Send your letters to the Editor, British Dental Journal, 64 Wimpole Street, London W1G 8YS. E-mail bdj@bda dentistry.org.uk
Priority will be given to letters less than 500 words long. Authors must sign the letter, which may be edited for reasons of space.

Sterilising Siqveland

Sir,— You report on the difficulty of completely sterilising Siqveland matrix holders and bands, when the band is attached (*BDJ* 2002; **192**: 40-49). Ninety-six per cent of the Scottish Dentists surveyed used Siqvelands. One answer to this problem is to use Nyström matrix holders, which also allow matrix bands to be drawn to two differing radii of curvature, thereby providing firm marginal ridge contact as well as a tight fit apically. Used in pairs, (for left or right side application), and usable with their own, or any available bands which fit, including deep contoured if needed, they have the advantage over Siqvelands of being readily removable from the band, in the mouth. This also permits the subsequent withdrawal of the band sideways as well as vertically, and with amalgam, reduces the tendency to damage the marginal ridge on withdrawal. The separate holder and band can then be cleaned and sterilised individually (if the band is to be re-used.)

A. Sayburn
Cottingham

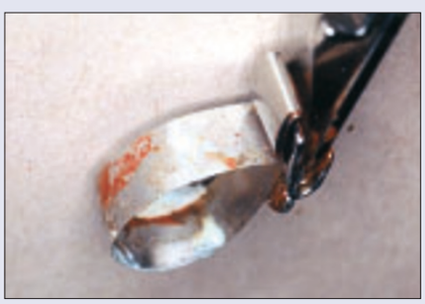

Fig. 1: Visible blood contamination on a used Siqveland matrix band and retainer.

Setting the Standard for Dental Health Education

Sir,— A revised fourth edition of 'The Scientific Basis of Dental Health Education' has been published in *Dental Profile,*[1] courtesy of the Dental Practice Board. The policy document originated in a seminar held jointly in 1971 by the Health Education Council and the British Association for the Study of Community Dentistry.

Since then, under the auspices of the Health Education Authority and latterly the Health Development Agency, it has enjoyed regular revisions to keep its contents up to date scientifically, the original fourth edition appearing in 1997.

The need for a benchmark for individual patient advice and wider community oral health promotion programmes is as evident today as it was thirty years ago. 'Modernising NHS Dentistry — Implementing the NHS Plan' states that the Government aims to improve oral health 'by providing good advice and information on how to prevent disease'.[2]

So what has altered in this latest revision? Subtle changes have been made, to ensure that the document maintains its role as an authoritative policy document. In part one, which is intended for a general readership, there is greater emphasis on the importance of avoiding ingestion of excessive fluoride toothpaste by infants.

Because of the concern that dental erosion may become more prevalent, the reference to sugar — free diet and low calorie drinks has been removed from the list of recommended between meal snacks and drinks, since most have erosive potential. The summary giving four key messages remains broadly the same.

The dietary advice follows the conclusions of the Committee on Medical Aspects of Food and Nutrition Policy, which reviewed its 1989 report on 'Dietary Sugars and Human Disease', and published a 'Statement on Sugar' in 1997.[3] However, the message on water fluoridation has been amended to reflect the view that it may no longer be cost-effective to implement new schemes in some areas of the UK where caries levels are low.

In part two, which contains additional notes on a range of topics, the currently agreed dosage schedule for fluoride dietary supplements has been included once again. When the fourth edition was in preparation, a modification of the schedule was being debated and in the absence of an expert consensus, a specific schedule was omitted.

Finally, the further reading list has been updated, for example to include the York review of water fluoridation.[4] The assistance in the revision process of Professor Anthony Blinkhorn and the Chair and Committee of the National Oral Health Promotion Group is gratefully acknowledged.

The future of the document remains in doubt however. Will a fifth edition be commissioned? Demand for this revised fourth edition provides proof enough of the expressed need amongst students, health professionals, and those with an influence on health such as teachers and childcarers, for such a guide to good practice, both in the UK and abroad. It will also be of value to NHS, commercial and charitable producers of dental health education resources for the public, helping to ensure accuracy and consistency of messages.

The potential to broaden involvement in the drafting process is substantial. Dental hygienists, therapists, oral health promoters, community nurses and community dieticians should all have a stake in a future edition, alongside the expert academic advisers who formulated the original text.

As the Department of Health has stated, 'promoting oral health is not just for dentists — existing initiatives on the wider public health agenda will embrace oral health promotion as an integral part of their role.'[2] We hope that 'The Scientific Basis of Dental Health Education' can continue to support this welcome development.

R. Levine and C. Stillman-Lowe
Reading

At the time of writing, the authors were independent scientific adviser, and public health adviser (oral health) at the Health Development Agency, respectively. Correspondence to: Dr R S Levine OBE, 370 Alwoodley Lane, Leeds, LS17 7DN.

