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Menance of Quack in Dentistry: A Case Report

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Abstract : *Dental disease being one of the most prevalent diseases in the community has been overlooked by the population for long. Dental treatment & profession has developed & modernized significantly in the last 2 to 3 decades. From being a family based business performed by unskilled and untrained professional it has evolved to highly specialized & skilled profession performed by skilled & specialized dental professionals. Huge mismatch in dentist to population ratio especially in rural area together with high dental treatment cost, illiteracy, absence of any form of health insurance has led to increased number of dental quacks performing dental treatment in most unhygienic, unsterilized and unconventional manner. They are easily available and low treatment cost draws the innocent and illiterate patients to them. The government has to intervene and take measures to make dental treatment more affordable and accessible to the rural population in particular.*

Keywords - *Dental Professionals, Dental Treatment, Quacks, Quackery.*

I. Introduction

Dental disease though being one of the most prevalent diseases in the community has been neglected for long by the general population. But since last two to three decades with increased awareness, literacy, emphasis on esthetics, advanced & sophisticated dental treatment & equipments and economic development has led to complete turnaround in the field of dentistry in India. Earlier dentistry used to be family based business, performed mostly by untrained & unskilled professionals dealing mostly in extractions, filling & replacement of missing teeth. However with advent of skilled & specialized dental professional, new dental materials and equipment has led to lot of new & scientific developments in the field of dentistry. Dentistry, like medicine, is a traditional, science-based, highly regulated health care profession that serves increasingly sophisticated and demanding clients (1).

Quack is defined as “one who misrepresents their ability and experience in diagnosis and treatment of disease”. “Quackery” derives from the word quacksalver (someone who boasts about his salves) (2). Quackery has also been defined as “the fraudulent misrepresentation of one’s ability and experience in the diagnosis and treatment of disease or of the effects to be achieved by the treatment offered” (3). Most of the individuals performing quackery derive knowledge from their forefathers as family business or while working as assistant in dental clinics. They have no formal education or skilled training and acquire knowledge while observing dentist doing professional treatment. Later they start their own dental business performing specialized dental treatment at low cost by doing unfair practice in rural and semi urban area leading to undesirable & harmful effect on patient’s oral health. They use unconventional, unsterilized and old instrument available in the market. They mostly perform treatment at street side under unhygienic conditions. Treatment carried out are filling of teeth with acrylic resin, using wires, self curing acrylic resin to fix removable partial denture as fixed partial denture, use of suction disc on the palatal surface of complete denture to improve retention etc leading to worsening oral condition and misinformation among the patients.

II. Reasons For Quackery

The most common cause of quackery is the short supply of competent and trained dental practitioners and costly dental treatment. Despite having more than 300 dental college and dentist to population ratio of 1:10,000 (4) there is massive shortage of trained dental professional specially in rural area due to mismatch in the distribution of manpower. As against the dentist to population ratio of 1: 10,000 in urban area, the ratio is 1: 2.5 lac in rural area (5) which has led the dental quacks to have flourishing business specially in rural & semi urban area. High cost of dental treatment, illiteracy, lack of awareness, poor accessibility to dental clinics and repeated dental appointments are the reasons for which most patients rely on these quacks (6). Reduced treatment time and low cost draws the population to these quacks for treatment.

III. Case Report

22 yr old patient reported to this dental centre with chief complain of pain, tenderness and swelling in upper anterior region Fig 1.

3.1 PDH (Past Dental Histroy)

According to patient about 10 -12 yr back he met with an accident resulting in fracture of his anterior tooth. As it was interfering with his esthetic he reported to a private dental practitioner who recommended Root Canal treatment with crown fabrication. Because of time constraint & cost factor involved the patient could not undergo treatment. After 2 to 3 yrs he reported to a quack having dental clinic wherein the fractured tooth was reduced in size almost till gingival margin & a removable partial denture was placed over the fractured tooth & the same was fixed with self cure acrylic resin Fig 2. Patient was informed that this was another form of fixed partial denture involving low cost and so the patient readily agreed for the treatment. Patient was very happy with his esthetics however of late he started having pain and intermittent swelling in upper anterior region.

3.2 O/H (Oral Habit)

High consumption of tobacco and related products and occasional intake of alcohol.

3.3 O/E (Oral Examination)

Clinical examination revealed acrylic partial denture in r/t 21 & 22 tooth with periapical lesion and pus discharge. Patient was advised to undergo IOPA radiograph of 21, 22 tooth which revealed that no RCT was done in 21 & 22 tooth and also that the tooth were reduced significantly to accommodate the acrylic tooth. Patient oral hygiene was also poor.

3.4 Treatment

After clinical & radiographic examination it was decided to perform root canal treatment followed by post and core build up of the tooth. After which crown reduction and PFM crown in r/t 21, 22 were to be fabricated.

