

# Letters to the Editor

## Dear Editor

I am becoming increasingly concerned with the lack of direction and availability to qualify as a Level 1, 2 or 3 skilled practitioner in NHS dentistry. Clinical pathways are being developed and implemented requiring these skills, yet not enough is being done by the Department of Health, the GDC or the Royal Colleges to facilitate it.

The NHS states that 'there is no more money' so presumably any further training will have to be self-funded, making a nice sinecure for academic institutions and yet again increasing the cost of education to our young graduates.

This is at one end of the scale.

At the other end is a cohort of very experienced practitioners who have no actual postgraduate certification but are very skilled in certain disciplines, particularly orthodontics and oral surgery, but may not wish to invest the time at their stage in life to obtaining the paperwork.

I would have thought it would be sensible – and cost-effective – to have some sort of 'grand-parenting' scheme whereby GDPs such as these could qualify as a Level 2 with submission of a portfolio of evidence which could include a consultant recommendation, reflective learning and case studies.

As in many aspects of education, it is useful to have parallel routes through which the same end can be achieved. It is important that we all start out with a BDS but, whilst I understand the need for proof of expert knowledge, I also know that, in such a practical skill as ours, the practitioner who has had years of experience in a specific discipline will be very skilled, regardless of the lack of certificates.

It would be a travesty to waste this talent; it could be a cost-saver to commissioners and patient care could be the better for it.

There must be a way forward; it just requires some lateral thinking. Surely the profession is up for this?

**Claudia Peace  
Winchester**

## Dear Editor

I have a male patient, aged 71 on no medication, a bruxer, suffering from unexplained, continued enamel erosion/wear. He has had considerable incisal edge wear and more loss of buccal enamel on the lower canines and premolars. Four years ago I opened the vertical dimension, with composite additions, to make up for wear and to leave sufficient room for

restorative material.

We have explored acid food and drink issues, with the patient keeping a diary. He has sought medical advice and treatment for potential GORD, OH methods have been explained over a number of years and the use of fluoride toothpastes, enamel repair pastes and high fluoride treatments have been discussed in detail.

Unfortunately, there has been a



recent deterioration in the buccal surfaces of the upper anteriors and, to a lesser extent, the lower anterior buccal surfaces.

I am at a loss to determine the possible causes and can only think that there is still some form of acid attack in conjunction with bruxism and traumatic toothbrushing.

I have asked Professor Burke's opinion who has also seen cases of similar, unexplained erosions and who suggested that I ask the readership of *Dental Update* for any suggestions.

All advice would be gratefully received.

**Tom Donnelly**  
General Dental Practitioner

## Dear Editor

I read with interest the recent article entitled 'Extra-oral appliances in orthodontic treatment' by Almuzian M, Alharbi F, McIntyre G (*Dent Update* 2016; **43**: 74–82).

Whilst this article provided a comprehensive review of the subject, it omitted any consideration of the airway. Recent concerns have been raised about the impact of orthodontic treatment on the airway. In particular, the reduction of overjet by upper premolar extractions and retraction of incisors.<sup>1,2</sup>

A number of authors have found that extra-oral traction to the maxilla reduces the depth of the oropharyngeal airway.<sup>3,4,5</sup> This has greater impact because it is generally used in Class II cases, which already have a reduced oropharyngeal airway compared to Class I or Class III cases.<sup>6,7,8</sup>

There is a well established relationship between reduced oropharyngeal airway and obstructive sleep apnoea.<sup>9,10,11</sup> Hence, the indiscriminate use of extra-oral traction could increase a patient's susceptibility to sleep disordered breathing and obstructive sleep apnoea and, for this reason, would be contra-indicated.

**M J Trenouth**  
Consultant Orthodontist  
(Retired)

## References

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## Dear Editor

We thank Dr Trenouth for his letter. Our article was to review the skeletal and dental effects of headgear and it was not possible to include information on any

proposed link with airway problems.

We note that Dr Trenouth fails to present a balanced view by not including the article by Kirjavainen and Kirjavainen which found that 'Cervical headgear treatment increases retropalatal airway space but does not significantly affect the rest of the oropharynx or hypopharynx in children with Class II malocclusion without retrognathia.'<sup>1</sup> Furthermore, the first two references Dr Trenouth quotes are letters submitted to the *British Dental Journal* and are therefore not peer-reviewed publications.

**M Almuzian, F Alharbi and  
G McIntyre**

## Reference

1. Kirjavainen M, Kirjavainen T. Upper airway dimensions in Class II malocclusion: effects of headgear treatment. *Angle Orthod* 2007; **77**: 1046–1053.

## Dear Editor

### Mouth Cancer for Clinicians Part 7 (Dent Update 2016; 43: 50–65)

Regarding the above article in the January/February issue of *Dental Update*, I think that the legends for Figures 8 and 9, respectively, have been transposed. The legend beneath Figure 8 should be under Figure 9 and the legend beneath Figure 9 should be under Figure 8.

In addition, I think that it may be of benefit to the readers that the authors advise, when carrying out an intra-oral examination, that the dentist asks a patient to touch the hard palate with the tip of the tongue to enable a thorough examination of the floor of the mouth and the ventral surface of the tongue.

**Dr Barbara Coyne**  
Dentist

## Editor's Response

We thank Dr Coyne for her eagle eye and advice.