1. Dental Practice Board (2001). Dental Profile (Issue 32 August and Issue 33 November). Text also available online at the Dental Practice Board website: *http://www.dpb.nhs.uk/publications/index.html.*
2. Department of Health (2000). Modernising NHS Dentistry - Implementing the NHS Plan. Stationery Office, London.
3. Department of Health (1997). Statement on Sugar, formulated by COMA. Published in Food Safety Information Bulletin, and available at *www.doh.gov.uk/coma/state.htm.*
4. NHS Centre for Reviews and Dissemination (2000). Fluoridation of Drinking Water: a Systematic Review of its Efficacy and Safety (Report No 18). University of York, York.

My view on fluoridation

Sir,— Let me state from the start, my views on plans to fluoridate more of Britain's water supplies. I am against it. Not because water fluoridation does not work; not because I have any doubt whatsoever about the risk to health; nor because there is any infringement of personal liberty; I am against it because it is a red herring, for I believe no British government has the real will to oversee its introduction.

When I was a dental student in the 60's, nearly all of us were inspired by the idea of water fluoridation. Here was a public health measure that would simply, cheaply, and efficiently lead to a significant reduction in dental decay, particularly in children. We were told its introduction was imminent. This was exciting! Yet here we are, two generations later, with less water being fluoridated than 30 years ago, and no sign that its introduction is likely in the near future. In that time thousands and thousands of children have needlessly suffered the ravages of dental caries, because this simple public health measure has not been available. And most of us know the reason why. It is because the anti-fluoridationists have been well-organised and vocal. No government wants a strong and sustained criticism with 'consultations' and 'strategy documents'. And there is a final blow!

There is no evidence that water fluoridation will save governmental money on NHS dentistry. The Dental Practice Board reports for instance, that the average cost per case for dental tratment is the same in fluoridated Birmingham, as in other unfluoridated cities.[1]

Fluoridated toothpaste has made an enormous contribution to the decline in dental caries in the United Kingdom, yet all practitioners (and particularly those in deprived areas) know that caries continues to cause widespread suffering, especially in children from disadvantaged backgrounds.

What then is the alternative to water fluoridation? The answer is simple. We should do what many European countries (including Switzerland, France, Germany and Spain) have done: introduce fluoridated salt. The work has alrady been done for us. There is significant published data showing that the use of fluoridated salt is effective, having a similar caries reduction rate to that of water fluoridation.[2] There is no reason why it could not be introduced into Britain tomorrow, since EEC regulations allow for the distribution and sales of fluoridated salt.

Does fluoridated salt then have any disavantages? There are two potential problems, but these are both in my opinion apparent rather than real. Firstly, some of the medical profession are concerned that salt consumption is associated with hypertension.

Should we as a branch of the medical profession therefore be encouraging its use? The answer is of course 'no'. This is not a problem provided fluoridated salt is available and not promoted. In Switzerland for example, both fluoridated and non-fluoridated salt is available in the shops, but fluoridated salt is usually subsidised to have a small price advantage.

The second potential disadvantage of fluoridated salt is fluorosis. If children are having other sources of fluoride such as toothpaste, is there not a danger of fluorosis? The age at which fluorosis can develop on the anterior teeth is between 18 and 30 months.

The Swiss experience, and studies from Hungary show that two sources of fluoride is not a problem.[3,4] This might well be because too little salt is eaten at an early age to cause this problem.

So let me re-iterate the advantages of fluoridated salt:

1. There is a large database of published data demonstrating the effectiveness of salt fluoridation at concentrations between 250 and 350 ppm.F/Kg.
2. It is cheap.
3. It is safe. Since salt is an emetic, toxic overdose is unknown.
4. It could be introduced into the United Kingdom tomorrow.
5. And lastly, and this is most important to some: it gives the consumer a choice.

M. Yewe-Dyer
Alton

1. Dental Practice Board for England and Wales. Personal communication 2001.
2. Fluorides and Health. Report of a WHO Expert Committee on Oral Health Status and Fluoride Use. WHO Geneva. 1994.
3. Marthaler T. Personal communication 1996.
4. Stephen K W, Macpherson L M, Gorzo I, Gilmour W H. Effect of fluoridated salt intake in infancy: a blind caries and fluorosis study in 8th grade Hungarian pupils. *Comm Dent Oral Health* 1999; **27**: 210-215.

Emergency dental services

Sir,— The paper on emergency dental services by Evans *et al* (*BDJ* 2001; **191**: 550-554) raised some interesting questions regarding standards for access to emergency dental care for the population. Reading the paper it would seem that the maximum considered appropriate in Newcastle is 'within about 4 hours'. The standard was adopted in Newcastle from a consensus opinion of 20 practitioners. The paper does not state what information was used to inform this standard.

