Letters to the Editor

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British Dental Journal,
64 Wimpole Street,
London
W1G 8YS
Email bdj@bda.org

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

HELPFUL AND TIMELY

Sir, I write as Chair of the Specialist Advisory Committee in Oral Surgery, in response to the paper by Messiha and colleagues[1] which describes self-assessed competencies of members on the oral surgery register. For accuracy, I should point out that the 'Guidelines for Oral Surgery Training Programmes'[2] were produced by my committee, rather than the Association of British Academic Oral and Maxillofacial Surgeons (ABAOMS), as suggested by the authors. These guidelines, and a subsequent document detailing the 'Career Development Framework for Consultant Appointments in Oral Surgery',[3] describe a comprehensive and robust training programme for producing the oral surgeons of the future. Our programmes will permit either three years of training in the core competencies (leading to a Certificate of Completion of Specialist Training, and entry onto the specialist register), or longer training periods allowing the development of extended competencies.

It is therefore helpful and timely that the paper by Messiha and colleagues points out some of the deficiencies of the past, when insufficient training opportunities were available for oral surgeons. Whilst the differing levels of surgical confidence that are reported result principally from the GDC's decision to combine the oral surgery and surgical dentistry lists (producing a very heterogeneous group), rather than differences in the competence of formally trained oral surgeons *vs.* maxillofacial surgeons, the need for additional formal training programmes in oral surgery is well demonstrated. Calculations based on the data published in their paper show that of the 280 'single registrants' who responded to the questionnaire, 142 comfortably performed some extended competencies, including at least 132 treating trauma, 59 undertaking salivary surgery, 64 orthognathic surgery and (surprisingly) 31 oncology. If the disappointingly low valid response rate of 47% reflects the remainder of the population, these figures could be more than doubled. Thus there is a very substantial skilled workforce that will in future need to be replenished from our oral surgery trainees, and we strongly encourage the funding of more training opportunities.

G. Ogden
By email

1. Messiha A, Chadha A, Al-Hadad I, Hussain Z, Heliotis M. A survey of self-assessed surgical competencies with respect to qualifications, training and working patterns of members on the oral surgery register. *Br Dent J* 2010; **208:** 65-69.
2. Oral surgery training – a modern flexible programme, March 2008 http://www.rcseng.ac.uk/fds/jcstd/higher-specialist-training-documents-and-curricula/documents/Guidelines%20For%20Oral%20Surgery%20Training%20Programmes%2007-2008.pdf
3. Career development framework for consultant appointments in oral surgery, January 2010. http://www.rcseng.ac.uk/copy_of_fds/publications-clinical-guidelines/docs/oralsurg/Career%20Development%20Framework%20for%20Consultant%20Appointments%20in%20Oral%20Surgery.pdf

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FACTUALLY INACCURATE

Sir, the British Association of Oral Surgeons (BAOS) welcomes the article *A survey of self-assessed competencies...* (*BDJ* 2010; **208:** 65-69), although unfortunately it is factually inaccurate on a number of points:

1. Prior to reconfiguration of the surgical dentistry and oral surgery lists in 2007 extended competencies were legitimately practised by those individuals on the oral surgery list which did not consist solely of academic oral surgeons but many others still practising today. It must be remembered, however, that the use of a specialist title does not restrict the right of any registered dentist to practise in any particular field of dentistry, including extended competencies
2. The oral surgery curriculum which included all of the extended competencies was defined by European Directives in 1998[1]
3. The PMETB report quoted does not specify, as claimed in the paper, a requirement for dual qualification prior to the practice of any specific competencies. Rather it indicates that dual qualification is desirable for registration on the OMFS specialist register.[2]

The article seeks to question the appropriateness of some registrants on the oral surgery list practising within their areas of competency without 'formal' training, and as such might be misconstrued as an attempt to denigrate oral surgery and oral surgeons. BAOS feel, however, that it is quite valuable in highlighting several important things, although whether it is truly representative of the scope of practice of oral surgeons is unknown due to the low response rate.

Importantly it shows that many singly qualified oral surgeons practise the whole spectrum of oral surgery (core and extended competencies).

What is revealed is that neither all the singly, nor dually qualified registrants are comfortable with the whole of either the core or extended competencies. It is reassuring that surgeons practise only

procedures they are comfortable with irrespective of single or dual registration. Curriculum specifications cannot be prescriptive in nature for any surgeon whether singly or doubly qualified.

Many oral surgeons carry out extended competencies despite having had very limited formal training availability since 1984 (none outside of AACOMS). This lack of training opportunities is an issue and BAOS fully endorses the urgent setting up of training programmes to address this.

BAOS recognises the value of this paper in highlighting the need to increase competency based postgraduate training opportunities in oral surgery that will ensure those gaining a CCST will be appropriately trained to sustain the valuable workforce that will be required in the future.

