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Priority will be given to letters less than 500 words long. Authors must sign the letter, which may be edited for reasons of space.

Cornerstone of surgery

Sir, there are not many subjects that would compel me to categorically contradict or comment on the opinion of another colleague. But the letter *Saliva sewer* of W. E. Skipworth (*BDJ* 2007; **202:** 239) has done so! For almost 20 years now I have run an emergency service and have not drained hundreds but thousands of teeth. One of the cornerstones of surgery is drainage of infection.

If there is soft tissue swelling associated with a non-vital tooth, where a tooth has an associated periapical radiolucency on a radiograph, I would always drain. Even if there is no swelling and the tooth is periostitic and painful I would advocate drainage. In many cases fluid almost 'fountains' from the tooth whether it be pus, blood, exudate etc. Symptoms can improve rapidly. Often the patients I have seen have had dressings placed over the tooth following drainage procedures carried out the same day. These teeth already have bacteria running riot in the root canals so opening them to the sea of salivary bacteria in the short term is not of major significance.

However, within a few days the drained tooth should have root canal therapy instituted if it is to be conserved and then a dressing may be placed over the tooth. Provision of antibiotics should be simultaneously administered when drainage is performed where there is evidence of swelling, cellulitis, associated lymphadenopathy, pyrexia etc. It is worth mentioning that a tooth being treated for acute pulpitis must always be dressed immediately and not left on open drainage.

Where a non-vital tooth is painful, tender to percussion and subsequently 'opened' and little drainage of fluid is experienced, then following root canal preparation and irrigation one might immediately dress the tooth, but equally if it is left on drainage for a few days before beginning root canal therapy it is of little significance.

In the case cited in the letter where cellulitis had ensued following drainage I expect that an antibiotic needed to be administered when drainage was performed. I have no doubt that should I review the thousands of record cards of patients I have treated and produce evidence based research, my 'opinions' would become sound clinical dogma. Pity under the new contract I have neither the time nor the inclination!

J. A. Cooper
Salford
DOI: 10.1038/bdj.2007.481

Critical reading

Sir, as an elder dentist I regret not receiving any formal tuition in critical reading skills, but even as an amateur I was struck by some of the assertions in Hew Mathewson's recent leader article entitled *A profession to the core* (*BDJ* 2007; **202:** 365).

Apparently the GDC's primary function is to stop unqualified persons setting up as dentists. Hew Mathewson made this point four times. A puzzle, then, that it used to do this perfectly well on an annual retention fee around 20% of the current sum. Nor does the struggle against dental 'Pretenders' seem to greatly occupy the GDC as anyone who has contacted them about tooth whitening beauticians over the last couple of years will know. As professionals I hope we all support the mission of protecting the public, surprising then that an organisation that seems to have an opinion and policy upon so much that occurs in the dental world, has been mute as government policy has steadily set about wrecking NHS dentistry, and with it a large section of that same public's access to any dental care.

It is true that Stephen Hancocks wrote about the threat to professionalism in an entertaining way; he is after all a dentist turned writer. In contrast, Hew Mathewson's leader is that of a dentist turned politician and this illustrates the problem with a mainly or entirely appointed GDC. There must be a real concern that the appointments will be made to suit government policy and ministerial careers rather than protecting the public. Hew Mathewson chose the reassuring fairytale of Goldilocks to describe his view of an appointed council, but those who will be subject to it, and our patients, may be worrying about Animal Farm.

P. Isaacs
Essex
DOI: 10.1038/bdj.2007.482

One-stop-shop

Sir, Professor Nairn Wilson in his editorial (*BDJ* 2007; **202:** 297) makes a passionate plea for a modern scientific dental education throughout a dental working life. This is because of the ever-changing nature of disease and the complexity of the interactions between healthcare personnel who are now, and will be even more so in the future, involved in the provision of patient care.

There are, I believe, two prerequisites for closer links with our medical colleagues.

Firstly, medical practitioners will need to be educated in the impact of oral and dental diseases on systemic health and disease and the significant effect on oral health status that common disease entities have in the mouth, for example diabetes. Currently this is not a feature of undergraduate medical education, rarely appears as part of either GP or specialist training and is unlikely to do so unless the dental profession takes the initiative to educate and keep our medical colleagues up-to-date using our expertise.

Secondly, general medical practitioners will need to be persuaded that dentists will see patients who currently go to their medical practitioner with dental problems because they are unable to obtain treatment under the NHS from a local dentist. The resentment that this causes in general medical practice is a real stumbling block to achieving the level of cooperation to which Professor Wilson aspires. I am well aware that the reasons behind this unhappy situation are complex and in many respects beyond the control of individual dentists. However, they are not really understood by medical practitioners who only see the resultant fallout. It is important that the dental profession as a whole and individually, make the effort

to inform our medical colleagues of the falsities behind their misconceptions.

