are unwilling to tackle risky but necessary procedures or prefer early retirement to the stress of practice and patients or the NHS are unable to afford the cost of treatment.

Dr Baker's paper states that there were 510 charges in a five-year period [an average of 102 per annum]. I understand that the GDC had paid for advertisements seeking complaints. This must surely be a misuse of registrants' fees as it encourages rogue lawyers to pursue fictitious claims.

According to statistics, in the five-year period 2013-17 there was an average of over 45,000 registered dentists. My geriatric maths makes the charges around 0.011% or one registrant for every 900 over five years. This is remarkably low compared to the performance of the Crown Prosecution Service or the record of MPs. The paper itself puts credit card fraud at 8.3%.

NHS Dental Statistics for England 2016-17 state that there were 39.9 million courses of treatment provided by 24,007 dentists who had performed NHS activity. Assuming that none of the average 102 charges applied to non-NHS practice [ignoring the many registrants in hospital, community service and private practice] this suggests that the incidence of charges is around 1:40,000 courses of treatment [ignoring the number of privately provided courses]. Whilst I do not condone malpractice in any form, I believe that these figures will stand comparison with any group including ministers of religion.

Accepting that human frailty makes zero risk unattainable, Dr Baker's paper fails to address the level at which over regulation becomes counter-productive.

There is another aspect of the GDC's activity that is not addressed in this paper. During my professional life, I have encountered many excellent dentists who, for valid reasons, have needed to practice on a part-time basis. They have made a valuable contribution to their communities. However, when the cost of registration, insurance and continuing professional development becomes excessive, part-time work is no longer viable and their skills and service are lost. This is not in the public interest.

Whilst Dr Baker concentrates his defence on the GDC and Dr Moyes, the BDA has to take account of the totality of regulation which continually grows. The latest concerns data protection. The burden of regulation appears to be becoming unmanageable in small practices. The future may belong to big corporates who can afford the fees of legally trained personnel to manage their compliance obligations. But would the closure of small practices be in the public interest? Perhaps in reappointing Dr Moyes, the Government has signalled that this is their objective? It may seem perverse but in condoning the excessive expenditure of the GDC, the Department of Health and Social Care allows more of the NHS budget to be diverted to non-clinical expenditure.

Dr Baker disparages the 'good old days'. My first six months in 'cons' was with a foot engine. Post-war scarcity ensured that there was much 'make do and mend'. There was no alternative to the hot water steriliser and I was amongst the first to use zylocaine. We treated AUG with chromic acid and hydrogen peroxide because today's medication was not available.

Not all new techniques have been successful. Inevitably there will be a period in which the new replaces the old. Perhaps we should remember that it is not the equipment which we use that matters but the manner in which we use it. In the 'good old days' we provided an essential service with equipment and materials that were the best available at the time. Today we would be 'struck off'.

I agree that all practices should update their equipment when necessary but to do so they need to be adequately funded. Money spent on registration and compliance with regulations cannot be used to upgrade equipment.

I must disagree with Dr Baker's criticism of you, sir! He suggests that you should 'moderate' controversy. Is this not an attempt to introduce censorship? Maybe this was acceptable 'in the good old days' but surely we are now mature enough to allow you to publish opinion papers that fully express the individual's opinions providing they are relevant to the Journal and are within the bounds of decency and legality.

It is also suggested that 'we should change our negotiators'. I believe that it is the duty of our negotiators to represent the views and needs of our members. We should respect the offices held but those who hold them must earn the respect.

The BDA negotiators are representing the views of the many members who are, it appears to me, convinced that the GDC is not working in the best interests of the community and is 'not working with dentists'.

A. Green, by email

1. Baker R A. Cause for concern: BDA v GDC. *Br Dent J* 2018; **224:** 769–776.

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Sense of humour?

Sir, I have very much enjoyed your past two good humoured *BDJ* Christmas editions, and having seen the 'call to arms' for items for this year's, wondered how I (and presumably many others, since there was only one submission) could have missed the same request for your 'Midsummer Madness' edition?

However, it is quality, not quantity, that counts and the Opinion article[1] from Mr Baker certainly fitted the bill, with his wonderfully bizarre examples.

My absolute favourite was: 'The GDC has attempted to cut costs, for example it cut catering costs in 2001-2 by 42%.'

He also references the 'Charlie and Rufus' videos and through your pages, I wonder if their editor, Mr Mike Wilson, could be persuaded out of retirement to do one more episode 'Dr Baker and the ARF solution'?

A. Lockyer, by email

1. Baker R A. Cause for concern: BDA v GDC. *Br Dent J* 2018; **224:** 769–776.

DOI: 10.1038/sj.bdj.2018.655

Oral surgery

Labial frenectomy: Indications and practical implications

Sir, orthodontic and oral surgery departments are becoming inundated with unnecessary referrals from dentists, and sometimes orthodontic specialists, requesting upper labial frenectomies.

The age ranges vary, with some practitioners referring children in the primary dentition, which is illogical. Alternatively, referrals are for patients in the mixed dentition developmental stage with physiological spacing (sometimes referred to as the 'ugly duckling stage' of dental development – a term best avoided for obvious reasons).

The presence of a diastema less than approximately 2 mm may be considered normal at this stage of dental development, with the diastema often closing spontaneously upon eruption of the maxillary canines.