R. Bunyan
President BAOS

1. The European Primary and Specialist Dental Qualifications Regulations 1998.
2. PMETB report on training in OMFS. paras 106, 112 and 115.

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INAPPROPRIATE REFERRALS

Sir, despite the NICE guidance on the removal of impacted wisdom teeth laid out ten years ago we are still receiving a large volume of inappropriate referrals for the removal of wisdom teeth. An audit of referral letters was carried out and new referral guidelines disseminated which resulted in an overall improvement in the standard of the referrals received by our Oral and Maxillofacial Surgery (OMFS) department.

However, there still remains a large number of patients referred that do not comply with NICE guidelines. As a reminder, 'the routine practice of prophylactic removal of pathology-free impacted third molars should be discontinued by the NHS'.[1] Surgical removal should only be embarked upon in patients with evidence of pathology. Such pathologies include:

1. Two or more episodes of pericornitis
2. Unrestorable caries
3. Non-treatable pulpal or periapical pathology
4. Cellulitis
5. Abscess
6. Osteomyelitis
7. Internal or external resorption of the tooth or adjacent teeth
8. Fracture of the tooth
9. Disease of the follicle including a cyst or tumour
10. Tooth or teeth impeding surgery or reconstructive jaw surgery
11. When a tooth is in or within the field of tumour resection.

I urge readers to re-familiarise themselves with this guidance as it is imperative that clinicians refer only those patients with a recognised clinical treatment need. Compliance with this should help to reduce the numbers of patients on OMFS out-patient and surgical waiting lists, avoid patient confusion relating to wisdom tooth extraction and maintain a high standard of evidence-based clinical practice.

R. O'Brien
London

1. National Institute for Clinical Excellence. Guidance on the Removal of Wisdom Teeth – Technology Appraisal Guidance No 1, March 2000. http://www.nice.org.uk/nice-web/Embcat.asp?page=oldsite/appraisals/wis_guide.htm

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RETAINED TOOTH FRAGMENT

Sir, we recently encountered this case and wish to share the findings with your readers.

A 46-year-old man, who was fit and well, presented to the emergency department complaining of a swelling of the left side of the lower lip (mucosal aspect), which had been present for three months. It was gradually increasing in size, sometimes painful and occasionally infected. Three months ago he was involved in a motorcycle accident in Greece in which his upper and lower lips were lacerated and also several of the upper and lower anterior teeth were fractured. His lips were sutured in Greece. Upon return to the UK he saw his GDP on numerous occasions for the extraction of necessary teeth and construction of dentures. The patient mentioned about the lower lip swelling but was reassured that it was probably a traumatic extravasation mucocele. He then consulted his GMP who said that the swelling was probably due to his dentures. The patient then resorted to attending the emergency department as above and on examination a firm lower lip mass, 0.5 cm in length, was identified, which was not currently infected. A lower lip soft tissue lateral radiograph was taken which shows a piece of tooth embedded in the substance of the lower lip (Fig. 1). The plan is for removal of this tooth fragment, under a local anaesthetic, via a trans-mucosal approach.

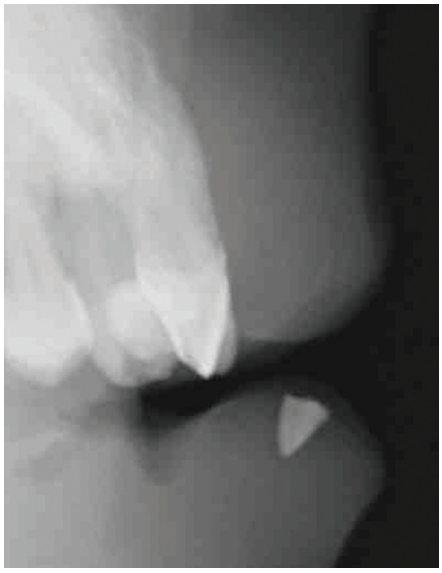

Fig. 1 Radiograph showing a piece of tooth embedded in the lower lip

This case demonstrates the value of taking a social and recreational history and also demonstrates the utility of soft tissue radiographic views in confirming the diagnosis, which have been recommended in such cases.[1]

In such cases, tooth fragments will most commonly be found in the lips (as opposed to other sites of the oral cavity); rarely, such fragments will spontaneously erupt from the mucosa[2] but the usual recommendation is that such fragments should be removed to prevent any undesirable foreign-body reactions and scarring.[1]

P. Gill
K. Fleming
By email

1. da Silva A C, de Moraes M, Bastos E G, Moreira R W, Passeri L A. Tooth fragment embedded in the lower lip after dental trauma: case reports. *Dent Traumatol* 2005; **21:** 115-120.
2. Roth J S, Walczyk J S. Occult tooth fragments spontaneously extruded after six months. *Cutis* 1994; **54:** 253-254.

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SUFFICIENT RETENTION

Sir, a 9-year-old boy who was undergoing orthodontic treatment with a