Access to dental care 'within about four hours' may be achieveable for a densely populated urban area with good public transports and a favourable dentist to population ration such as Newcastle. In rural areas this standard could not be achieved without significant investment of resources.

Or is the interpretation of the standard that the emergency situations described are in the sphere of dental practice, but may actually be appropriate for Accident and Emergency departments to provide care for? The answer is where such a scheme such as Newcastle's is not available.

Legislation such as the European Working Time Directive and the Human Rights Act (where the courts recently found that undisturbed sleep for residents near Heathrow airport is a human right), could make staffing emergency dental services highly problematic.

Do the authors consider that access to emergency dental care for patients 'within about four hours', should be made available as a national standard, or just where practical and should local standards prevail for differing local situations?

D. P. Landes
Durham

The authors D. J. Evans and co-authors respond:

Mr Landes refers to the outcome of the consensus conference whereby emergency dental care was defined and was agreed that, ideally, the dental emergency should be seen within about four hours. This information was based on the recommendations of the triage system that was, at the time, being used by NHS Direct.

This American software system allowed general nurses to triage symptoms and for certain items such as those mentioned within the paper as dental emergencies the patient would be advised to seek further professional advice and/or treatment within four hours. These algorithms were based on the most recently available evidence and produced by clinicians within the United States. They had been in use for a period in excess of five years

without any complaints or litigation.

Whether or not the advice and/or treatment was provided by a dentist in and out of hours scheme or by an appropriately qualified person in an E&E department was entirely a matter of local decision. It was considered that in Newcastle these were primary care dental emergencies and as such it was not appropriate to refer them to secondary oral maxillo facial surgery out of hours services.

Since this time NHS Direct, on a national basis, have moved to a new software system called NHS CAS. The algorithms within this system are again evidence based and have been developed by experts within the United Kingdom and included members of the General Dental Services Committee. These were not developed in Newcastle and were part of the Department of Health development work with NHS Direct.

New algorithms give a timespan where ideally a patient should receive further professional advice and/or treatment. This varies from one hour to 48 hours depending on the condition. How services are developed to meet the need of patients out of hours must be a local solution to local needs and demands and will differ throughout the country depending on available services and resources.

We have never advocated the standard that emergency dental care should be seen within about four hours. We have raised these and related issues at the Department of Health and understand that these issues are part of ongoing discussion around modernising access to primary dental care.

Raising the ARF?

Sir,– I read with interest the article by John Chope in the GDC gazette regarding the future need to raise the annual retention fee (ARF) considerably following the dramatic increase in legal costs to the council after the greater number of complaints that were being pursued.

Some years ago in 1998 and 1999 when the ARF was being hiked at 50% a time, there was considerable dissonance echoed by many dentists, including letters to dental press.

At that time I personally exchanged letters with Margaret Seward (the then President) and later Nairn Wilson who both told me that at that time it was not possible to recover legal fees from dentists who had been found guilty of professional misconduct, but that the use of costs was now being looked into.

It is now some two years later and yet again we are hearing rumblings and warnings that the ARF must substantially increase because of the increased numbers of complaints that have to be investigated.

At this time however, nobody appears to have applied themselves to the issue of 'looking into' or recovering costs from those found guilty of misconduct, even though this is standard in all criminal and civil courts.

Can someone I wonder do something to raise this issue with council and ask them to fulfil the promise of two presidents that it would be looked into, and in consequence keep ARF to its minimum?

R. B. M. G. Kitchen
Bristol

The GDC Chief Executive and Registrar Antony Townsend responds:

Thank you for bringing to our attention concerns over the article in the recent GDC Gazette (pg 9) about increasing the ARF. The Council welcomes all feedback and comments, particularly during this time of reform, to help shape and support a new GDC in which patients and the dental team can have influence.

Our governing legislation the Dentists Act (1984) does not allow us to recover costs as a result of our conduct procedures (with the exception of unsuccessful appeals to the Privy Council). And it was not until last year that the Council was given the opportunity to begin to change our legislation (particularly to deliver policies and initiatives that lie outside our prescribed remit).

Changes planned for 2002/2003 include the modernisation of our conduct procedures. A Council Review Group is currently carrying out a wide-ranging review of all aspects of our fitness to practise arrangements. Dr Kitchen's suggestion, along with views from others in the profession, are being considered as part of this work.

We are also investing in preparations for the registration of all members of the dental team which will improve the regulation of dentistry, and double the number of registrants.

Preserving the benefits of a profession which – in partnership with patients – sets and commits itself to high clinical standards cannot be done on the cheap, though our fees are considerably lower than those of some other professions. I can assure your readers that the Council continues to work at keeping the ARF to a minimum whilst building regulation fit for the 21st Century and able to cope with the challenges of increased accountability.