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Priority will be given to letters less than 500 words long. Authors must sign the letter, which may be edited for reasons of space

Clinical audit

Sir,- I write in reply to P Thornley, who wrote to the *BDJ* suggesting that with the loss of NCCPED as a separate entity, (*BDJ* 2003, **195:174**), the Clinical Audit and Peer Review payment system had been dismantled. I would like to assure your readers that this is not the case.

Lee Surry, who administers the payment system, has simply moved offices to the Department of Health in Waterloo House.

Practitioners should still complete their payment request on the appropriate form PAY2, and send it with the final report, to their Local Assessment Panel (LAP) who will process it in the normal way. It will then be forwarded to Lee who authorises the DPB to make the payment, normally within ten working days from receipt.

Payment is made on the first available schedule after the DPB receives authorisation. The LAPs sit regularly and payment to the practitioner should occur within ten weeks after LAP approval.

We are pleased to report that over 14,000 dentists have submitted applications and many of these have already completed their activity and received payment.

Although the office move did delay some payments during May and June, the system is now back to normal and practitioners can be assured that payments for Clinical Audit and Peer Review will continue to be paid promptly.

The Department of Health has demonstrated its commitment to the scheme by making available over £18m to support dentists complying with their terms of service over the last three years.

L. Jacobs, Chairman, CAP
L. Surry, Policy Manager of Dental Education, DoH
London
doi: 10.1038/sj.bdj.4810580

Tooth notation

Sir,- I am writing in response to the discussion regarding tooth notation in the change in wording of tooth notation in the *BDJ* (*BDJ* 2003, **194: 387**) and comparisons with the American system. I wish that the system in the United States was as clear as G Belok (*BDJ* 2003 **194:646**) would suggest. Unfortunately, I have to tell you that there is almost as much confusion here as in other places. The Palmer Classification is still widely used in the USA by orthodontists and some general dentists, whilst the so called Universal System (which is actually anything but universal since it is only used in the USA and parts of Canada) is the one that was introduced by the Delta Dental Insurance Company to make their lives easier for billing purposes and has therefore become the standard for insurance billed cases.

As someone who is involved in dental medical legal work in the USA, I am asked for advice several times a year regarding extractions of the wrong tooth because two people used a different classification.

It is generally because the orthodontist used the Palmer Classification whereas the oral surgeon used the Universal Classification and therefore the upper right 4 for the orthodontist is actually tooth number 5 for the oral surgeon.

The Palmer Classification has advantages when you want to compare one side with another, or even all four quadrants, so that you can talk about 'four 8's' or 'four 4's' instead of having to give the individual tooth numbers.

As if that wasn't enough, we now have the FDI Classification which is being taught in many American dental schools and is already starting to be used very selectively in correspondence and even clinically. It may therefore mean that rather than having one system in the USA, we could actually end up with three systems trying to work side by side.

This is just to say that nobody has the right answer with this, but it does appear to me that the FDI system has a lot of sense associated with it and combines some of the better points of the Palmer System and the so called Universal System.

M. A. Pogrel
San Francisco
doi: 10.1038/sj.bdj.4810581

Sir,- I have to disagree with the letter from G Belok. Some years ago, Dr M J Trenouth wrote to the *BDJ* about tooth notation and pointed out that one of the common mistakes in typing was transposition. As far as the FDI numbering system is concerned, there is a world of difference between tooth number 32 and tooth number 23.

The same problem equally applies to the notation system recommended by G Belok involving numbers from 01-32 because the possibility for transposition still exists.

On the other hand, designating the quadrant by UR, UL, LR, LL and a single number reduces the risk of dictation and typing errors. In my opinion, the BDJ has chosen the very best way to specify teeth. To use G Belok's phrase, - come and join the *BDJ* in the 21st Century!

J. R. Pilley
Kilmarnock
doi: 10.1038/sj.bdj.4810582

Sir,- I have read G Belok's letter and must comment that internationally (except for the United States) a notation system was adopted years ago by the FDI numbering the teeth from 18 to 48, using the first digit as the quadrant (1 being upper right and continuing clockwise for those remembering analogue clocks) and the second digit being the tooth numbering from 1 to 8 starting from the midline.

For deciduous teeth the quadrants are 5 to 8. Tooth 18 is pronounced 'one eight' to distinguish it from the US Navy system to which the author of the response refers.

