Please note that all letters must be typed. Priority will be given to those that are less than 500 words long. All authors must sign the letter, which may be shortened or edited for reasons of space or clarity. All letters received are acknowledged.

Symptomatic third molar removal

Sir, — The last decade has shown a steady swing towards a less aggressive management of third molars, especially asymptomatic teeth. Most clinicians now adopt the recommendations by the Royal College of Surgeons of England[1] subsequently endorsed by the NHS Centre for Reviews and Dissemination, York in *Effectiveness Matters*.[2]

There remain uncertainties, however, as to whether contra-lateral pathology-free third molars should be removed simultaneously with symptomatic teeth or be left, particularly with the small but identifiable risk of treatment under a further general anaesthetic. However, the York document does favour conservative management: 'Given the lack of reliable evidence, a general anaesthetic for the removal of a symptomatic third molar should not normally be sufficient justification for removing pathology-free third molars at the same time'.

In an attempt to quantify re-admission rates for third molar surgery, we looked at the number of admissions for the removal of wisdom teeth; 2,690 cases out of a total of around 7,000 admissions over the last seven years. The unplanned re-admission rate amounted to only four cases (0.15%). A conservative approach would therefore appear justified. The York document does, however announce the rather amazing statistic that 'around 9,000 of patients on waiting lists for oral and maxillofacial surgery are scheduled for third molar removal. This caused us to look at the patients currently on a district general hospital waiting list for third molar removal (either local anaesthetic or general anaesthetic), which in our case amounted to 42%. Strangely enough, this percentage is similar to the level of activity over the last seven years (38.4%).

The premise that 90 % of patients on the waiting list are for the removal of third molars can therefore be seen to be a huge over-estimation in relation to a district general hospital.

A Haddock
A Flower

References

1 The Royal College of Surgeons of England. Faculty of Dental Surgery. The Management of Patients with Third Molar Teeth: Report of a Working Party convened by the Faculty of Dental Surgery. London: The Royal College of Surgeons of England, 1997.
2 NHS Centre For Reviews And Dissemination, University of York: Prophylactic removal of impacted third molars: is it justified? *Effectiveness Matters* 1998; **2:** 2

Useful description

Sir, — Thank you for publishing the article by I C Mackie and F I Hill on endodontic treatment of immature permanent teeth.

Although I have used this technique before, and had some success with it, it was still very helpful to have it described in such detail. Actually, last time I performed it successfully I also wrote a discription of it. The difference was that I described it to the DPB who thought the entire course of treatment was worth £21!

N R Hopkinson
Wetherby

TSL awareness

Sir, — I would like to congratulate you on the publication of the first part of the articles on tooth surface loss by Martin Kelleher and Carl Bishop. The article discusses, and makes clear, what is an increasingly common problem among youthful as well as middle-aged and elderly patients. Martin Kelleher and Carl Bishop are to be congratulated on making a complex subject understandable, and in bringing it to the attention of colleagues. I look forward to the development of the articles, but I feel that this is one of the most important articles to be published by the *British Dental Journal* for several years.

C M Woodhead
Bristol

Community dental services

Sir, — I read with interest the article by Naylor and Winter (*BDJ* 1999; **186:** 102) regarding the dental care of the disadvantaged child, and agree with them wholeheartedly on their solutions.

However, I would point out that, while the school dental service no longer exists, the community dental service does still exist in its wider remit, which includes the treatment of children, some of whom may be disadvantaged. The community dental service now has a more equitable role in providing a full range of treatment to people who have experienced difficulty in obtaining care within the general dental service. This includes the development of specialist care services.

The community dental service still screens children three times during their school career and, as in the days of the school dental service, will encourage children to seek care if it is thought this is required. While it is true that the 'school clinic' no longer exists, community dental services are set up in areas where the need is greatest for the total population and provide a very important role in bringing equity of service to all members of the local community.

C Allen
Aylesford

Millenium bug

Sir, — I have been working through the useful BDA advice sheet, *Managing the Millenium. The year 2000 Problem*. I was very alarmed to read on page 10 that 'Any item of equipment containing a microchip, having a digital display or an electronic clock might be vulnerable'. A similar message was given at a talk by our local health authority. The theory goes that equipment that shows time may have an internal chip that has a date function, even if the date is not displayed and cannot be altered by the operator. This could lead to catastrophic failure in the millennium.

Fortunately, this has been described as an 'urban myth' by the Medical Devices Agency on their web site (www.medical-devices.aov.uklv2k-uvdate.htm).

The MDA states:

'Embedded computer chips — fact or fiction?:

That some medical devices will fail at the start of the year 2000, even though the product has no date functionality and the user has no ability to set/reset the date.'

MDA's view:

'This is extremely unlikely since, for it to happen, all the following need to be true:

- The device circuits include all the elements of a computer — processor, memory, clock.
- The calender/clock function has its own battery which continues to power it when the device is turned off.
- The date was set at some stage during the manufacture, and has been updated correctly ever since, even though the user has no ability to reset the date.
- Any resultant failure has an impact on the normal working of the device but does not trigger any internal alarm.
- The device manufacturer fails to identify the problem beforehand, and either to provide a solution or, at worst, to warn users not to use the device.

The crucial feature is the internal battery

— unless the clock keeps ticking when the device appears to be switched off, it cannot hold an accurate calendar date and will not fail at the start of 2000 due to date problems.

We have not heard of any examples of medical devices with this particular problem'.

