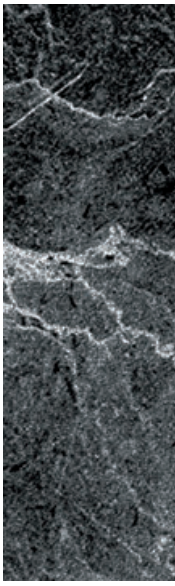

Perspectives

DENTAL TOURISM—A GLOBAL ISSUE?

Dental tourism may be a new concept to North American dentists, but here in the United Kingdom this phenomenon has taken seed. The driver is the high cost of private UK dental treatment and the relative low cost in eastern European and developing countries. This, coupled with the expansion of no-frills budget airline routes, the global recession and migration, even across continents, has made dental tourism a realistic possibility. The disadvantages, however, are all too often overlooked by patients, intent on getting the latest or most complex forms of treatment including implants. This has been highlighted by recent articles.[1] Medical tourism is also recognized and in extreme cases has resulted in organ donors being sought in developing countries for which payment is made.

There are several issues that need to be considered: who provides the long-term care and maintenance, especially in complex "high-end" cases; should the public health sector provide remedial treatment when the privately provided treatment is of poor quality and fails; what guarantees or safeguards are there for patients who received treatment in another country?

There has been little debate on the ethical issues that arise when things go wrong and little guidance for clinicians. The National Health Service (NHS) is funded out of the public purse, and as a UK hospital specialist working in it, should I provide remedial treatment in such cases? I believe my duty of care is to relieve pain and provide a functional dentition, but not necessarily to replace the work carried out overseas. The demands on the public sector outstrip supply such that some difficult decisions have to be made. Explaining to patients that replacement of failing cosmetic work or crown and bridgework or other complex items of treatment will not be carried out demands diplomacy and sensitivity.

Two cases recently seen at the Liverpool University Dental Hospital illustrate this type of case.

In case 1, a 46-year-old male had bridges placed in both upper posterior quadrants in SE Asia where he originally came from. Having settled in the UK, he returned to visit his family and had two straight cantilever bridges fitted 2 years prior to attending the hospital. The main presenting complaint was intermittent pain ever since the bridges were fitted. The upper right bridge (two units) was poorly contoured, bulbous, and had a poor contact point with the natural tooth distally. The upper left bridge (four units) had double abutments and double pontics. It, too, was poorly contoured and had marginal deficiencies. The radiographs show the situation on presentation (Figures 1 and 2). Removal of the bridgework revealed the preparation margins to be ill-defined, akin to a feather edge. After preparation modification, separate provisional crowns were fitted. The patient was reviewed several weeks later, and the pain had resolved. He was advised to see his local dentist to get three crowns and accept the posterior gaps.

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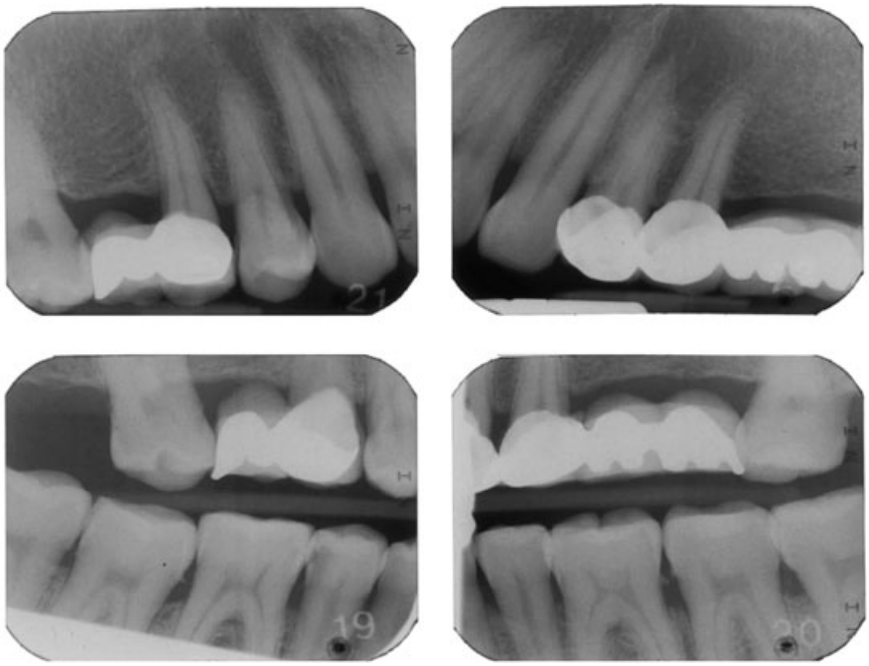

