consider dentistry today.[3] For example, what types of people now become dentists, what problems face them, what outside interests help to keep them sane. I will continue to read the pages of the *BDJ* carefully in the hope of seeing some answers.

S. Gelbier, London, UK

References

1. Hellyer P. The growth of general dental practice in a developing Sussex seaside resort: 1885-1916 - Part 1: the early settlers. *Br Dent J* 2019; **227**: 419-425.
2. Hellyer P. The development of general practice in a new seaside resort: 1885-1916 - Part 2: the next generation. *Br Dent J* 2019: **227**: 519-539.
3. Hancocks S. The Bexhill dentists. *Br Dent J* 2019: **227**: 433.

https://doi.org/10.1038/s41415-019-0952-9

Conservative dentistry

Long term attachment

Sir, I was interested to read Damian Panchal's case report on crown fracture.[1] I carried out a very similar re-attachment of the incisal half of an upper central incisor for a 19-year-old male on a Sunday morning in October 2006 following trauma on the previous evening.

I used no preparation and merely attached the fragment with acid etch, bond and low viscosity composite (Fig. 1). Rubber dam was not used and other treatment options were not considered. A very limited prognosis was suggested.

Although we were all very satisfied with the immediate result, I went away thinking that it was not likely to last long-term. Having given it some further thought, I then took an impression for a non-precious metal backing which was cemented in place with Panavia Ex two weeks later. In 2013 he came back to see me. The tooth was still looking good. There was no discolouration, no apical pathology and a vital pulp test (Fig. 2). I recently contacted him (now almost 13 years since the reattachment) to gain consent for this letter and he tells me that all is still good.

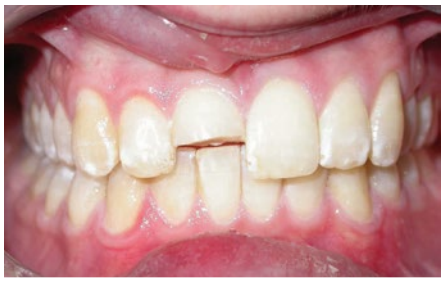

Fig. 1 The tooth fragment was attached with acid etch, bond and low viscosity composite

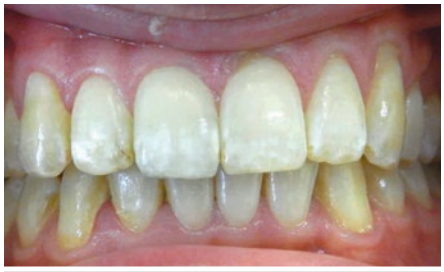

Fig. 2 The tooth seven years later

These days, if the incisal edge were more translucent, an alternative backing material could be considered. If space is needed for the backing, I would suggest temporarily adding a little pimple of composite labially to the lower incisors that oppose the upper incisors adjacent to the traumatised tooth. The backing can then be cemented and impressions taken for an upper vacuum formed retainer to be used only at night to maintain the position of the upper teeth. The occlusion will then settle 'Dahl style' and the composite can be removed from the lower incisors. If appropriate, the continued use of the retainer could be considered on an occasional basis. I did not provide a retainer.

D. A. Rhoden, Worthing, UK

Reference

1. Panchal D. A case report of uncomplicated crown fracture: tooth fragment reattachment. *Br Dent J* 2019; **227:** 259-263.

https://doi.org/10.1038/s41415-019-0955-6

Aesthetic dentistry

Cant in the interpupillary line

Sir, establishing the occlusal plane is a fundamental step for occlusal balance. The anterior occlusal plane plays a significant role in developing aesthetics, symmetry and harmony while rehabilitating a patient. In complete denture prosthodontics, the interpupillary line is almost always used as a reference plane to establish the anterior occlusal plane.[1] The maxillary anterior occlusal plane is established parallel to the interpupillary line with the Fox occlusal plane indicator and a ruler. An anterior occlusal cant of 4° results in a slanted smile which can be observed even by laypeople.[2] This can influence the aesthetic and psychological outcome of the treatment. Furthermore, anterior occlusal cant may not be perceptible in the mounted casts or photographs but can be observed only in the patient's mouth in relation to the facial features.[3] In our practice, in many patients the interpupillary line is not straight and cannot be relied upon as a reference plane such as in cases of vertical orbital dystopia.

Various causes of vertical orbital dystopia have been identified which include congenital (craniofaciocervical scoliosis complex, coronal craniosynostosis and facial clefting syndromes), trauma, torticollis, tumours, iatrogenic and idiopathic factors.[4] Among these the congenital factor plays a crucial rule. Certain cases of strabismus, unilateral proptosis and ptosis can also add to the difficulty in establishing the parallelism. Studies are needed to identify and classify these conditions in cohorts. A study report supports the fact that only in 13% do subjects' incisal plane coincide with the interpupillary line.[5] Establishing the anterior plane perpendicular to the facial midline and choosing a reference plane closer to the oral cavity would be more acceptable. A simple and reliable method or an instrument needs to be designed to establish the anterior plane without relying on the interpupillary line.

M. Kavitha, Coimbatore, India

References

1. Rifkin R. Facial analysis: a comprehensive approach to treatment planning and aesthetic dentistry. *Pract Periodontics Aesthet Dent* 2000; **12:** 865-871.
2. Kokich Vo, Kikak A, Shapiro P A. Comparing the perception of dentists and lay people to altered dental aesthetics. *J Esthet Dent* 1999; **11:** 311-324.
3. Sasbri R. The eight components of a balanced smile. *J Clin Orthod* 2005; **39:** 155-167.
4. Tan S T, Ashworth G, Czypionka S**,** Poole M D, Briggs M. Vertical orbital dystopia. *Plast Reconstr Surg* 1996; 97: 1349-1361.
5. Gupta R, Aeran H, Singh S. Relationship of anatomic landmarks with occlusal plane. *J Indian Prosthodont Soc* 2009; **9:** 142.

https://doi.org/10.1038/s41415-019-0954-7

Communication

Anonymous referrals

Sir, as a hospital-based dentist I am regularly in receipt of communications from other dentists regarding patients. The majority of these include the referring dentist contact details so that we can correspond with them as required. There is one group, however, who rarely give any such details. These are level 2 surgeons providing MOS services outside the hospital who have seen a patient and decided that an onward referral to secondary care is necessary. I am sure they would never consider sending a professional letter anonymously under normal circumstances, so why make an exception for these onward referrals? May I use the letters page of the Journal to implore all level 2 surgeons to submit their contact details when making such a referral?

J. Fraser, Cambridge, UK

https://doi.org/10.1038/s41415-019-0951-x