

Letters to the editor

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OMFS

Abscess or airway?

Sir, most readers of this journal appreciate the continuum from dental abscess to cervicofacial infection. In my OMFS DCT post, however, I have observed that some non-dental colleagues appear more concerned with the aetiology rather than the potential severity of the sequelae. Surprisingly, dismissive attitudes from some hospital staff have been noted when something is of odontogenic origin, resulting in a drop of their guard, lack of urgency and delays to theatre. Consequently, our department is frequently bleeped several hours post-presentation of the patient to A&E. Considering the time-sensitive nature of some cervicofacial infections, I believe this not to be best practice. In September 2021, across all emergency departments in England, only 64% of patient attendances were managed within four hours.¹ These delays can be significant for those with airway compromising swellings. We therefore must rely on our A&E colleagues to appropriately triage and involve us in cases that require surgical intervention.

Conversely, some small, isolated dental abscesses that present to A&E are being referred to us with buzzwords such as 'Ludwig's' to encourage a swifter maxillofacial input. This can create frustration amongst juniors and ultimately has the potential to harm those with actual Ludwig's angina since it is impossible to attend every referral with the same required resources.

In response, our hospital is working with ED staff to ensure suitable and timely maxillofacial triaging is carried out. There is a lot of room for improvement, but one suggestion could be a situation in which local practices, with contracted emergency dental services, have a closer working relationship with secondary care. This would facilitate

efficient referrals to dental settings for cases that can be appropriately managed there. This can ease the pressure off an already stretched A&E system and allow prioritisation of urgent cases.

With the total number of dental abscess-related admissions increasing more than 3.5-fold in the last 20 years,² I feel strongly that our community should highlight this continuum to prevent patients with a deteriorating airway from sitting unattended in the corner of an ED waiting room. A dental abscess is best managed by a dentist. A cervicofacial abscess, even of odontogenic origin, is best managed in hospital.

D. Innes-Taylor, London, UK

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Paediatric dentistry

Consent congrats

Sir, regarding the recently published article by Asma Keshtgar *et al.*, entitled 'Consent and parental responsibility – the past, the present and the future' (*BDJ* 2022; **232**: 115–119), I wanted to congratulate all three authors on a very erudite and extremely helpful publication on a topic that is of great clinical importance.

I was also involved in publishing results of a national audit on the understanding of consent amongst consultant orthodontists 14 years ago and my hygienist wife and I, although now both retired, currently participate in the national COVID-19 vaccination programme and from here on,

we will both be using the very succinct and user-friendly flowchart and the Parental Responsibility Form contained in this article, in order to help clarify issues of parental responsibility when they might arise, ie as and when a child is brought for vaccination by someone other than their biological mother and who is also deemed not to have Gillick competence.

R. A. C. Chate, Colchester, UK

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Paediatric urgent dental care

Sir, we read with great interest the recent article regarding repeat patient attendance for urgent dental care.¹ It is reasonable to postulate that the COVID-19 pandemic will have long-lasting effects in fortifying such findings.

The reduction and subsequent cessation of elective dental appointments in March 2020 resulted in the transformation of our paediatric dentistry urgent walk-in service based at St Thomas' Hospital, London to an urgent dental care centre accepting referrals via the NHS 111 pathway. Our service evaluation included 125 paediatric dental patients seen between September and October 2021 at St Thomas' Hospital. Nearly 50% of patients were under five years old, 38% of patients were 6–10 years old and 13% of patients were 11–16 years old. A quarter of patients had a significant medical condition including autism, behavioural disorders, co-morbidities such as asthma and three patients had a medical syndrome. Only 46 patients were registered with a general dental practitioner and many parents reported struggling to register their child with an NHS dental practice. Of primary diagnoses made, 13% were for dental trauma, 66% for caries and 11% presented with facial swelling. One patient required urgent admission for intravenous antibiotics. While 24% of patients required true

urgent dental care, ie management of facial swellings and dental trauma, 74% of referrals were accepted. These findings allude both to the lower threshold of accepting patients due to the impact of the COVID-19 pandemic on patient access, as well as to the increased pressures faced by dental practices in managing the burden of disease that has amassed during the pandemic.