Another area to which Professor Wilson refers is the role of the dentist as team leader. What he does not say is that the dental team of the future will, in all probability, be working in a health care 'one-stop-shop' and in close proximity to the medical practitioners with whom he believes we should be working.

All the more reason to resolve the current difficulties without delay. There are exciting times ahead!

S. Morganstein
London
DOI: 10.1038/bdj.2007.483

Spellbinding strokes

Sir, I found it both saddening and revealing to read Ken Cranston's obituary in the Journal (*BDJ* 2007; **202:** 361).

I remember, while on holiday during my three weeks' summer break from dental school following military service, seeing Ken Cranston's Eleven play Learie Constantine's, later Lord Constantine, West-Indian team at Colwyn Bay Cricket Festival.

It was spell-binding on that beautiful day seeing cricket played for pure entertainment with strokes never usually seen.

I ponder today, whether dental schools have their own grounds, like I enjoyed, and another amateur could rise from the ashes of the profession?

T. S. Longworth
Dartmoor
DOI: 10.1038/bdj.2007.484

Undefined relationships

Sir, the letter *A wider spectrum* (*BDJ* 2007; **202:** 300) raises the importance of psychological factors like distress, sleep disturbance and aspects of illness behaviour in cases of TMD. Sleep disturbance, subjective pain intensity and psychologic distress have been reported in patients with TMD.[1] However, the inter-relationship between these factors has not been defined.

In the 1970s I performed overnight recording of tooth contacts using stainless steel bands on opposing incisor teeth as electronic contact switches.[2,3] Computer analysis of the recordings showed a significant difference between the tooth contacts in control subjects and in patients with clinical signs of temporomandibular joint dysfunction. More importantly, the pattern of tooth contacts throughout the night differed between the two groups. The control subjects showed regular peaks at 60-90 minute intervals, which almost certainly coincide with the sleep cycle. The number of contacts increased towards the end of the sleeping period, as sleep became lighter and arousal greater. Patients with temporomandibular joint dysfunction showed a more irregular cycle with increased activity early on in the sleeping period with decreasing activity towards the end of the night, which suggests difficulty in getting into deep sleep initially.

I proposed that stress and disturbed sleep could account for these findings. Stress has been found to increase non-functional tooth contacts during the daytime in humans,[4] and cause brux-like activity of the masseter in rats.[5] Experimental bruxism has been shown to result in temporomandibular joint pain.[6] Stress and anxiety have also been found to disrupt the sleep cycle in monkeys, spending a greater percentage of the time in light sleep.[7] It has been well established that tooth-grinding episodes are associated with arousal in the lighter stages of sleep.

It could therefore be postulated that stress and anxiety cause disturbed sleep and bruxism which results in muscle spasm and temporomandibular joint dysfunction.

M. J. Trenouth
Preston

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8. Robinson J E, Reding G R, Zepelin *et al.* Nocturnal teeth-grinding: a reassessment for dentistry. *J Am Dent Assoc* 1969; **78:** 1308-1311.
9. Satoh T, Harada Y. Electrophysiological study on tooth-grinding during sleep. *Electroenceph Clin Neurophysiol* 1973; **35:** 267-275.

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Mandibular mesiodens

Sir, mesiodens are defined as the most common type of supernumerary teeth[1] although are very rare in the mandibular region. In March 2007, a 21-year-old woman presented complaining of pain in the maxillary posterior teeth. On intraoral examination aside from occlusal and aproximal caries in the permanent molars, a small mesiodens was observed in the lingual region of the anterior mandible (Fig. 1). She was not concerned with this erupted mesiodens.

A periapical radiograph showed a small tooth opacity that is superimposed on the mandibular left second incisor image (Fig. 2). Root canal treatment and restorations were planned and the patient referred to the surgery department for extraction of the mesiodens due to the probability of it irritating the tongue.

A. Z. Zengin
Turkey

1. Luten J R. The prevalence of supernumerary teeth in primary and mixed dentition. *J Dent Child* 1967; **34:** 346-353.

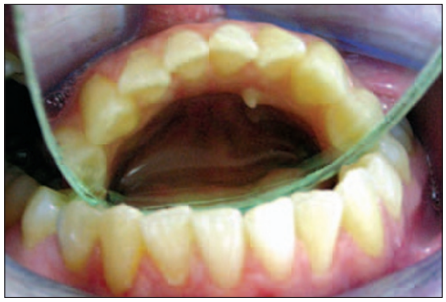

Fig. 1 Intraoral view of the mesiodens

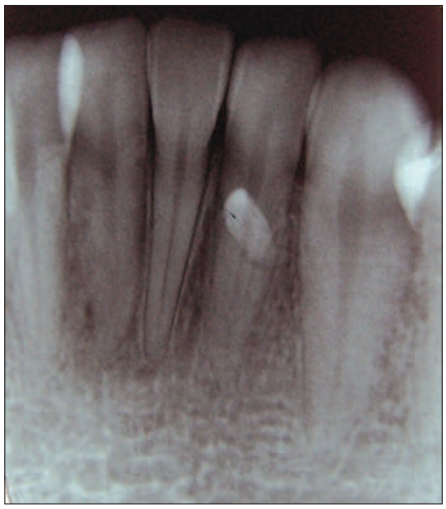

Fig. 2 Mandibular mesiodens on periapical image

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Distress in the detail

Sir, Mr Duncan Rudkin's words (*BDJ* 2007; **202:** 367) regarding public records are very reassuring, but completely at variance with my experience. He states, 'registrants can change their address very quickly and simply' by phoning or email.

