COMMENT

Letters to the editor

Send your letters to the Editor, *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.

Aesthetic dentistry

Advancing the maxilla

Sir, I read the paper by Drs Chan, Mehta and Banerji (*BDJ* 2017; **223:** 272–278) with interest: a well-designed paper confirming that dentists and non-dentists differ in their judgement of aesthetics depending on how much of the face is exposed. Somewhat naturally the dentists thought the teeth had the most influence in the 'zoomed' views, however when more of the face was exposed in the 'lower two thirds of the face views' the judgements of the two groups became more unified. The authors concluded 'both the lips and teeth seem to contribute to the aesthetic appeal of a smile'.

Interestingly, Perrett *et al.*[1] showed that attractive eyes are one of the most distinctive features of a good looking face. Most eyeballs are very similar and it is the prominence of the zygomatic process which creates much of their beauty. This process of course is part of the maxilla but is an area hardly visible in the views shown in this paper. While most orthodontists consider that the maxilla cannot be moved by appliances, the orthotropic group considers it essential to advance the maxilla to improve appearance. I attach a photograph to illustrate this (Figs 1–2). Those involved in the aesthetics of dentistry should perhaps include most of the face in their observations.

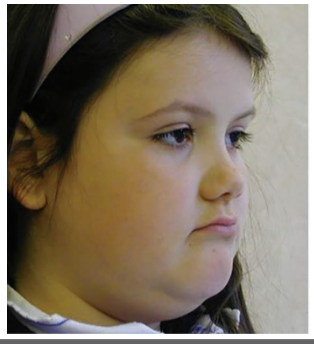

Fig. 1 Aime age nine

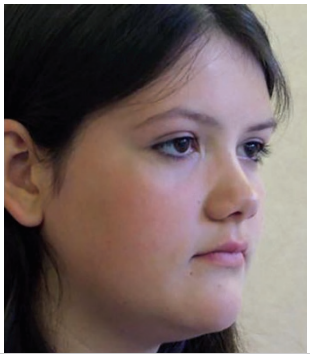

Fig. 2 Aime age 13

J. Mew, East Sussex

1. Perrett D I, May K A, Yoshikawa S. Facial shape and judgements of female attractiveness. *Nature* 1994; **368:** 239–242.

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Dental caries

Caries risk assessment tools

Sir, Rai asked whether there is any official parameter for low/medium/high risk category which could be used for caries risk assessment.[1] This topic has been discussed by Doméjean *et al.*[2] in the recent themed issue of minimum intervention in the *BDJ*.

Scientific reviews of the literature have found that the single best indicator of a patient developing caries in the future is past caries experience.[3] Several other factors may be helpful when used in combination with past caries experience. These factors are outlined in the two caries risk assessment forms developed by the American Dental Association. One form is for patients aged 0-6[4] and the other is for patients over six years of age.[5] These forms are accompanied by completion instructions.[6]

The Faculty of General Dental Practice (UK) has produced guidelines on the use of dental radiography according to caries risk status for children and adults. Individuals who do not clearly fit into high or low caries risk categories are considered to be at moderate caries risk.[3]

Different caries risk assessment models have been developed to help dental professionals assess patients' caries risk.[2] While many dentists apparently do some type of informal caries risk assessment, there remains the need for broadly adopted ideally electronic caries risk assessment tools that can help dental professionals in establishing and documenting the caries risk status of their patients as well as tracking changes over time.

C. A. Yeung, Lanarkshire

1. Rai K. Oral health: Caries risk category. *Br Dent J* 2017; **223:** 307–308.
2. Doméjean S, Banerjee A, Featherstone J D B. Caries risk/susceptibility assessment: its value in minimum intervention oral healthcare. *Br Dent J* 2017; **223:** 191–197.
3. Faculty of General Dental Practice (UK). *Selection criteria for dental radiography.* 3rd ed. London: Faculty of General Dental Practice (UK), 2013.
4. American Dental Association. Caries Risk Assessment Form (Age 0-6). Available at: http://www.ada.org/~/media/ADA/Member%20Center/Files/topics_caries_under6.pdf (accessed September 2017).
4. American Dental Association. Caries Risk Assessment Form (Age >6). Available at: http://www.ada.org/~/media/ADA/Science%20and%20Research/Files/topic_caries_over6.pdf (accessed September 2017).
5. American Dental Association. ADA Caries Risk Assessment Form Completion Instructions. Available at: http://www.ada.org/~/media/ADA/Member%20Center/Files/topics_caries_instructions.pdf (accessed September 2017).

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Oral health

The Sakata model

Sir, to tackle major challenges to its health system, Japan has enacted recent legislation to create integrated community-based comprehensive services (ICCS)[1] of which, as Wilson articulated in his commentary,[2] oral health is an essential part. The committee organised by the Japan Ministry of Health, Labour and Welfare recently recommended the promotion of inter-professional collaboration, oral care in the context of ICCS, and preventive oral health care.[3] The Japanese government is currently developing a new vision for oral healthcare along this line.

