental Council (GDC)

Official journal of the British Dental Association.