During 1st sitting the acrylic partial denture was removed and oral prophylaxis was done along with IOPA radiograph for working length (Fig 3). After Bio-mechanical preparation & two asymptomatic closed dressing, preobturation radiograph was taken to determine the placement of post and length of gutta percha Fig 4 after which the tooth was obturated and post fixed using GIC luting agent. Core in r/t 21 & 22 was built up using light cure restorative material. After this the crown reduction was done Fig 5 & 6 and upper & lower arch impression taken with rubber based impression material and send to dental lab for PFM crown fabrication. After 1 week the PFM crown in r/t 21 & 22 was fixed Fig 7.

As the treatment was carried out at government dental centre, patient did not pay any amount for RCT and post and core but as lab facility was not available at this centre patient had to get PFM crown fabricated from private dental lab for which he had to pay Rs 1200/ as lab charges. Patient was satisfied with esthetics Fig 8.

IV. Discussion

4.1 Tackle Quackery

In India, under Chapter V, Section 49 of the Dentist Act of 1948 requires dentists, dental mechanics, and dental hygienists to be licensed. These quacks can be penalized under The Dentist Act leading to imprisonment & penalty but stricter laws need to be reinforced and implemented (7). However the best way to tackle this menace is to provide affordable and accessible treatment option to the rural population in particular. It will be highly beneficial to have one basic dental clinic for basic treatment at each PHC being run by government and dental professionals can be recruited for the same. A comprehensive oral health programme should be formulated and implemented under National Rural Health Mission to make dental care more accessible.

Together with this these quacks may be given some form of formal dental training and allowed to perform basic dental treatment under registration. World Health Organization suggests of having New Dental Auxiliaries like dental aid, dental licentiate, and frontier auxiliaries with little training to work in rural remote areas (8). Until the Government intervenes, takes them into the health system, and provides a stable means of income, there are more chances that the quacks may thrive to earn money by practicing quackery (9). There is urgent need of re-location of dental colleges. Some cities within a state has number of colleges leading to under-utilization whereas the other cities in the same state is deprived of dental college & hospital and the population has to rely on private practitioners & quacks for dental treatment.

V. Figures

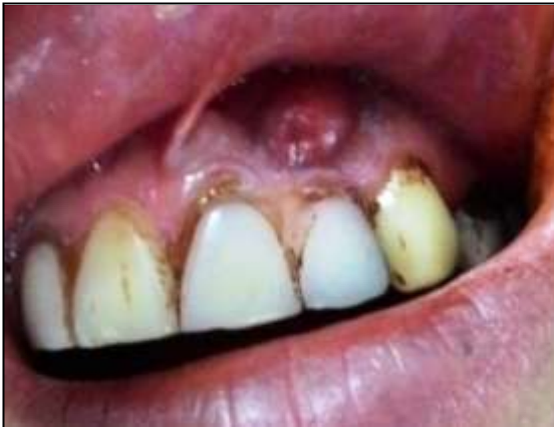

Fig 1 intra oral photo showing swelling & intra oral sinus in r/t 21. 22

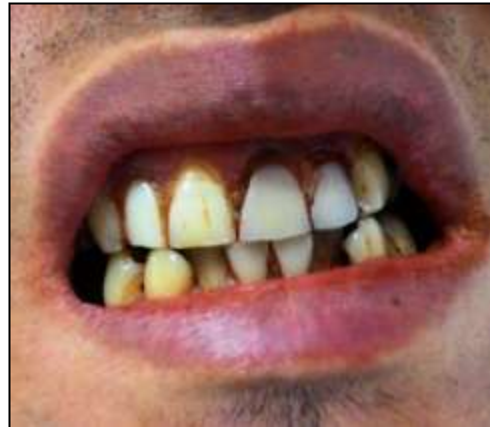

Fig 2 intra oral photo showing artificial acrylic teeth in r/t 21, 22

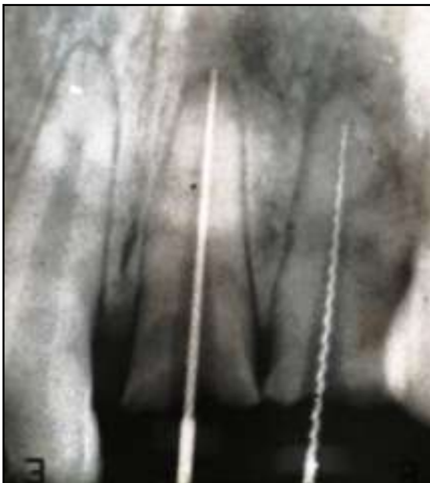

Fig 3 working length IOPA radiograph after acrylic teeth removal

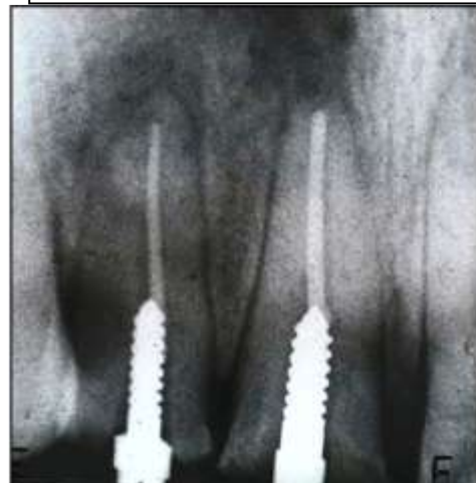

Fig 4 pre-obturation radiograph to determine the position of post and length of gutta percha

