

Letters to the Editor

The provision of orthodontic treatment

SIR, — I WOULD LIKE TO COMMENT on the recent correspondence regarding the provision of orthodontic treatment. Brian Selwyn-Barnett (*BDJ* October 7) compared GDPs undertaking multiband treatments to someone riding a high powered motorbike from Lands End to John O'Groats having previously mastered only rudimentary pushbike skills.

I am such a GDP. In fact, I possess other motor vehicles which could be harmful to the public if not driven with due care and attention. I quite often drive my crown and bridge motorbike on the same day as my endodontic machine and my oral surgery chopper occasionally gets an outing. My not very glamorous amalgam and scaling pushbikes are also still used quite frequently.

There are too many orthodontic patients wanting to get from Lands End to John O'Groats by any mode of transport. GDPs are best placed to identify their problems and to treat some of them. Because a practitioner can carry out other treatments it should not disqualify him from undertaking multiband treatments. Specialists tend to see GDP

treatments that have gone wrong, rather than the successful ones, and so tend to think that GDPs are forever messing things up.

The problem of finding a simple and effective method of getting pushbike practitioners to become motorised orthodontists, in sufficient numbers to satisfy the public, has been solved in Cornwall.

The local consultant appoints clinical assistants on open ended contracts, in appropriate geographical areas. They carry out treatments under his guidance, at the local hospital. The consultant can increase the difficulty of the cases at a rate appropriate to the individual practitioner. He can place oil patches and hair-pin bends in the path of the GDP's orthodontic motorcycle while he supervises the rider's response. When appropriate, the practitioner can begin treating patients at his practice. The fact that the clinical assistants are not on time limited contracts has the advantage that long term contact with the local consultant is maintained. The practitioner is not just given a taste for

orthodontics before being left to his own devices after 2 years or so.

This form of training is very effective in producing GDPs who can provide orthodontic services to an acceptable standard. It does not however produce a recognised orthodontic qualification. How then are the public and local colleagues able to judge orthodontic competence? There are many postgraduate qualifications available for the GDP to aspire to. They give the public an indication as to the general competence of the practitioner. Competence, or otherwise, will become apparent to colleagues and patients alike, as badly treated orthodontic cases are hard to hide.

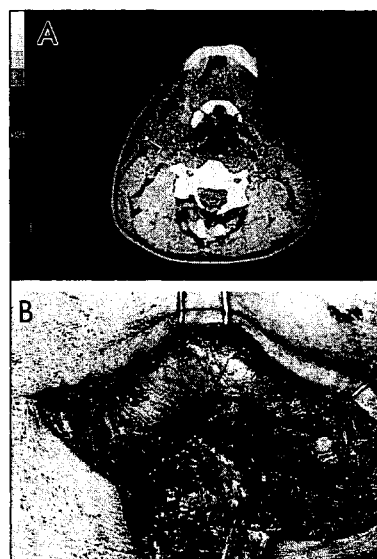
GDPs who have acquired and maintained appropriate skills have a duty to put those skills at the disposal of their patients. This should be the case even in areas that are sometimes considered to be 'specialist'. GDPs should have a selection of motor vehicles at their disposal. They must however make sure that they can drive them all safely.

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Location of bone and tooth fragment following mandibular fracture

SIR, — A 20-YEAR-OLD MALE visited our hospital with the chief complaint of a swelling in the left side of his neck. He had become conscious of this one month following intra-oral open reduction with mini-plates after therapy for acute inflammation arising from a mandibular fracture, which had persisted for 5 months. The fracture extended from the left third molar to the mandibular angle. The lower left third molar was removed. Swelling had steadily increased during the 5-month period, and clinical examination revealed a swelling 2.5cm in diameter at the anterior region of the sternocleidomastoid muscle. There was no redness of the overlying skin and no tenderness to palpation in the region was found. The mass was partially immobile at the inferior border of the mandible. The patient had no difficulty in breathing or swallowing. No submandibular or cervical lymphadenopathy was present, and the oral mucosa was normal. Lateral and oblique roentgenographic examination revealed no unusual findings other than the mini-plates, which had been applied on the mandibular angle for the treatment of fracture 6 months previously. A computed tomography (CT) scan revealed the presence of a soft tissue mass containing a rice grain-sized, well circumscribed opacity consistent with calcification. It was located apart from the

mandible on the cervical fascia of the anterior region of the left sternocleidomastoid muscle (Fig.A). The mass was excised by the transcutaneous approach via the submandibular region. The mass was attached to the inferior border of the mandible at the mandibular fracture line via a 1.8cm pedicle (Fig.B). No inflam-



matory changes were noted at the fracture line, nor were any impacted or supernumerary teeth observed. The patient recovered uneventfully after exclusion of the mass.

The formation of a tumour may have been preceded by inflammation arising from mandibular fracture and the retention of the tooth and bone fragment for some months in the neck. Indeed, the retained root and bone fragment was located in the centre of the tumour. The anatomic location of the tumour was far from the mandible and the pedicle was continuous with the inferior border of the mandible at the fracture site, suggesting that trauma was an etiologic factor. Scanning electron microscopic examination of decalcified histologic specimens of the lamellar bone and dentinal tubules also suggested them to be root and bone tissue.

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