LETTERS

JADA welcomes letters from readers on articles and other information that has appeared in The Journal. The Journal reserves the right to edit all communications and requires that all letters be signed. The views expressed are those of the letter writer and do not necessarily reflect the opinion or official policy of the Association. Brevity is appreciated.

TALKING TO PATIENTS ABOUT EATING DISORDERS

For many years I used an approach similar to the one presented by Dr. Nancy Burkhart and colleagues in their August JADA article “Communicating Effectively With Patients Suspected of Having Bulimia Nervosa” (JADA 2005;136:1130-7). However, I found this approach turned my relationship with my patient into an adversarial confrontation. After one look at the eroded lingual and palatal surfaces of the patient’s teeth, I knew the patient had an eating disorder and that the patient knew he or she had an eating disorder. A confrontation would only be counterproductive.

I eventually developed a more direct approach. I would complete my oral examination and, then, facing the patient, I would simply ask, “So, how do you do it? Do you use a spoon, or do you just put your fingers down your throat?” I would say this in an innocuous tone of voice, similar to asking, “So, how was your day?” Before realizing it, the patient would tell me “how” he or she induced the vomiting.

The secret was out. The patient would be embarrassed momentarily by the admission, but also relieved. More importantly, the patient still would see me as his or her ally, rather than adversary. Gaining this type of admission allowed me to ask the more important question, “Would you like me to help you?”

I hope this direct approach will help practitioners avoid the confrontational aspect of diagnosing bulimia nervosa and, thus, allow dentists to be more effective in helping their afflicted patients obtain proper treatment.

Miles E. Kuttler, D.M.D.
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Authors’ response: We appreciate Dr. Kuttler’s response to our article and his suggestions in approaching the difficult issues with patients having disordered eating practices. We acknowledge that there are numerous approaches that may be successful.

Dr. Kuttler’s approach certainly may be appropriate with some patients. We do believe that the ultimate “best” approach will be one in which the dentist feels comfortable, based on individual personality profiles. The dentist must be prepared to change the tenor of the dialogue if it does not appear to be working in any given situation.

The intent of the article was to offer an initial dialogue. The practitioner also may not feel comfortable with the issue because of uncertainty regarding the clinical findings. In some cases, the findings may not be clearly diagnostic for disordered eating practices. The personality of both the patient and the dentist will play a large role in individual approaches.

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SMOKING CESSATION AND ORAL CANCER

Dr. Michael Glick’s August JADA editorial, “Smoking Cessation: No Longer a Choice,” was right on target (JADA 2005;136:1076-8).

Coincidentally, we at the Queens County Dental Society in New York City already came to the same conclusions and have taken action. It also should be noted that the death rate from oral cancer has remained relatively unchanged for 20 years, while death rates from other cancers have fallen.

We as a profession need to make an effort to do a thorough oral cancer examination of every patient. Early detection of cancer remains the best means of improving survival rates.

It has been my experience that telling a patient that you are looking for signs of oral cancer is crucial. Patients are grateful that you took the time to do a more thorough examination, and often tell their friends and family, “My dentist checked me for oral cancer. Did you have it
done by your dentist?” In addition, the examination will provide an opening to discuss tobacco use and cessation options. Therefore, an oral cancer examination can be a potentially life-saving addition to a dental examination, as well as a practice-builder.

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MANAGING DIABETES

It was truly disheartening to read the results of Dr. Carol Kunzel and colleagues’ August JADA article, “On the Primary Care Frontlines: The Role of the General Practitioner in Smoking-Cessation Activities and Diabetes Management” (JADA 2005;136:1144-53). The authors documented a lack of mastery of knowledge and behavioral practices by active general dental practitioners in regard to involvement in screening and monitoring patients with diabetes.

Approximately 16 million Americans are believed to have diabetes, which, if not properly managed, can result in death from atherosclerotic disease (for example, myocardial infarction and stroke), renal failure and overwhelming sepsis.1,2 Diabetes is, however, one of the systemic illnesses whose control, in part, is dependent on proper dental treatment.

