An observation within the last year has highlighted an increased number of younger and otherwise healthy patients of an increased BMI who cannot be accommodated by a standard dental chair.[3] Although frequently accustomed to discussions offering healthy choices regarding sugar content, practitioners may be less well-versed in the sensitive discussion of weight and implications upon other health conditions. Dental practitioners regularly review patients and as such often gain a level of rapport due to frequency of visit. This poses the question of the dental team being gatekeepers to weight management services. Do we have a duty of care to liaise with and inform our, often less visited, medical colleagues of these findings? Policies, guidance and training, supported by published evidence, need to be put in place to support practitioners in these discussions.

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References

1. World Health Organisation. Obesity. 2021. Available at: https://www.who.int/health-topics/obesity#tab=tab_1 (accessed 6 May 2021).
2. Public Health Scotland. Diet and healthy weight. 2021. Available at: http://www.healthscotland.scot/health-topics/diet-and-healthy-weight/obesity (accessed 6 May 2021).
3. Reilly D, Boyle C, Craig D. Obesity and dentistry: a growing problem. *Br Dent J* 2009; **207:** 171-175.

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The practice of dentistry

Guidelines are not standards

Sir, I commend Robert L. Caplin's Opinion (*BDJ* 2021; **230:** 337-343). As an expert witness and specialist in periodontics, I frequently see breaches of duty being defined by guidelines with little consideration of clinical judgement or mitigating factors.

The GDC have provided a set of generalised standards that do not allude to particular treatments; defence organisations want to settle civil cases to avoid court costs and the NHS provides a system for dentists to work in which is not fit for purpose. In addition, the dearth of reliable evidence provides little sound basis for many breaches to be adequately assessed by experts.

Guidelines are not standards; this is not their purpose and such use is unjust. The requirement is for a GDP to be 'reasonably competent'. Today's straight 'A' students learn the basic knowledge and technicalities of dentistry, but as graduates they enter the real world of NHS fees, time constraints and the idiosyncrasies of the general public which do not align with dental school tuition and complicates provision of NHS dental care. Are we not to allow these highly intelligent graduates to use the tools of their education to form a strategic plan of treatment using their developing clinical judgement without fear of being found in breach of duty?

The advent of dental implants, the blame culture of UK society and the sometimes unrealistic expectation of teeth for life has led to an era of allegations of substandard dentistry in order to replace lost teeth. While every assistance should be given to individuals who have suffered harm from dental treatment or lack of treatment, it is appropriate to ask what exactly constitutes a breach of duty. Fraud or infection control issues are understandable breaches, but infrequency of radiographs or inaccurate BPE implies there is a script from which deviation is disallowed. While not wishing to belittle these diagnostic aids, civil claims for dental implants to replace periodontally affected second molars in long-term heavy smokers with poor oral hygiene seems inappropriate and even unnecessary. Perspective is paramount in consideration of such claims.

Treatment of periodontal disease will only be beneficial with the compliance and cooperation of a patient regarding their duty of care with oral hygiene. A patient may not be able or willing to provide adequate care making ideal treatment difficult. Dental therapists/hygienists offer a great service but they are costly to an NHS practice. There is limited recourse to NHS periodontal specialist provision leaving only private high street specialist care. The GDP is stuck between a rock and a hard place.

The delay of the overdue updated NHS dental contract has likely seen some of the best talent leave the system to provide dentistry privately, overseas or not at all. Change in the system is imperative to provide appropriate dental care in the NHS and avoid the huge costs to the profession of the litigation machine, which only questionably improves overall standards.

E. Roberts-Harry, Wetherby, UK

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Restorative dentistry

But surely

Sir, I write in response to the letter *Of little consequence* (*BDJ* 2021; **230** 553-555).

A 360-veneer is a crown, is it not?

Correct me if I am mistaken, but surely the only way to place a 360-veneer on an incisor is to fit adjoining veneers on the labial and palatal aspects!

C. Redican, Winchester, UK

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Oral microbiology

COM crisis

Sir, clinical oral microbiologists (COMs) form a specialty that has been highlighted by the COVID-19 pandemic as vital to supporting the quality and safe delivery of dentistry. Their Association raised several concerns in 2016, still unaddressed, around meeting the needs of the population and profession.[1] Currently, there are only seven COMs on the GDC register, the most recent added in 2014, and no trainees. With the five-year duration of training the number is not projected to increase in the immediate future, meaning that there will have been no COM training posts open for a continuous seven years. COM are involved in education and training undergraduate and postgraduate dental students and actively undertaking research, but the small number means that this is not the case in every UK dental school. Recently, level 7 and 8 postgraduate programmes were launched in two UK universities, preparing future candidates to be eligible for competing on shorter training pathways (nationally and internationally).