Figure 1. Peri-apical & bitewing radiographs show poor contacts, marginal deficiency (15) and caries distally in 45 (FDI notation).

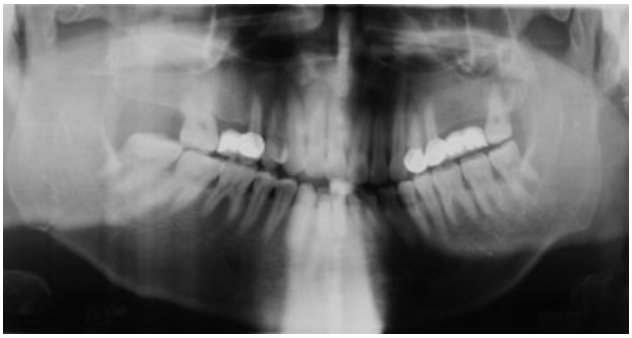

Figure 2. Despite the long span of the double pontic on the upper left straight cantilever fixed prosthesis, there is surprisingly little mobility of the abutments.

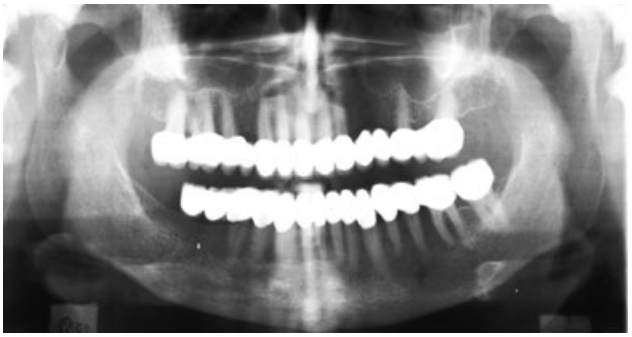

Figure 3. Pan-oral image of the extensive single casting across the upper & lower arches.

The next case is a 50-year-old female who complained of "teeth not sitting comfortably," bilateral discomfort in the mandible, and looseness of the teeth on the right (Figure 3). She originally wanted cosmetic dentistry and subsequently received full mouth rehabilitation in eastern Europe but was not sure why all the teeth were crowned. On examination, all the remaining upper and lower crowns were splinted such that there was one casting across each arch. Once again, the crowns were very bulbous and impinged upon the interdental papillae, resulting in marked gingival inflammation.

There were multiple large overhangs and a double pontic distal extension in the lower right quadrant. The occlusion was significantly deranged. The only teeth in contact in centric occlusion were the left upper and lower incisors, and it was not possible to guide the mandible into centric relation. Fortunately, temporomandibular disorder was not a problem. She was advised to return to the dentist and seek remedial treatment.

The General Dental Council (GDC) is the regulatory body in the UK and has produced a booklet in conjunction with the British Dental Health Foundation "Going abroad for your dental care?" with sensible advice regarding the risks and the checks that should be carried out. This is available to any patient through the GDC Web site at http://www.gdc-uk.org.

Tourism can provide affordable dentistry, and I am sure there are satisfied patients who have had a positive experience. The freedom to choose cheap dental treatment may, however, turn out to be expensive, not only financially but dentally as well. Furthermore, a single item of dental treatment is not the same as dental care. Even if one-off treatment is successful, long-term care and maintenance nearer to home may be less easy to obtain.

Caveat emptor, buyer beware applies equally to treatment within the country of residence, but maybe more so if intending to travel abroad for treatment.

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