My colleagues and I3 have demonstrated that the removal of oral sites of infection (that is, treatment of periodontitis and removal of teeth with excessive alveolar bone loss or periapical infections, as well as oral hygiene instruction, full-mouth scaling, subgingival curettage and root planing) can result in a significant improvement (17 percent) in glycemic control.

These results are critically important because strict control of blood glucose levels has been shown to prevent, or mitigate, the numerous systemic complications associated with the disease.4 The primary care role of dentists certainly extends to monitoring those aspects of systemic illnesses for which our inventions have been shown to be helpful.

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SPECIAL-NEEDS PATIENTS

I read with interest Dr. Gordon Christensen’s August JADA article, “Special Oral Hygiene and Preventive Care for Special Needs” (JADA 2005;136:1141-3). This is an important and often overlooked issue. Dr. Christensen rightly indicates that high-risk groups, such as the intellectually and physically disabled, as well as those with high caries and periodontal disease activity, require additional vigilance and interventions to prevent oral disease activity.

I would like to point out two additional overlooked populations in this regard: hospitalized patients and nursing home residents. Subjects admitted to hospital intensive care units or nursing homes often are found to have more dental plaque than do community-dwelling people.

These patients also harbor bacteria such as Pseudomonas aeruginosa, Staphylococcus aureus and enteric bacteria on the teeth.1 These bacteria then may be released into the oral secretions, to be aspirated into the lower airway to cause infection. It also is possible that inflammatory mediators, such as cytokines produced by the periodontium released into the secretions, can be aspirated to have proinflammatory effects in the lower airway. Accumulating evidence suggests that the oral health status of institutionalized subjects contributes to a higher risk of developing lung infections.2 Thus, it is increasingly clear that preventive interventions to maintain oral health are required in this group of patients.

In addition, it was surprising to note that Dr. Christensen did not mention the use of chlorhexidine products for plaque control in high-risk patients. It has long been known that chlorhexidine rinses (Peridex, Zila, Phoenix; PerioGard, Colgate Oral Pharmaceuticals, Canton,
Mass.) reduce gingival inflammation in periodontal patients.

Other studies have shown that chlorhexidine rinse and varnish reduce *Streptococcus mutans* levels in patients with coronal and root caries.3,4 These products also may serve to reduce the risk of developing pneumonia and other diseases in ventilated patients, other hospitalized patients, patients undergoing cancer chemotherapy and nursing home patients.2,5

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**ORAL IMPLANTS**

As a general practitioner doing many different implant modali-
ties over the last 30 years, I would disagree with several aspects of Dr. Clark Stanford’s August JADA article, “Application of Oral Implants to the General Dental Practice” (JADA 2005;136:1101-5).

The one statement that most concerns me is, “Should implants be connected to natural teeth?”

When I did my literature research on this subject and found many more articles in support of connecting implants to natural teeth rather than against, I wondered why the author did not choose to use any of these, to show that not everyone agrees with the contention that implants should not be splinted to natural teeth.

I have never had a problem with this, nor has anyone whom I have talked with seen this happen in his or her practice. I would call the author’s contention controversial at best.

M. Max Weaver, D.D.S.
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**Author’s response:** I would agree with Dr. Weaver that there are ongoing controversies concerning connecting implants to teeth. In my article, the purpose of this section was to review the fact that it is not considered common practice to routinely connect teeth to implants, though there are times when anatomical limitations, patient’s desires or costs necessitate this approach. It should be done with care, using rigid framework designs and with informed consent of the patient.

The literature contains numerous citations (commonly, case reports or serial case series) that cite acceptable outcomes with prosthetic connection between implants and teeth, though concern has been raised with two recent systematic evidence-based reviews.

In one, a prospective, randomized clinical trial was performed indicating an elevated incidence of complications.1 A systematic review of the entire dental literature (The Cochrane Collaboration, “www.cochrane.org/docs/descrip.htm”) and the recent systematic review of dental implant systems2 also raise concerns about the clinical concept of connecting teeth to implants.

Dr. Weaver is correct that many clinical procedures are controversial, and this places on the clinician the responsibility to plan the restorative treatment carefully, using materials and procedures supported by the current best evidence.

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