COM are involved in specialist management of systemic and local oral and maxillofacial infections caused by microorganisms, and are trained in medical microbiology to make strategic decisions on the most effective therapy for acute and chronic infections guided by clinical presentation and laboratory reports. This highly specialised focus is needed and unlikely to be fulfilled by any other groups. For example, the successful management of infections such as osteomyelitis, stage II and III of medication-related osteonecrosis of the jaw (MRONJ) and actinomycosis in the head and neck region, requires specialist COM input with an

appreciation of the anatomical region and key differential diagnoses. Laboratory diagnostic testing is one part of their role by providing appropriate clinical advice vital in achieving infection resolution and improving patient outcomes.

Two other major roles are in leading the antimicrobial stewardship programme and infection prevention and control in dentistry. This is of importance in the era of emerging complex and resistant infections that resulted in more than 3 million deaths secondary to COVID-19 since December 2019, and more than 700,000 annual deaths secondary to drug-resistant infections.[2] Additionally, treatment for patients with multiple co-morbidities is resulting in complex decision making that requires such specialist infection management. We wish to highlight the urgent need for prioritisation of workforce planning of COMs or this vital dental specialty faces a real threat of non-existence in future years.

M. Dave, Manchester; N. Seoudi, P. Coulthard, London; M. Wilson, Cardiff, UK

References

1. Pankhurst C, Rautemaa-Richardson R, Seoudi N, Smith A, Wilson M. Antimicrobial resistance: Antibiotics and consultant oral microbiologist posts. *Br Dent J* 2016; **220:** 2-3.
2. World Health Organisation. New report calls for urgent action to avert antimicrobial resistance crisis. 29 April 2019. Available at: https://www.who.int/news/item/29-04-2019-new-report-calls-for-urgent-action-to-avert-antimicrobial-resistance-crisis (accessed 14 April 2021).

https://doi.org/10.1038/s41415-021-3135-4

CASE REPORT

Restorative dentistry

Success and poor predictions

Sir, an 81-year-old male patient presented to an undergraduate restorative clinic in 2019 for a new patient assessment, following a near 20-year absence from dental treatment.

He first presented to Liverpool Dental Hospital back in 1986, having just been provided an upper complete denture and complaining that 'his teeth felt unclean'. His notes from 1986 recorded a diagnosis of 'Chronic Periodontal Disease', which translates into the new 2017 periodontal classification as, 'Generalised Periodontitis, Stage IV, Grade C, Currently unstable with no risk factors'.[1] His clinical notes from 1986 included the OPG seen in Figure 1.

The last standing molars (47/38) were extracted immediately, and after some oral hygiene instruction and trials of at-home irrigation of deep pockets with chlorhexidine, he was considered an appropriate candidate for periodontal surgery. Between June and July of 1987, this patient underwent periodontal surgery involving apically repositioned flaps from the canine to the last standing molar bilaterally, without regenerative techniques or grafting.

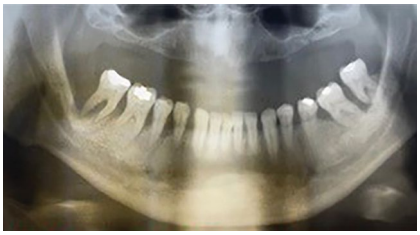

Fig. 1 Full OPG from 1986 showing severe bone loss in posterior sextants

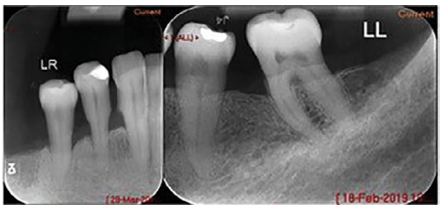

Fig. 2 Periapical radiographs from 2019 showing LR and LL posterior teeth

Despite a 20-year absence of professional periodontal treatment and self-reported 'poor cleaning at home', this patient presented in 2021 having maintained the 45 to the 37 for over 35 years! The most recent periapical radiographs even show a significant improvement in bone level and the patient has been re-enrolled in supportive periodontal therapy (Fig. 2).

The patient consented both verbally and in written format.

We hope this serves as a reminder to us all to not give up hope on periodontally involved teeth in the long term, and to empower patients to maintain these teeth we label as having a 'poor prognosis'.

A. Brandon, N. Longridge, Liverpool, UK

Reference

1. British Society of Periodontology and Implant Dentistry. Implementing the 2017 Classification of Periodontal Diseases to reach a diagnosis in Clinical Practice. Available at: https://www.bsperio.org.uk/professionals/publications (accessed May 2021).

https://doi.org/10.1038/s41415-021-3136-3