

Letters to the editor

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Cone beam CT

Governance concerns in CBCT interpretation and reporting

Sir, we read with interest your recent publication on the current practice in the use of cone beam CT in UK dental practices.¹

Although it is difficult to generalise based on the limited sample of respondents in this study, we share the concerns of the authors regarding the interpretation and reporting of CBCT scans. We would like to share our experience of referrals and associated imaging received in secondary care.

As a regional oral and maxillofacial unit, we often receive referrals from colleagues in primary care sending patient referrals in with radiographs (OPT) with incidental findings. We do in these cases provide a second opinion to the patient and the practitioner regarding further management and, where appropriate, provide the necessary care.

Our response to CBCT imaging received for the same reason with incidental findings and normal anatomical structures is different. The practitioners are advised to have the images reported by an appropriate radiologist. This is purely because we should all work within our scope of practice and competence and we do not have access to CBCT scans within the hospital trust yet.

In these situations, there is clearly a need for practitioners to be aware of their responsibilities and to keep up to date with skills in radiographic interpretation. In addition, they should have a robust clinical governance process in place for this sophisticated imaging modality.

We have also in recent months received referrals from colleagues in primary care accompanied by a CBCT including a report from an imaging centre.

However, the report was from a radiologist with no GDC/GMC registration credentials. Teleradiology and outsourcing of reporting

is increasingly common, but all who report on patients in the UK, wherever in the world, should be registered with a UK healthcare regulator.

The Royal College of Radiologists has published a comprehensive document² in its *Standards for interpretation and reporting of imaging investigations* which defines the standards and best practice which our patients should expect and is aimed at radiologists and other reporters.

We would strongly recommend this guidance to clinicians and imaging centres with cone beam CT scans, to allow them to provide high quality, safe care for our patients.

*A. Mahmood, J. Shah and A. Majumdar,
Bed Herts and Bucks Maxillofacial Network,
UK, by email*

References

1. Yalda F A, Holroyd J, Islam M, Theodorakou C, Horner K. Current practice in the use of cone beam computed tomography: a survey of UK dental practices. *Br Dent J* 226: 2; 115-124.
2. Royal College of Radiologists. *Standards for interpretation and reporting of imaging investigations, Second Edition*. 2018.

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Dermal fillers

Dermal filler dangers

Sir, in a time of austerity and increasing surgical waiting lists, the time taken for completion of combined orthognathic and orthodontic treatment is inevitably prolonged.

In addition, there is an increase in the use of dermal fillers from both medical and dental practitioners, as well as beauticians. Perhaps unsurprisingly in this context, it has been observed that several of our patients have used dermal fillers whilst awaiting their initial assessment, or during the primary orthodontic treatment to disguise any perceived aesthetic defect.

This is troublesome for both planning any potential orthognathic movements, due to the altered soft tissue contour, and may possibly adversely affect the surgical outcome.

We would stress the importance of the general dental practitioner in advising patients to avoid such treatments before or during any orthognathic treatment.

*A. Power, Y. Safdar and B. Solanki,
Bradford, UK, by email*

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Coronectomy

Coronectomy consent

Sir, the coronectomy procedure has become widely used in the treatment of vital teeth which are deemed at 'high risk' of causing inferior alveolar nerve injury (IANI).

Once the root of the tooth is deemed to be involved with the inferior alveolar nerve (IAN) canal radiographically, there is a 20% risk of the patient developing temporary IANI and a 1-4% risk of developing permanent IANI with surgical removal.¹

With the push by managing bodies to find cost effective alternatives to providing high quality care, there have been oral surgery contracts commissioned to provide services in primary care settings, which are usually delivered by secondary care providers, through specialist dentists or dentists with specialist interests.

Although the duty of gaining consent from the patient lies mainly with the operating surgeon, there is an onus on the referring practitioner to be able to provide the various treatment options to allow the patient to make an informed decision and prevent inappropriate referrals.

Although indicated in the National Institute for Health and Care Excellence (NICE) as an alternate treatment for third molar extractions, coronectomy is often

overlooked by the general dental practitioner (GDP).

With the rise in third molar surgery being carried out in a primary care setting, it is important for the GDP to be competent in giving the patient all treatment options to allow an informed decision to be made.