Twenty-four percent of parents reported their child was already on a dental referral pathway, which is likely to have been underreported. Many families were travelling outside their local boroughs to attend the appointment. These findings demonstrate the knock-on effect of limited patient access on tertiary dental services and the ethical dilemma surrounding the acceptance of patients directly while existing patient waiting lists continue to grow. While reassuring that extra funding has been allocated to dentistry, there is valid concern that this will remain underutilised as dental practices struggle to cope with existing targets of activity.² It is hoped that the COVID-19 pandemic results in the actualisation of extensively debated NHS contract reform. This may prove to be the much-needed solution to dwindling patient access and reduce the need for urgent dental care in some of the most vulnerable members of society.

S. Mamdani, D. Pathak, N. Bhujel, London, UK

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Military dentistry

Some concern

Sir, I read with interest, but also with some concern, the article discussing the 'use of dental therapists within the UK Military Dental Service' (*BDJ* 2022; **232**: 232–238).

I retired from the Royal Army Dental Corps in 2010 after a 45-year career, 35 years spent in uniform and ten as a civilian dental practitioner continuing to work for the MOD. I saw a lot of changes during my career, many of which involved cuts in the uniformed manpower strength of dental

officers, dental hygienists, dental technicians and DCPs. Some of these cuts obviously went hand in hand with the misplaced periodic reduction in the overall strength of our Armed Forces. Many of these cuts were made not always in the best interests of the organisation, but as a cost-cutting exercise – contracted civilian personnel being a much cheaper option than those in uniform.

Unless there are extenuating circumstances, any increase in the number of civilian dental staff has to be made through a compensating reduction in the number of uniformed personnel.

I wonder, with the present frightful ongoing situation in Ukraine, and an awakening and realisation that cuts in the UK Armed Forces have gone too far, if now is the right time to be even contemplating employing more civilians within any military organisation?

J. H. Hardy, Farnham, UK

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Water fluoridation

Dental fluorosis

Sir, we write regarding the letter by Bland and Bland¹ and seek to reassure the authors and readers regarding fluoridation and dental fluorosis.

The World Health Organisation's recommendation² of a maximum fluoride concentration in drinking water of 1.5 mg/L is designed to be protective against any adverse effect, including dental fluorosis which might be unsightly. The target level for fluoridation in England is 1.0 mg/L and in some parts of the UK, developing teeth are exposed to fluoride in water occurring naturally at similar levels.

The most recent study of fluorosis in England (2016)³ compared children in fluoridated Newcastle and Birmingham with non-fluoridated Liverpool and Manchester. A higher prevalence of any dental fluorosis was observed among children in the two fluoridated cities (61% vs 37%) and of fluorosis above the threshold generally considered to be aesthetically objectionable (10% vs 2%). There was, however, no significant difference in the degree of aesthetic concern held by the children themselves in the fluoridated and non-fluoridated cities.

Bland and Bland suggest that successive generations of children may find fluorosis more objectionable. This may be true, but research to date suggests a complex picture of mild fluorosis possibly making teeth more attractive⁴ and fluorosis possibly diminishing with age.⁵

Swallowing excess fluoride toothpaste during tooth development is also a potential risk for dental fluorosis and recent guidance has re-stated the importance of avoiding excess ingestion.⁶

We agree that ongoing professional education is important regarding counselling and managing patients presenting with dental mottling. Where mottling is severe enough to have an aesthetic impact, differential diagnosis should include the possibility of alternative diagnoses such as systemic disease or amelogenesis imperfecta and a specialist opinion considered.

With many years of collective experience working in fluoridated and non-fluoridated areas, fluorosis has not been a general cause of concern for our communities but the impact of caries on individuals and services remains a significant burden, especially for non-fluoridated communities. Water fluoridation is an effective and safe public health measure.

A. J. Morris, R. O'Connor, R. Holmes, D. Landes, K. Shah, A. Tandy, C. Vernazza, Birmingham, UK

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