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.

Environmental concerns

EU Regulation 2017/852 on mercury

Sir, it must be 20 years almost to the day when, during an evening surgery, I treated a patient in the middle of her pregnancy using amalgam.

Unknown to me there had been an item on the BBC News that evening about the possible effect that mercury in amalgam can have on a foetus. The media had been informed about this but the profession had not been alerted. Consequently, when the patient returned home she was distraught that her baby could have been damaged.

The British Dental Association (BDA) were very apologetic that they had failed to inform the dentists and were incredibly supportive. Indeed Dianna Scarrott from the BDA travelled up to Nottingham the following day to speak personally with the family.

Given the amount of media publicity at that time it seems incredible that avoiding amalgam in pregnancy has moved from advice to becoming mandatory only now, 20 years on. Also it seems illogical, given the regulation, that women between the ages of 15 and when they have their babies can continue to have their teeth restored with amalgam.

P. Ward, Nottingham

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One word: 'plastics'

Sir, I write to share a recent experience that encouraged me to consider the environmental impact of oral hygiene products.

While concluding a check-up appointment for a healthy and articulate patient, the well-rehearsed oral hygiene instruction that I am used to delivering was interrupted. My patient declared that she will no longer use plastic toothbrushes or nylon dental floss because they are not recyclable. She asked if I was aware that unless incinerated, every plastic toothbrush that has ever been made still exists somewhere on earth, and that because they are non-biodegradable they may continue to do so for 700 years. Furthermore, she enquired, which type of natural toothbrush, (bamboo bristle, or pig hair) was best, and did we stock either hemp or 100% woven silk dental floss in the practice.

I had to concede that I had little knowledge as to the efficacy, or even the existence of some of the products she described. And although I have every confidence in the oral health benefits of the evidence-based products I am used to promoting, I had never considered their environmental impact when multiplied by the millions of people who use and dispose of them on a daily basis.

Recently, programmes like the BBC's *Blue Planet*, and campaigns run by *The One Show* have been extremely effective in demonstrating the environmental damage caused by non-recyclable plastics. Consequently, I believe we are likely to encounter an increasingly environmentally-aware public, who may expect the dental profession to give advice and to offer safe, biodegradable alternatives. Whilst we have all seen patients refuse radiographs, fluoride, or 'mercury fillings' – I would hazard that most of us will be as unprepared as I was to field questions about all-natural oral hygiene products.

Practitioners may feel uncomfortable recommending contemporary natural products that a patient has found in a health food store, or online. Indeed, when reviewing the literature there is little to support these products that could be considered evidence based. Perhaps it is time for the profession to urge the major oral health manufacturers to provide safe, plastic-free alternatives, which may help improve both the health of our patients, and our planet.

R. Leck, North Shields, Tyne and Wear

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Working patterns

Out of hours provision

Sir, I would like to address a few of the points raised by Miss Kanoun in her recent letter (*BDJ* 2018; **224:** 665) regarding the effect of the new junior doctors' contract and hospital at night system on dental core trainees (DCTs).

Having worked in two rather different maxillofacial units, both with no out-of-hours (OOH) DCT cover, I've found that the current system actually works rather well. On one occasion I worked a night shift, I was contacted only once at 3 am regarding a patient who could 'feel his nasogastric tube in his throat' and 'can you request a chest X-ray'. Suffice to say this wasn't a sensible or welcome call and demonstrates that many units actually have very little OOH OMFS activity. These units have adopted daily urgent clinics in order to address the lack of OOH DCT cover. Properly used and implemented, these can be highly effective ways of providing non-emergency care within the competence of a DCT.[1]

The cover by consultants and second on-call middle grades remains unchanged. The latter being available to call for advice by the night doctor and both being appropriately reimbursed for this. If the night doctors are properly inducted into OMFS and assured they will not be ridiculed or made to feel a burden by calling the second on-call, there is no reason that inappropriate admissions or hospital transfers should occur. In fact most night doctors I've encountered feel completely the opposite and refuse to mistakenly assume the correct management, when they know an off-site second on-call is being paid for that exact role.

Having DCTs overnight in all but the busiest centres is neither financially prudent nor educationally beneficial. The rota must

either take DCTs from daytime theatres and clinics, where learning and training is supervised and highly efficient, or recruit even more DCTs (which would require lowering the entry standards), thus taking even more dentists from the underfunded primary care sector. All this in order to plug a costly part of the rota with low efficiency, unsupervised 'training' at greater cost to the NHS.

Long gone are the days of the 84-hour-week OMFS SHO on the 1-in-2 rota, and I would say this is a welcome change. Many are quite happy and secure with our career choices without having to experience 'life as a proper doctor'. DCT training is already sufficiently disruptive to personal lives in terms of yearly reapplication, OOH work, and the implications of moving post every 6-12 months; without also working nights which are shown to be nothing but harmful to the health of doctors[2] and patients.[3] I suspect many would much rather have our sacred EWTD (European Working Time Directive) 48 hours per week spent in theatre or clinic, experiencing one-to-one, hands-on teaching, rather than coming to the ward at 3 am to reassure both patient and nurse that their NG tube is meant to be in their throat and doesn't possess the sentience to perform intra-oesophageal somersaults and tracheal abseiling.

