

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.

Infant mutilation

Cultural impact on dental care

Sir, in an increasingly multi-cultural society, it can be challenging to recognise dental or medical anomalies which can result from cultural behaviours.

A 7-year-old boy presented to the Department of Paediatric Dentistry complaining of 'brown teeth'.

On examination, there was an extensively carious primary dentition with three primary canines (53, 73, 83) clinically and radiographically absent with 63 being diminutive. The unerupted 32 and 42 were positioned distal to 72 and 82 and the primary lateral incisors were not being resorbed (Fig. 1).

On questioning, the patient's father confirmed that the patient had been treated by a local healer in Somalia as a baby for 'fever'. The treatment had involved the gouging of his gingivae with the removal of some dental tissue.

Following a discussion of the various options for dental treatment, the patient was

listed for the extraction of multiple carious primary teeth under general anaesthesia.

Long-term management involved regular follow-up with intensive prevention and monitoring of the developing dentition. Lower deciduous incisors 72 and 82 were extracted to encourage normalisation of the 32 and 42 positions.

A safeguarding referral was also made to the local children's social care services. This was particularly important as the patient had younger siblings who were potentially at risk of similar injury. It was established that the siblings had not been subjected to dental gouging.

The practice of canine gouging is widespread in African countries, such as Somalia, and has been reported as far back as 1969. This involves the 'digging' of unerupted primary canine tooth buds from the gingivae, purportedly as a cure for illness.¹

It is believed the unerupted tooth bud is infested by worms. Febrile illnesses such as fever, diarrhoea and vomiting in a child have led to local healers using objects such as bicycle spokes, nails and knives to

enucleate the primary canines; frequently without any anaesthetic.

Long-term consequences of this practice may include damage to the permanent tooth bud ranging from hypoplasia to total atrophy. Damage to the surrounding soft tissue, teeth and bone may also occur, such as impacted teeth and osteomyelitis of the bone and crucially, death from illnesses such as septicaemia.²

It is imperative to raise awareness of this practice. Key signs are multiple missing primary canines and centre line shifts. Vigilance is necessary in making a safeguarding referral for these patients, in particular, to protect any younger siblings from such abuse.

A. Bibi, C. Dixon, S. Barry, by email

1. Dewhurst S, Mason C. Traditional tooth bud gouging in a Ugandan family: a report involving three sisters. *Int J Paediatr Denti* 2001;11: 292-297.
2. Noman A, Wong F, Pawar R. Canine gouging: a taboo resurfacing in migrant urban population. *Case Rep Dent* 2015; 727286.

Editor's Note – An opinion piece on this issue will appear in the BDJ in the New Year.

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Dental and medical complexities

Generalisations over age

Sir, I have read with considerable interest the paper by Geddis-Regan and Walton titled 'A guide to treatment planning in complex older adults'. I thought that the subject was well argued, the examples apposite and the conclusions thought provoking.

Indeed it was everything that the *BDJ* does so well, with the exception of the title. I thought that the use of the term 'complex so closely linked to older adults' a touch pejorative!

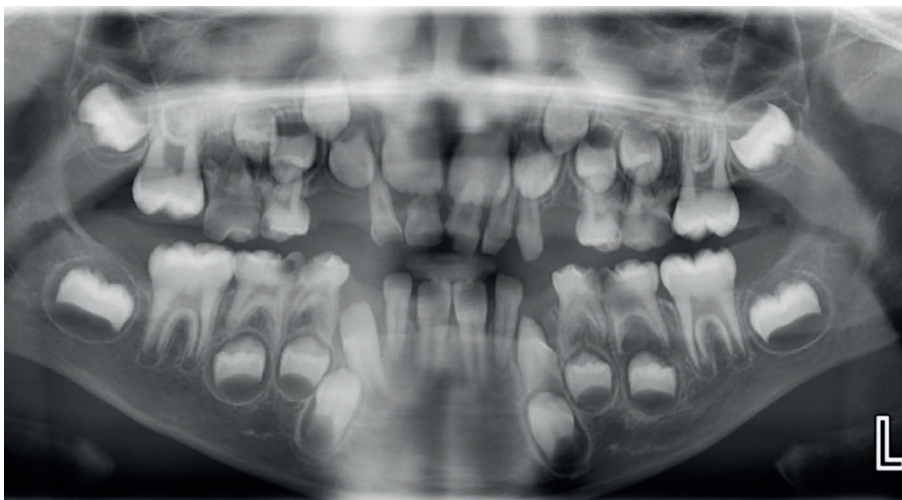


Fig. 1 DPT radiograph showing an extensively carious primary dentition, diminutive 63, absence of 53, 73, 83 URC, LLC, LRC and distally positioned 32 and 42