Firstly my experience is that email notification is not acceptable. I suspect telephone requests would similarly be disallowed. Secondly when writing to the GDC, as required to do, I found

that the procedure was far from quick. For complicated personal reasons I wanted to change my registered address quickly. I wrote advising of change of address and, after a month, when there was still no change on the internet, I wrote again. A month later I contacted my defence organisation to enlist their help. Eventually after over two months, my details were updated. Perhaps Mr Rudkin considers this to be quick, but I do not and the experience has caused me a lot of distress.

E. Gankerseer
By email
DOI: 10.1038/bdj.2007.487

Crucial distinction

Sir, I write in response to the recent letter linking 'open root canals' to a facial abscess (*BDJ* 2007; **202:** 239). In my experience, the reason these unfortunate people end up with abscesses is misguided pharmacotherapeutics, ie many a time these people are prescribed an analgesic along with an enzyme, such as Serratiopeptidase, which is really a spreading factor in the presence of infection and only aids healing in the absence of infection. This crucial distinction is not widely known.

Another factor is improper prescription of antibiotics such as cephalosporins, which are not first line drugs for the oral cavity, and infections arising thereof.

Last is the obsolete practice of warm fomentation to 'allow the abscess to point' for easy incision and drainage, which is damaging to say the least.

Agreed, open drainage is not the best thing to do, but then there are so many worse things that are being done.

S. Jindal
India
DOI: 10.1038/bdj.2007.488

Internet revolution

Sir, I am happy to read the series by Dr Downes on the internet revolution in the UK. The internet has become a major tool even in developing countries like India, where there are more than 700,000 broadband subscribers. Cyber cafes have also helped fuel internet usage and although India, like the UK, seems to have developed the internet with a degree of ambivalence, these 10,000 plus cafes are used with tremendous enthusiasm so that an estimated 60% of users access the net via this method.

The number of internet users has grown steadily with the majority from the corporate world and educational institutions, many of which have subscribed to give online access to various journals. It is indeed a welcoming relief that we get to see the latest issues of the *BDJ* immediately, as many of our institutions now subscribe online. As a student I used to get to see a *BDJ* May issue in December! The internet is a great revolution even in the developing world.

Meghashyam Bhat
Manipal
DOI: 10.1038/bdj.2007.489

Access to the chin

Sir, we believe that access to the chin point to allow genioplasty is facilitated by having the patient's teeth in occlusion, which relaxes the soft tissues. When genioplasty is performed as part of orthognathic surgery, the fixed appliances can be used to place intermaxillary fixation (IMF). However, when performed as an isolated procedure, the orthodontic brackets may not be in place and the teeth can be handheld in occlusion, or IMF applied conventionally using interdental eyelet wires and IMF. Although previous work using the Rapid IMF™ system has been on patients with maxillofacial trauma,[1] we have found that using Rapid IMF™ in such cases is easy, quick, avoids the potential for needle-stick injury and allows for adequate relaxation of the facial soft tissues to allow good access to the chin (Fig. 1); therefore, this versatile system has applications during certain orthognathic procedures.

R. M. Graham
G. C. S. Cousin
Blackburn

1. Thomson E, Nugent M, Cousin G. Temporary intermaxillary fixation: another technique. *Br J Oral Maxillofac Surg* 2003; **41:** 132-133.

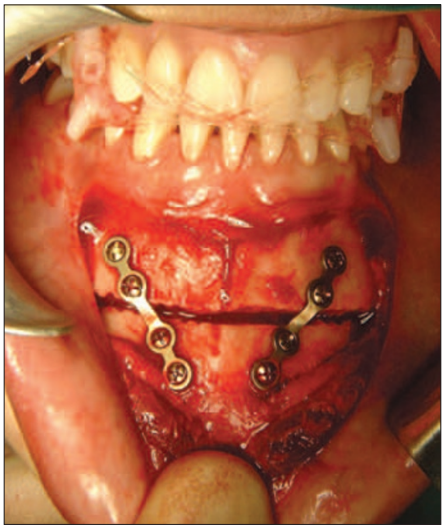

Fig. 1 An intraoperative photograph of a genioplasty, showing use of the Rapid IMF™* system for temporary IMF

*Rapid IMF™; Synthes CMF, 1302 Wrights Lane East, West Chester, PA 19380, USA.

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