J. White, by email

1. Abou-Foul A K, Shah N P, Mirza J, Anand P. Cross-cover of oral and maxillofacial surgery out-of-hours: an audit of a new adult treatment clinic. *Br J Oral Maxillofac Surg* 2016; **54:** 868–871.
2. Harrington J M. *Health effects of shift work and extended hours of work*. *Occup Environ Med* 2001; **58:** 68–72.
3. Postgraduate Medical Education and Training Board. National Training Surveys 2008-2009, Key findings. 2008. Available online at https://www.gmc-uk.org/-/media/documents/National_Training_Surveys_2008_09_20090929.pdf_30512348.pdf (accessed 9 July 2018).

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Restorative dentistry

Tooth wear terms

Sir, we read the well-composed themed issue of the *British Dental Journal* on tooth wear (*BDJ* Vol. 224, Issue 5, 2018) with great interest. This successfully collected contributions from well-known authors from all around the globe, each with their own specialities. The statements that 'prevention is key', 'the progression of tooth wear is not inevitable' and 'restorations are not the only option' are of great importance for clinical dental practice. This was also clearly stated in a recently published European consensus paper.[1]

Nevertheless, we believe that this issue of the *BDJ* offered a great opportunity to address two additional important areas:

1. The choice of the most appropriate nomenclature of the various subtypes of tooth wear
2. The development of a universally applicable tool for the assessment of tooth wear.

The first deals with the nomenclature of subtypes of tooth wear. In this special issue, the traditional terms of dental erosion, attrition, and abrasion were used. Although the dental community is used to these terms, these do not adequately emphasise the multifactorial nature of tooth wear. Tooth wear is an umbrella term with two main subtypes, ie chemical (erosive) tooth wear and mechanical tooth wear. Both subtypes are further subdivided into intrinsic and extrinsic forms. This means that there are a total of four subtypes, ie intrinsic erosive tooth wear (due to stomach acid), extrinsic erosive tooth wear (due to an erosive diet), intrinsic mechanical tooth wear (due to tooth-to-tooth contact, through function or bruxism) and extrinsic mechanical wear (due to other reasons, like nail biting, pen biting, tooth brushing, etc).[2] The traditional terms describing subtypes of tooth wear have been used for a long period of time, but now the next step forward should emphasise the multifactorial nature of tooth wear.

The second area which should be addressed relates to the need for a tool for assessment of tooth wear. The Basic Erosive Wear Examination (BEWE) as one such assessment tool. However, the name BEWE is confusing and the authors suggest it should instead be the 'Basic Tooth Wear Examination (BTWE)', because all subtypes of tooth wear are being assessed with this tool- not only chemical (erosive) tooth wear. As mentioned in the editorial, the tool only yields a numerical score as to quantify the severity of the observed wear, but qualification, ie establishing which subtype(s) of wear are present, cannot be performed with this tool. The editorial recognised that identifying the first subtle changes due to wear is difficult but of great importance. Hence, qualification is a necessity. Since the BEWE is not suitable for this purpose, its applicability is limited. To overcome that limitation, a modular evaluation system was designed, the Tooth Wear Evaluation System (TWES).[2] This comprehensive yet clinically applicable system allows, amongst other factors, both quantification and qualification of tooth wear. The authors suggest that the dental community use this universally applicable tool for the assessment of tooth wear, thereby improving the communication between dental clinicians diagnosing and managing tooth wear, as well as between researchers studying this intriguing, clinically relevant, and increasingly prevalent condition.

P. Wetselaar, F. Lobbezoo, Amsterdam, The Netherlands
H. Beddis, Leeds, UK

1. Loomans B, Opdam N, Attin T *et al.* Severe Tooth Wear: European Consensus Statement on Management Guidelines. *J Adhes Dent* 2017; **19:** 111–119.
2. Wetselaar P, Lobbezoo F. The tooth wear evaluation system: a modular clinical guideline for the diagnosis and management planning of worn dentitions. *J Oral Rehabil* 2016; **43:** 69–80.

The Guest Editor of the BDJ *Tooth Wear themed issue, Professor David Bartlett responds:*

I would like to thank the authors of the letter for their kind words and I am delighted to hear they enjoyed and valued everyone's work. I appreciate their views on terminology but there remains differing views on what should be used to describe worn teeth. Common terminology becomes the norm even when to some it is not accurate. I have similar views with the term 'tooth wear' but this is not held globally and a better reflection is 'erosive tooth wear' as it captures the views and beliefs of more dentists from more cultures. I fully accept there are challenges, but on the whole it's what most people use and that leaves us using this common term.

In a way the comments about the BEWE are similar. We specifically chose the term erosive tooth wear to reflect the different terminologies and to reflect the views of other dentists from overseas, most notably Europe. For this reason, we used the term erosive tooth wear which in my view encompasses both erosion and tooth wear. But some dentists focus more on erosion only. Achieving consensus across different cultures and countries is always a compromise and I hope that the index receives support to allow dentists the opportunity to screen for the condition and those that undertake research the capacity to record it.

Thanks again for your kind comments.

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