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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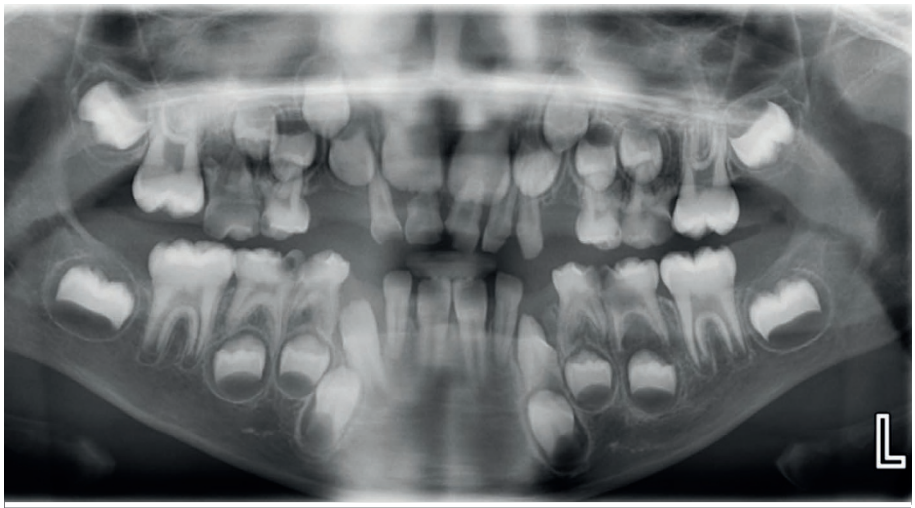

Fig. 1 DPT radiograph showing an extensively carious primary dentition, diminutive 63, absence of 53, 73, 83 URC, LLC, LRC and distally positioned 32 and 42

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!

Official journal of the British Dental Association.

I am one of those who might be an older adult, I have a complex and complicating medical history and I have numerous complexities, but I am not a complex person. Such sweeping categorisation can cause inadvertent offence when used in relation to patients.

A more appropriate title would be 'A guide to treatment planning for older adults with dental and medical complexities'.

S. Morganstein, by email

1. Geddis-Regan A, Walton G. A guide to treatment planning in complex older adults. *Br Dent J* 2018; **225:** 395–399. https://www.nature.com/articles/sj.bdj.2018.742 (accessed on 22 October 2018)

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Associate specialists

The lost tribe

Sir, I am currently a dental core trainee in a district hospital. My sessions are often under the direct supervision of an associate specialist in oral and maxillofacial surgery (OMFS), and in Orthodontics.

I am grateful for their vast clinical experience. I am in a district hospital and there is nothing much to do. I spend my days going to the gym and pondering why I've moved to a remote location. I remind myself that I am getting good experience.

During one particularly wet day, jogging on the treadmill and playing sudoku, a thought occurred which worried me.

An associate specialist working on the pre-2006 contract could have earned from £38,836 up to £84,2401 more if on-call. This was the case for dentists working in a maxillofacial and oral surgery department.

An associate specialist in OMFS has disappeared as a job title for dentists and replaced with 'speciality doctor'. The pay scale is from £37,923 to £70,718.[1] The role of a speciality doctor in OMFS usually requires one to have two years' experience as a DCT in oral and maxillofacial surgery and MFDS/MJDF.

An orthodontist associate specialist, on a pre-2006 contract and top banding, might take a pay cut if he were to train to become a consultant, as the pay-scale starts from £76,761 up to £103,490.[2]

If the orthodontist decided to retire, he/she could be replaced with a 'speciality doctor' potential starting salary £37,923 or 'associate specialist' starting £53,169,[1] or perhaps even a part-time consultant orthodontist and an orthodontic therapist.

I don't have a mortgage yet, due to the lowly DCT salary, but if I did, I would bet my mortgage that the DCT post I have will cease to exist in the future.

I worry that there are many associate specialists in OMFS and orthodontic departments working as educational and clinical supervisors for DCTs and they will soon be (or already are) the 'tribe of forgotten associate specialists'.

I am concerned the lack of consultant posts available for oral surgery will have a knock-on effect for our education and the running of the OMFS departments in some regions, particularly at district hospitals.

A. Hassan, by email

1. British Medical Association. 2018 'Pay scales for SAS doctors in England'. Available at https://www.bma.org.uk/advice/employment/pay/sas-pay-england (accessed 21 September 2018).
2. British Medical Association. 2018 'Pay scales for consultants in England'. Available at https://www.bma.org.uk/advice/employment/pay/consultants-pay-england (accessed 21 September 2018).

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Oral and maxillofacial surgery

MaxFax training opens up the world of dentistry

Sir, having come to the end of Year 1 DCT in oral and maxillofacial surgery, I would like to reflect on what a valuable experience it has been.

Coming out of foundation training it was difficult to know if I'd made the right decision to abandon my newly developed and (very nearly) honed skills in general practice to venture into the unknown world of maxfax, especially with the threat of 'deskilling' on the horizon.

However, despite this being a common concern voiced by many of my peers who chose to progress into practice, what I found was quite the opposite; my skillset has vastly expanded in a way which I feel will be invaluable in whatever career path I eventually pursue.

I chose DCT1 in OMFS to improve my oral surgery techniques, widen my knowledge of the management of medically compromised patients and get exposure to facial trauma and disease – reasons I'm sure are generic amongst other trainees in similar posts.

As it turned out, this was just a small part of what I was to gain. My ability to cope with and perform in stressful situations was tested right from the first day on call, where I learned that prioritisation and time management would be key.

My communication skills blossomed. I began to more fully appreciate the value of effective teamwork, whether between members of my own department, doctors from other specialities, ward staff or the A&E department. Finding myself in new and varied settings made me tailor my approach to patient management according to the situation.

One aspect that I feel particularly grateful for is the knowledge that I will have the confidence and ability to manage more cases independently should I return to practice.

Having been on the receiving end of a number of questionable referrals and patients sent directly to the emergency department I know how frustrating it can be when something could have been dealt with more appropriately in practice. The thought of how some of my consultants would react would certainly make me think twice before submitting a referral in future!

While many remain of the opinion that maxfax is not relevant to dentistry, I would strongly argue the contrary.

I would encourage anyone contemplating a post in the specialty to seize the opportunity. I feel it has provided me with all the tools I might need to become a good clinician in whatever field I find myself. Not only that, I have had my eyes opened to the big wide world outside of the dental surgery where life or death situations are a daily occurrence.

As I go in to my second year of OMFS Dental Core training, I hope to continue to build to skills I have developed, and look forward to where it may lead me.

R. Unyolo, by email

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Cosmetic dentistry

Facial aesthetic treatments and clinical and radiological implications

Sir, cosmetic facial treatments are a rapidly developing area of clinical practice with increasing numbers of GDPs providing facial aesthetic treatments. As their popularity grows, more patients are now undertaking such procedures. We would,