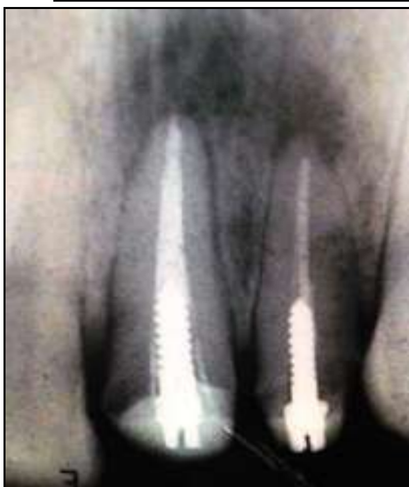

Fig 5 post-obturation radiograph showing post and core build up & reduction

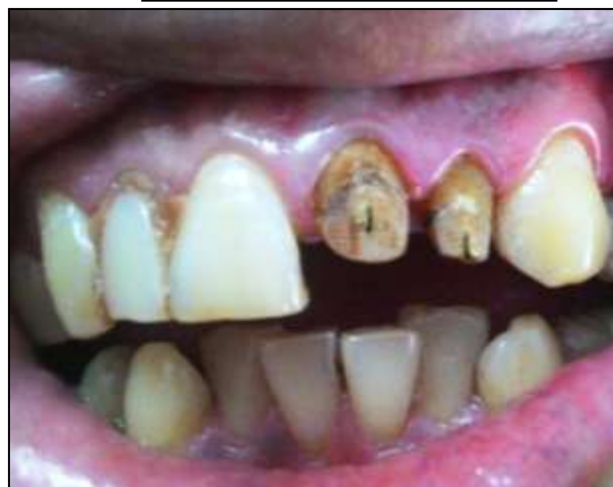

Fig 6 intra oral photo showing post & core build up and reduction

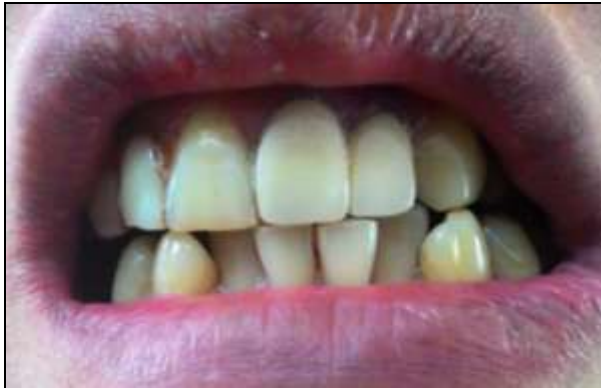

Fig 7 intra oral photo showing PFM crown placed in r/t 21, 22 teeth

Fig 8 post operative photo

VI. Conclusion

There is urgent need to fill the gap between the availability of trained dental professional for the rural and urban population. Despite the fact that 25,000 dental professional are passing out every year in India majority of the population are deprived of quality dental treatment and are dependent on quacks for treatment. Majority of new dental professional are forced to work in established dental clinics and doctors' under minimal salary and long working hours were as dental quacks in rural area are earning huge sum of money by providing wrong treatment & information to rural population. Government has to increase the intact of trained dental professional and provide basic dental clinic for rural area for the betterment of both the dental profession and the rural population at large and formulate tough laws to tackle the menace of dental quacks.

References

[1]. Goldstein BH. Unconventional Dentistry: Part I. Introduction. J Can Dent Assoc, 2000; 66:323-6.
[2]. De Silva D, Gamage NT. Unqualified dental practitioners or quacks in Sri Lanka. Sri Lanka Dental Journal, 2011; 41(03):46-51.
[3]. Eskinazi DP. Factors that shape alternative medicine. JAMA 1998; 280:16:21-3.
[4]. Ahuja NK, Parmar R. Demographics and current scenario with respect to dentists, dental institutions and dental practices in India. Ind J Den Sci. 2011; 3(2): 8-11.
[5]. Lal S, Paul D, Pankaj, Vikas, Vashisht BM. National Oral Health Care Programme (NOHCP) implementation strategies. Indian J Community Med. 2004; 29:3–10.
[6]. Naidu RS, Gobin I, Newton JT. Perceptions and use of dental quacks (unqualified dental practitioners) and self rated oral health in Trinidad. Int Dent J 2003 Dec; 53(6):447-54.
[7]. http:/en.wikipedia.org/wiki/Quackery.
[8]. Oumeish OY. The philosophical, cultural, and historical aspects of complementary, alternative, unconventional, and integrative medicine in the Old World. Arch Dermatol 1998; 134:1373-86.
[9]. Sandesh N, Mohapatra A. Street dentistry: time to tackle quackery. Indian J Dent Res. 2009; Jan-Mar; 20 (1):1–2.