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We think, however, that holistic care is not sufficient as the health system should be rebuilt in the future as a new 'social system' which is integrated to provide values to patients. In 2015, an advisory panel appointed by the health minister of young experts in their 30s and 40s, developed a vision of health care: Health Care 2035.[4] Sakata City (100,000 population) is a unique rural community in Japan, having a model with this point of view. Since 1980, a group of dentists (re-educating themselves and other dentists nationally to become 'oral physicians' rather than dental surgeons), hygienists, specialists, community nurses, school teachers and government officials have collaborated with the private sector, academic institutions and civil society. The group has gradually developed a new social system to enhance oral care in a holistic manner with an emphasis on the patients' values.[5]

Local industries have started to pay for preventive oral care, which benefits employees and their family members and enhances productivity. The group has developed a consortium with large companies to advocate and facilitate the continuum of quality care after patient transfers. The consortium has developed a cloud-based, people-centred health information system. This system integrates various personal data and facilitates a personalised approach to health promotion and disease prevention by empowering each individual to design their own life style, with an ambitious goal, namely 'KEEP 28' to keep all of your own teeth for your general and oral health even for a 100-year life span. In 2016, Sakata City legislated for a holistic approach to oral care,[6] obviously being influenced by these activities of the group. Professor Wilson's proposed advancements in oral health along with the Health Care 2035 vision are already taking place in a rural town in Japan.

T. Kumagai, N. Kumagai, M. Nishi, K. Shibuya, by email

1. Reich M R, Shibuya K. The future of Japan's health system – sustaining good health with equity at low cost. *N Engl J Med* 2015; **373:** 1793–1797.
2. Wilson N. Holistic care should be coming your way. *Br Dent J* 2017; **223:** 568–569.
3. Committee on the Future Vision and Work Style Reform in Health Care. Tokyo: Ministry of Health, Labor and Welfare. April 2017. Available at: http://www.mhlw.go.jp/stf/shingi2/0000160954.html (accessed December 2017).
4. Japan Vision: Health Care 2035. Tokyo: Ministry of Health, Labor and Welfare. June 2015. Available at: http://www.mhlw.go.jp/seisakunitsuite/bunya/hokabunya/shakaihoshou/hokeniryou2035/future/ (accessed December 2017).
5. Preventive medicine changes your life (In Japanese). December 2016. Available at: http://www.ashita-lab.jp/special/7424/ (accessed December 2017).
6. Legislation to promote teeth and oral health care. Sakata City (In Japanese). March 2016. Available at: http://www.city.sakata.lg.jp/jyorei/act/frame/frame110001932.htm (accessed December 2017).

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Gerodontology

Denture loss in hospitals

Sir, with regard to the loss of dentures, nothing much seems to have changed over the last 20 years. The investigation by Mann and Doshi (*Br Dent J* 2017: **223:** 435–438) of denture loss in hospitals in Kent, Surrey and Sussex concludes that consideration needs to be given by hospitals to find ways to reduce the number of dentures lost every year and stresses the financial burden on the NHS.

They are indeed correct in their conclusions but it should also be noted that whilst this is annoying for the staff and a financial burden to the NHS it is also of greater consequence, and can be quite distressing, to the patient. This is especially true for the elderly who are usually less adaptable and have difficulty in learning to control new dentures.

I wrote an article for the *Nursing Times*[1] in which I pointed out that the internal referral records of a large university hospital showed that of 286 consultations for denture problems over 30 months, 79 were because of lost dentures. The age range for this group was 24–100 and most were from geriatric and psychogeriatric wards, although a number had been misplaced in general wards and in casualty and the radiology department.

The importance of marking dentures with the patient's name or code number is often not appreciated. Although it is not possible to say how many of the dentures misplaced in hospital could be returned to their owners if the dentures had been marked, those found in ward bathrooms or returned from the laundry after being discovered in pyjama pockets or among sheets certainly could be. Ideally all dentures should be marked in the laboratory during construction but if not temporary marking can be done on admittance to hospital using a denture marking kit or at the simplest level, with a permanent marker pen. A simple denture marking system was described in 1986.[2]

A. Harrison, Bristol

1. Harrison A. Denture care. *Nursing Times* 1987: **83:** 28–29.
2 Harrison A. A simple denture marking system. *Br Dent J* 1986; **160:** 89–91.

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Smoking

Developing the evidence base

Sir, we read with interest the 'Perspectives' feature published on the occasion of the ten-year anniversary of the smoke-free legislation in England.[1] We enjoyed reading the personal views of dental professionals on this topic, including those who were working before and after the smoke-free legislation came into effect. It was very encouraging that they all advise patients to stop smoking and warn them of the negative impacts of smoking on oral health.

However, there is a clarification to the article that we think is important to make. The feature states that 'The smoking ban has since been extended to cover the use of electronic cigarettes'. This is incorrect. The smoking ban was introduced, after much debate, on the basis of well-established evidence of the harms of second-hand smoke, which is not the case for electronic cigarettes (e-cigarette) vapour. There are voluntary restrictions on the use of e-cigarettes, but the smoke-free legislation does not cover e-cigarettes anywhere in the United Kingdom (UK). Indeed, Public Health England (PHE) and Action on Smoking and Health (ASH) have produced useful guidance on this, which encourages organisations to develop evidence-based policies to the benefit of public health.[2,3]

Many NHS organisations have followed this guidance with e-cigarette use being allowed in some NHS grounds and in certain circumstances inside buildings (eg single occupancy bedrooms in inpatient mental health settings).

The feature also mentioned the role of e-cigarettes in smoking cessation on several occasions and this has been previously discussed in a *BDJ* letter earlier this year, which highlighted that e-cigarettes have been effective in helping smokers in England to quit.[4]

With respect to the standardised packaging of tobacco (SPoT), the UK was the second country in the world to introduce this, after Australia. The move was evidence-based with government commissioned systematic reviews of over 50 studies[5,6] and an independent review[7] concluding that SPoT would 'lead to a modest but important reduction [in smoking] over time'. It is important to put SPoT into context; it's not going to single-handedly eradicate smoking, but it is an important component of a comprehensive tobacco control strategy, and may be particularly

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