I hope this reduces some of the administrative load on practices in dealing with the problem. If you can switch your autoclave, scaler, curing light etc off and it still works next morning when you switch it on, and it doesn't have a battery or date function, it is unlikely to fail.

P Thornley
Sutton Coldfield

Deciduous caries and screening

Sir, — Milsom *et al* (*BDJ* 1999; **186:** 37-40) highlight the difficulties in getting agreement within the profession on the care of deciduous teeth.[1] At the same time Curzon and Toumba are highly critical of the standard of care provided for disadvantaged children in general dental practice.[2] Those of us who work in the community dental service are caught between these two competing forces. To suggest that we drop deciduous caries from the screening criteria because GDPs don't agree on how or when to treat it, just ignores this problem.

The General Dental Council places a duty of care on all of us to 'provide a high standard of care'.[3] What is required are not criteria based on the lowest common denominator, as Milsom *et al* have produced, but rather a clinical protocol agreed across the whole profession for the management of the carious deciduous tooth. Until such a protocol is produced, I believe that routinely ignoring the disease at screening would be a failure in the duty of care of community dental officers to those children they see.

P Bateman
Sheffield

References:
1 Milsom K, Tickle M, Jenner A and Moulding G. The identification of agreed criteria for referral following the dental inspection of children in the school setting. *Br Dent J* 1999; **186:** 37-40.
2 Curzon MEJ and Toumba KJ. The case for secondary and tertiary care by specialist dental services. *Community Dent Health* 1998; **15:** 312-315.
3 General Dental Council. Maintaining Standards, para 3.2.

Sir, — I read with great interest the paper by Milsom *et al* in the current journal (*BDJ* 1999; **186:** 37-40), for it fulfills a considerable gap in the evidence-base for a large slice of CDS activity. However, as a CDO carrying out a large number of screenings annually, I do find the rejection of untreated dental caries in the primary dentition as an agreed reason for referral to be astonishing.

My experience in an area with very high levels of untreated dental disease in children is that this should not have been so rejected — for untreated decay today will frequently become tomorrow's pain emergency and next week's anaesthetic case for multiple extractions.

So far as I can discover, there is no scientific basis for routinely leaving damaged deciduous teeth to degenerate further. Their restorative (or other) care would be an indication that some form of care-plan, hopefully including oral health education, was extant — simply watching the degeneration is not usually recognised as care in the circle in which I move.

While the paper gives the overall findings of the group in which the CDS was, thankfully, represented, but remained very much in the minority, there is no manner of determining whether this rejection was supported or opposed by the CDS representatives as a sub-group. Could the authors provide this additional information?

D Baird
Winchester

Sir, — Milsom *et al* present an innovative approach to the tricky problem of school screening (*BDJ* 1999; **186:** 37-40). The revival of the term 'school dental inspection' would seem to be sensible, as the process, as currently practised, fulfils few of the requirements of health screening.[1]

It would have been interesting to hear what parents would expect school dental inspections to reveal. At present parents rely, erroneously, on the school dental inspection to confirm that their children are dentally healthy. Some even regard it as a substitute for a full six-monthly examination. If parents are only informed when their child has sepsis, caries in the permanent dentition or a large overjet, then they will be unaware of conditions which they might consider as serious. It might even be regarded as neglect if parents are not informed of, for example, caries in the primary teeth, trauma that should be treated or submerging primary molars.

Surely one of the aims of school dental inspections is to enable parents to take preventive action or seek treatment, having been informed by a clinician of the condition of their child's mouth.

G Hawley
Manchester

References
1 Wilson JMG and Jugner G. Principles and practice of screening for disease. Public Health Papers No 34. Geneva: WHO.

The authors respond: *It is suggested that there was difficulty getting agreement within the profession on the care of deciduous teeth. In fact, our paper demonstrates how simple it was for the key stakeholders within the profession in Ellesmere Port to agree a common position on this matter. Further, the consensus arrived at in this small study may well reflect the national lack of enthusiasm within the General Dental Services for the restoration of the deciduous dentition.*[1] *Screening children and referring them to general dental practice for the restoration of deciduous caries will surely only be of value if the dental practitioners receiving those children intend to restore carious teeth.*

An evidenced-based approach is required for the management of the deciduous dentition. Currently none exists. Mr Bateman suggests that 'ignoring' deciduous caries at a dental screening exercise (by that presumably he means the identification of deciduous caries failing to trigger a referral) is a failure in the duty of care of those undertaking the screening exercise. This position would only be tenable if restoration of the carious deciduous dentition was the only route to dental health. We would argue that there simply isn't the evidence available to support this view. It might be argued that by rejecting the presence of deciduous caries as a criterion for referral following screening, the dental profession in Ellesmere Port is merely acknowledging the unsuitability of the current school dental screening process as a vehicle for delivering dental health to the local child population.

References:
1 *O'Brien M. Children's dental health in the United Kingdom 1993. London: HMSO 1994.*

Oral health packs

Sir, — While it is deeply gratifying to have the publication *Oral Health Promotion: a practical guide for health visitors and school nurses* mentioned in your letters page (*BDJ* 1999; **186:** 159) for the sake of my colleague Paula Snadden's sanity, could I ask that readers requesting a copy of the manual and its accompanying self-assessment pack write rather than telephone. An address label with each order would be appreciated and readers should note that the remaining copies of the manual are going like hot cakes and will be distributed on a first come, first served basis.

Catherine Stillman-Lowe
London

NB: packs should be ordered from the HEA (Health Education Authority) and not JIFA, as previously printed in the *BDJ*.