M. Silverberg
Toronto
doi: 10.1038/sj.bdj.4810583

Overbrushing

Sir,- For some time now I have been concerned about the increasing number of articles regarding 'over-brushing' and the associated damage to the teeth and gums

There is certainly the possibility of some wear and even cervical margin sensitivity but these can be dealt with if necessary.

In over 35 years as a practicing hygienist I have not come across one

patient who has lost teeth through overbrushing.

My concern is with the psychological effect I see in my patients from these articles.

More patients are presenting increased cervical plaque from a fear of 'over-brushing' and therefore creating much more risk to their oral health.

What is more it is very hard to explain the possible real risk of tooth loss to patients who believe what they read in newspapers or see on TV especially when stated by a professor. Does anyone share my concern?

E. Harrison
Tunbridge Wells
doi: 10.1038/sj.bdj.4810584

Do-it-yourself dentistry

Sir,- Lost anterior teeth can be a real aesthetic problem for patients, and are now typically substituted by removable dentures, bridges or implants placed by professionals.

However, in most circumstances, and particularly where professional dental care is accessible, do-it-yourself (DIY) dental treatment would usually be regarded as at the very least, inappropriate.

We recently saw a bizarre case where a 63-year-old Brazilian male patient, a heavy smoker, consuming two packs of cigarettes a day for 45 years, and a very poorly controlled diabetic presented with severe periodontitis.

Examination revealed PVC-type plastic strips each carrying the crowns of three natural teeth and bent to adapt to the dental arches, fixed with superbond to the palatal and lingual surfaces of the canines, rather along the lines of Maryland bridges (Figures 1 and 2).

Having extracted his own maxillary and mandibular incisors, he had constructed the bridges by removing the crowns from the roots of his own newly-extracted teeth with a saw. Though the patient could not use the bridges for mastication, and the devices needed to be recemented daily, he was otherwise quite happy with the aesthetics.

He chewed mainly on his canines and on his posterior alveolar ridges, the remaining standing upper premolars on each side and one standing upper left molar.

The mandibular posterior alveolar ridges were irregularly white, due to frictional keratosis caused by the trauma of mastication.

The patient was of a low income group, and in such instances, or where access to dental professional care is difficult, the need for self-care (DIY) can be readily appreciated. In the distant past however, devices were sometimes constructed by the patient or by non-professionals, but nowadays these self-made devices are rare, as in this instance.

Though many clinicians will have encountered patients who carried out such DIY procedures such as the occasional self-extraction, denture or appliance adjustments and relines, denture and tooth repairs, and particularly tooth-whitening, there are surprisingly few formal reports of such DIY dentistry in the literature.

Reports include the self-adjustment of a partial prosthesis where the remaining standing teeth had been lost[1], and self-extraction of teeth[2].

Others have commented on the self-re-cementing of prostheses and the possible disadvantages and even occasional dangers of such DIY dentistry, such as the inhalation of material[3,4].

O. Di Hipolito, M. Ajudarte Lopes, O. Paes de Almeida, Brazil, C. Scully, London
doi: 10.1038/sj.bdj.4810585

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2. Ring M E. Do-it-yourself dentistry. *Bull Hist Dent* 1993; **41:** 33-4.
3. Granstrom G. Upper airway obstruction caused by a do-it-yourself denture reliner. *J Prosthet Dent* 1990; **63:** 495-6.
4. Getz II. The dangers of do-it-yourself dentistry. *Gen Dent* 1987; **35:** 361-2.

This letter has been reprinted due to an ommision of one of the authors name's. It was originally printed in BDJ 2003 ***194: 531.***

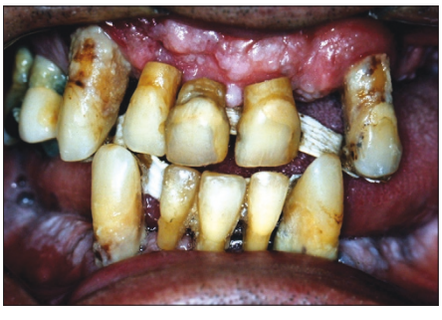

Figure 1

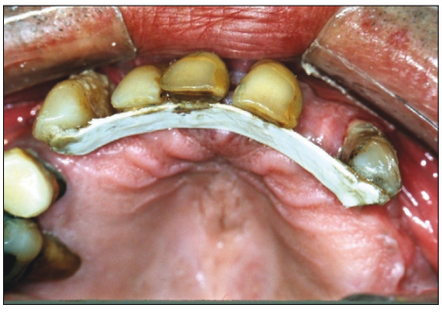

Figure 2