

proved not to be the case. Certainly, some practices behaved like this, but the vast majority were paid in line with the recommendations.

The equipping of NHS surgeries has relied during periods of below (dental) inflation uplifts to contracts on non-NHS income, which more and more practices have needed to turn to, to ensure such investment. Time-limited contracts in the NHS have exacerbated investment problems.

Dr Marks talks about historic clawback post-implementation of new contracting arrangements, and another type of clawback due to a failed UDA contract has been a growing problem for years. The loss of 1,000 dentists from the Performers List last year, with many more reducing the whole-time equivalence in NHS provision, hardly reflects this golden era Dr Marks believes we have been through. The exodus from the NHS is happening at the greatest rate in my career and it is why Maria Caulfield said to her own local radio station a fairer system to patients and the profession is so desperately needed. Let us hope her words are matched by action. Recouping the spend, if Dr Marks is correct, will cut the final strings of NHS dental provision.

I am sorry Dr Marks seems so angry with his colleagues that provide NHS care. Collective work of all across the profession is needed to ensure those least able to afford modern dental care have a mechanism of access post-pandemic.

E. Crouch, Chair, BDA Principal Executive Committee, West Midlands, UK

Reference

1. Marks C. Moaning Minnies. *Br Dent J* 2022; **232**: 69. <https://doi.org/10.1038/s41415-022-3942-2>

Be excellent to each other

Sir, Mr Marks' correspondence¹ and the inevitable social media storm that followed provide prime examples of the division and unhappiness that is rife within our profession. As with any aspect of life, there will exist groups straining against one another: who can shout the loudest, who can deliver the most cutting analysis, who can drown out the other with mountains of data, who has the worthier opinion, etc.

Let us set aside the rhetoric and remember that all 'sides' are human, and

that we as a profession are better than this. Mutual dialogue and respect are key to facilitating improvements for all. Personal attacks, sweeping statements, and scoffing at colleagues serves no one, and drives a wedge deeper into an already wounded profession. Neither faction in this seemingly never-ending NHS vs private sector debate has covered themselves in glory.

Let us afford our colleagues, and ourselves, a greater kindness. In the immortal words of Bill and Ted, 'be excellent to each other'.

R. Fulford, Sheffield, UK

Reference

1. Marks C. Moaning Minnies. *Br Dent J* 2022; **232**: 69. <https://doi.org/10.1038/s41415-022-3943-1>

Orthodontics

Orthodontic training

Sir, I write in response to the editorial by O'Brien *et al.* ('Back to the future...', *BDJ* 2021; **231**: 599) on the need for a higher degree as part of specialist training. I fully agree a higher degree is an ideal, and maintains compatibility with non-UK specialist training programmes. It should be noted that these specialist MSc/Doctorates are taught degrees, not research degrees, allowing a significant level of teaching to occur and hence meet clinical training requirements. However, in non-UK countries there is minimal linkage between the national health services and universities in access to and delivering speciality training, leaving greater opportunities for non-UK graduates to gain access to specialist training.

The current situation in the UK of an NHS monopoly is very unhealthy. This NHS monopoly in controlling access to speciality training means new graduates have to make life-defining choices on exit from dental school as to whether to follow a specialist training pathway or general practice. In orthodontics, in particular, there is no opportunity to undertake speciality training other than in an NHS-funded post. Hence, it is almost totally impossible to spend time in general practice gaining rounded wide experience in dentistry before deciding on entering specialist training. This cannot be healthy for the speciality, profession or patients.

I would suggest that, in line with other specialities, there is a need for an 'open

access' MSc in orthodontics training programme delivered by accredited providers for specialist training separate from the NHS in order to meet the increasing demand for orthodontics by both public and profession.

R. Hobson, Newcastle upon Tyne, UK

<https://doi.org/10.1038/s41415-022-3944-0>

Special care dentistry

Auto-extraction in special care patients

Sir, auto-extraction can be defined as the extraction of one's own teeth without professional competence and/or clinical indication.¹ Auto-extraction behaviour (AEB) has been described in learning disability, autism, patients experiencing mental illness and rare disease, but also in people without disabilities but who experience dental pain.^{2,3} In certain cases, AEB is simple to diagnose, such as patients who have capacity and attempt removal of their own teeth due to dental pain and their inability to access dental care (which is an increasing problem during the COVID-19 pandemic). However, AEB in special care patients is difficult to diagnose, especially if patients are seen by several different dental professionals and there is no continuity of care.