Neither the presence of an upper labial frenum, nor a maxillary dental midline diastema, is in itself an indication for a frenectomy. This is the case even when pulling the upper lip away from the dentoalveolus leads to visualisation of blanching in the palatal mucosa. This blanching is an indication that fibrous tissue from the labial frenum is passing between the central incisors, usually through an alveolar notch in

the region of the diastema, and inserting into the palatal mucosa.

Maintenance of orthodontic closure of a significant diastema would require a palatal bonded retainer regardless of whether a frenectomy has been undertaken, owing to the fact that such space closure is predominantly unstable. As such, there is no automatic requirement for an additional frenectomy.

Furthermore, undertaking a frenectomy too early and removing the interdental fibres leads to scar tissue formation, generating an obstacle which may lead to difficulties in subsequent diastema closure.

Therefore, frenectomy is almost always contraindicated prior to orthodontic treatment. When a frenectomy is indicated, the timing should be agreed between the orthodontist and surgeon.

The frenectomy may be undertaken when the incisor teeth are orthodontically aligned and space closure is imminent or partial space closure has been undertaken, ie during orthodontic treatment.

As such, the surgeon has interdental space to carry out the procedure safely, and space closure may be instigated or resumed immediately following surgery. Theoretically, the subsequent scar tissue formation may help to keep the diastema closed.

However, it is imperative to point out that as stability remains an issue, a bonded retainer will still be indicated. Therefore, the presence of a labial frenum with interdental fibres passing through to the palatal mucosa is not, per se, an indication for a frenectomy.

The principal indications for an upper labial frenectomy are the presence of a low (inferiorly attached, towards the gingival margin), thick and fleshy frenal attachment, which may be unattractive, a potential obstruction to maintenance of good oral hygiene, or causing recurrent trauma with tooth brushing, and/or tethering of the upper lip by the frenum, leading to hypomobility of the philtrum of the upper lip. These situations are uncommon.

The maxim remains for all practitioners – when in doubt, refer. However, it is worth repeating that the simple presence of a labial frenum, or a maxillary dental midline diastema, should not be a habitual reason for referral or an unconsidered indication for frenectomy.

F. B. Naini and D. S. Gill, London

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Coronectomy

Coronectomy & CBCT – A marriage of convenience!

Sir, cone beam computed tomography (CBCT) is an established radiographic investigation for accurate delineation of the inferior dental nerve (IDN) in high-risk mandibular third molars (M3M). In recent times, it is commonly used as part of the preoperative work up and risk assessment for coronectomy procedures.

Coronectomy is 'deliberate surgical removal of the dental crown and vital tooth retention to prevent iatrogenic damage to associated vital structure(s)'. In the case of M3M teeth, the proximity of the IDN can be radiologically assessed using a simplified risk assessment tool based on various criteria proposed in the past (Table 1).[1,2]

Cross-sectional imaging such as CBCT and medical CT may be required to further delineate the intimate structures and assist in surgical planning.

Occasionally, teeth found to be intimate to IDN on plain radiographs may appear well separated on the CBCT. We feel that doing a coronectomy in these cases is not justified as there is no higher risk to the nerve in the first place. Coronectomy is to be considered only if benefits outweigh its risks in management of high-risk M3M.

A retrospective study of 80 patients booked for coronectomy procedure was conducted in our unit. All patients had an orthopantomogram (OPT) radiograph, following which 73% (58/80) patients had further CBCT assessment.

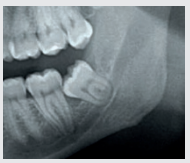
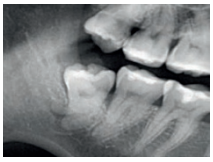
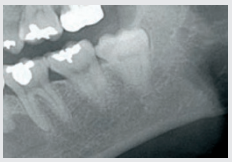
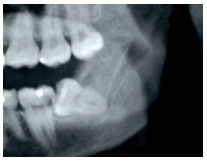
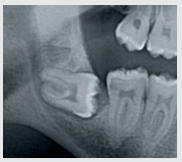
Based on the risk assessment tool, the imaging was evaluated to assess whether surgeons are using CBCT correctly while planning coronectomy.

This small cohort study demonstrated that only two thirds (66%) of the booked patients satisfied the criteria for the coronectomy procedure.

Slightly more than a quarter of these patients (n = 22) had only OPT imaging as part of radiological assessment. More than two thirds of these patients (68.2%) were booked to have a coronectomy in spite of well separated M3M and IDN.

Furthermore, in patients who had CBCT assessment, 21% (n = 12) were not adequately risk assessed in spite of availability of cross sectional imaging. This could have been due to a lack of general consensus in the use of CBCT for assessment of impacted M3M and understanding of the indications for coronectomy.

Table 1 Radiological risk assessment of M3M (any one)

1	Darkening of roots	
2	Deflection of roots	
3	Narrowing of roots	
4	Narrowing of canal	
5	Interruption of canal	

Hence, we recommend a standardised coronectomy criteria to assist clinicians in making correct and informed decisions.

The authors wish to highlight the importance of justifying investigations/procedures to prevent harm and improve surgical outcomes. Additionally, coronectomy should only be performed in select cases where complete extractions may cause more harm than benefit to the patient.

S. Mumtaz, S. Girgis, L. Cheng, London

1. Rood J P, Shehab B A. The radiological prediction of inferior alveolar nerve injury during third molar surgery. *Br J Oral Maxillofac Surg* 1990; **28:** 20–25
2. Renton T. Notes on Coronectomy. *Br Dent J* 2012; **212:** 323–326.

DOI: 10.1038/sj.bdj.2018.657