M. Shaath, Manchester, UK, by email

References

1. Renton T, Hankins M, Sproate C, McGurk M. A randomised controlled clinical trial to compare the incidence of injury to the inferior alveolar nerve as a result of coronectomy and removal of mandibular third molars. *Br J Oral Maxillofac Surg* 2005; **43**: 7–12.

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Advice post operation

Postoperative care advice: who cares?

Sir, adequate postoperative care advice (PCA) empowers patients and prevents morbidity. Improved awareness amongst patients and development of new communication methods has vastly increased the need for accurate and helpful PCA. There is a binding need to involve and listen to the patients in the care they receive.

We investigated if the patients have a choice regarding who should be delivering the PCA after a surgical procedure. One hundred patients who underwent minor oral surgical procedures in our local oral and maxillofacial surgery department agreed to participate in a survey between September–November 2018.

Both the surgeon and the nurse were blinded in this survey to prevent bias. The survey forms were given by the receptionist to the participating patients post-operatively.

All participants underwent routinely performed procedures in the department including wisdom tooth removal, complex extractions and oral biopsies.

Males dominated the cohort (62%) with the majority of our patients above the age of 40 (72%). About two-thirds of the patients (66%) were given PCA by both the surgeon as well as the nurse with only 20 patients being advised by the nurse only.

Based on the survey, about 60% of patients preferred involvement of the surgeon in provision of PCA. Further data analysis did not reveal any statistical difference between genders and different age groups regarding preferences for PCA delivery (Table 1 and 2).

Traditionally, the nursing staff deliver the PCA in most oral surgical units using verbal information as well as written leaflets, a practice endorsed by the Cochrane review (2005).¹

Our study shows a lack of rigidity amongst patients as to who should be the deliverer of the PCA. This was also noted in a large study of 636 participants by Bornstein *et al.* (2000).²

Due to small sample size, significant analogies cannot be derived and the authors are fully aware of the drawback of this humble study.

Nevertheless, the involvement of the operating surgeon in all modes of patient

care is reiterated by this survey. We hope that this small study will be a precursor for further research into the subject of patient choice in all modalities of care.

S. Mumtaz, C. Batchford, and L. Shepherd, London, UK, by email

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 2. Bornstein B H, Marcus D, Cassidy W. Choosing a doctor: an exploratory study of factors influencing patients' choice of a primary care doctor. *J Eval Clin Pract* 2000; **6**: 255–262.

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Infective endocarditis

Infective endocarditis guidance

Sir, as you are aware in 2016, the National Institute for Health and Care Excellence (NICE) released guidance that ‘antibiotic prophylaxis against infective endocarditis (IE) is not recommended routinely for people undergoing dental procedures’.¹

The subjective term ‘routinely’ is open to interpretation and has caused uncertainty amongst healthcare professionals.

Following this, in August 2018, the Scottish Dental Clinical Effectiveness Programme (SDCEP) published guidance 64 to provide clarification for the management of patients at increased risk of IE.²

It has separated high risk patients into two groups:

1. Patients considered to be at high risk of IE
2. Patients considered to be at high risk of IE and of potentially severe and life-threatening complications.

Although this guidance aimed to provide clarity, we felt it was still open to interpretation.

At Mid-Yorkshire Hospitals NHS Trust, a consensus protocol was jointly developed by Oral and Maxillofacial Surgery and Cardiology, providing an easy to use algorithm for management of these patients – <https://www.midyorks.nhs.uk/oral-and-maxillofacial-surgery>.

This protocol has simplified the management of patients at increased risk of IE undergoing invasive oral procedures.

In turn this has streamlined the process and reduced delays to treatment, as communication with cardiology regarding each individual case is not necessary.

Table 1 Gender specific preference

Gender/preference						
	Surgeon	Nurse	Both	Neither	SD	P value
Male	20	12	18	12	2.06	0.094
Female	8	12	14	4	2.22	

Table 2 Comparison of age groups & their preferences (One-way ANOVA and Bonferroni analysis)

Age preference					
	Surgeon	Nurse	Both	Neither	P value
0–17	2	0	2	0	0.790
18–40	4	2	8	0	0.296
41–60	12	12	10	4	0.889
61–80	10	6	8	10	0.691
>80	0	4	4	2	0.494