Signs potentially indicative of engagement in AEB in special care patients are:¹

1. Unexplained bleeding from the mouth or around one or two adjacent teeth despite good periodontal health
2. Unexplained isolated tooth mobility (not associated with periodontal disease, dental infection or other pathology)
3. History of, or recent, unexplained early loss of teeth, which may be rapid (particularly if anterior teeth are lost, which are normally the most likely teeth to be maintained by patients and dentists)
4. There may be a known history of AEB
5. Patients presenting with blood stains on clothing and fingers due to auto-extraction attempts
6. Displaced/lost restorations (in particular, non-tooth-coloured restorations which may be interpreted as foreign by special care patients)
7. Habit of placing fingers or objects in the mouth
8. Evidence of concomitant peri-oral self-injurious behaviour such as excoriation

9. Aggressive/challenging behaviour towards carers or family
10. Patients who fall within the high-risk groups such as learning disability, autism, mental illness
11. Recent or sudden change in routine or stressful periods (especially in autists).

The management of AEB in special care patients is complex and often requires a multidisciplinary approach involving psychiatrists, the GP, dentist and specialist carers/nurses. Oral health in special care patients with a history of AEB may deteriorate rapidly and such patients require more frequent recall. It is therefore important for dentists to ensure that this information is shared with future medical, dental and social care professionals so that the behaviour can be monitored.

I. Khan, West Midlands, UK

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<https://doi.org/10.1038/s41415-022-3945-z>

Prosthodontics

Third muscle layer

Sir, the masseter muscle is one of the most potent muscles of mastication which has a multipennate arrangement of the fibres which are divided into superficial and deep parts. It has predominant importance in oral and maxillofacial rehabilitation procedures. The masseter has a role in the elevation, protraction and lateral movements of the mandible. From the prosthodontist perspective, the masseter influences the fabrication procedure of the complete denture prosthesis; the distobuccal borders of the mandibular and maxillary dentures are influenced by the masseter in conjunction with the buccinator muscle and remaining muscles of the modiolus of the face and mouth. Along with the fabrication process, it influences the occlusal force and temporomandibular joint stability.^{1,2}

According to recent radiological and macroscopic investigations,³ there is a third

layer of the masseter muscle in humans that originates posteriorly on the inner, temporal side of the zygomatic process of the temporal bone, with the muscle fibres running diagonally anteriorly, the muscle attaching at the base and along the posterior margin of the mandible's coronoid process. The forces exerted by the coronoid part of the masseter on the coronoid process of the mandible are lateral, posterior, which have a stabilising and retracting effect on the anterior-superior part of the mandible. Thus, future investigations are needed to determine the significance and influence of the newly discovered third layer (the coronoid part of the masseter) on the fabrication, maintenance, and survival of the prosthesis.

V. Chakradhar, B. Lakshmanarao, B. Bhargavi, Rajahmundry, India

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<https://doi.org/10.1038/s41415-022-3946-y>

Gag reflex

Salty solution

Sir, managing patients with severe gag reflex is a familiar problem encountered by all clinicians. Gagging can result from various dental procedures, but more commonly when taking intraoral radiographs and impressions. This often makes supposedly straightforward procedures become challenging or even impossible to perform. Therefore, it is unsurprising that patients who suffer with severe gag reflex tend to avoid dental care as much as possible, making them more susceptible to oral health issues.

Numerous pharmacological and non-pharmacological interventions have been suggested for the management of gag reflex, such as use of topical, local and general anaesthetic, sedation, acupuncture, anti-emetics and behavioural therapies.¹ Whilst some may be aware of the use of salt as a distraction technique, this remains underrated with limited research evidence. However, based on studies and personal experience, placing a tiny amount of salt on a patient's tongue before taking a radiograph or impression may reduce

the severity of gag reflex and often make these procedures tolerable.^{2,3} It has been suggested that when salt stimulates our taste buds, this activates the chorda tympani nerve which in turn results in inhibition of gag reflex.³ This trick has been personally advocated on both paediatric and adult patients and has been well received. Apart from the use of salt during procedures as mentioned above, it has also been used during placement of separators and preformed metal crowns on a gagging child. Paediatric patients seem to get particularly excited when being told they would get some salty chip sprinkles!

It is very interesting as to whether this technique works due to the possibly plausible scientific explanation, or is it the psychology of giving patients hope with a 'new trick' which would help them. Either way, it is simple, cheap and definitely worth a try!

P. Loo, Liverpool, UK

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<https://doi.org/10.1038/s41415-022-3947-x>

BDJ covers

Sticky problem

Sir, may I plead with you to stop using that awful glue to stick adverts to the front of my copy of the *BDJ*. I can't believe it is good for the environment, it ruins the cover as I remove it and anything that is so advertised is immediately consigned to the bin.

D. King, Macclesfield, UK

The Editor-in-Chief responds: I thank Dr King for his letter and comments. The 'tip on' cards provide the journal with a valuable source of advertising revenue and generate a considerable amount of positive responses to the relevant advertisers – hence their continuing presence. Our production department have committed to trialling different types of glue to minimise tears to the front cover but also suggest that the colder weather may affect the brittleness of the glue at this time of year.

<https://doi.org/10.1038/s41415-022-3948-9>