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E-mail bdj@bda.org
Priority will be given to letters less than 500 words long. Authors must sign the letter, which may be edited for reasons of space



Smoking cessation

Sir,- The rationale for the dental team to take an active role in encouraging smokers to give up is theoretically sound, and has been well covered recently by the *BDJ*¹. However, I am concerned that the knowledge and skills needed to effectively deliver even brief interventions on a one-to-one basis² may be lacking within the dental team at present. Certainly, published studies of actual interventions show variable and even discouraging results, both in the UK and abroad^{3,4}.

Does undergraduate training for dentists (or indeed hygienists and therapists) cover the subject of helping individual smokers in the required depth? If not, are 'hands-on' postgraduate courses available which will give dentists the confidence and expertise that they need? If the answers are 'no', then all the exhortations in the world for dentists to do their public health duty may be in vain.

C. Stillman-Lowe

Reading

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1. Watt RG, Daly B. Prevention. Part 1: Smoking cessation advice within the general dental practice. *Br Dent J* 2003; **194**: 665-668.
2. Health Development Agency. Standard for training in smoking cessation treatments. London: Health Development Agency, 2003.
3. Smith S, Warnakulasuriya K A A S *et al*. Smoking cessation programme conducted through dental practices in the UK. *Br Dent J* 1998; **185**: 299-303.
4. Rikard-Bell G, Donnelly N, Ward J. Do patients listen when we tell them to stop smoking? *Br Dent J* 2003; **194**: 159-164.

Anaesthetic solutions

Sir,- I was interested to read the recent letter from SP van Eeden (*BDJ* 2003; **195**: 230) on the incidence of articaine-induced prolonged paraesthesia and his obvious concern that this adverse reaction is not well recognised. Articaine local anaesthetic solutions have been licensed in the UK since 1998. To date the Committee on Safety of Medicines (CSM) has received 72 Yellow Cards describing 146 suspected adverse drug reactions associated with articaine. Of these suspected reactions 10 describe

hypoaesthesia, 23 describe paraesthesia and 5 describe delayed recovery from anaesthesia (personal communication). Locally from within CSM Mersey we have received only one Yellow Card for articaine, which described dizziness lasting 24 hours.

The relatively small number of Yellow Cards received does not appear to reflect the incidence of prolonged paraesthesia associated with articaine as suggested by van Eeden's letter. I would urge dentists to report all cases of paraesthesia following articaine infiltration, that have not resolved within 2 weeks, on a Yellow Card (there are 4 Yellow Cards at the back of each Dental Practitioners Formulary).

The CSM use information on suspected adverse drug reactions collected via the Yellow Card Scheme to continually assess the risks and benefits of all medicines on the UK market. Where alteration in the prescribing information or strengthening of safety warnings is needed they will act to amend the prescribing (Summary of Product Characteristics) and package insert information. Further information on the Yellow Card Scheme and an electronic version of the Yellow Card can be found on the CSM/MHRA website <http://medicines.mhra.gov.uk/aboutagency/regframework/csm/csmhome.htm>

C. Randall

Liverpool

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Study group funding

Sir,- We write concerning a funding crisis that has affected our MGDS study group in Norwich following the move of the Norfolk and Norwich study group onto its new private finance initiative funded hospital site.

We are a study group based loosely around the MGDS syllabus. The educational format is largely participatory rather than through formal lectures. The group was founded in 1987 and has met fortnightly during academic term times in the postgraduate medical education centre of the hospital. Our meetings are open to all dental professionals and we have a

regular attendance of 10-12 members, and occasionally run larger meetings which attract a wider audience. During the past 16 years our members have achieved three passes at DGDP, six at MGDS, one at FFGDP, three at DPDS, one MSc in prosthodontics and two MSc in endodontics.

Until April this year we received Section 63 funding of £60.00 per meeting and free use of a room in the postgraduate education centre. In April our funding was cut and consequently having lost our Section 63 funding we find ourselves unable to use the postgraduate facilities at one of the country's newest hospital/medical schools unless we pay a £500.00 per meeting room hire fee.

Meanwhile endless repeat Section 63 courses continue apparently unrestricted by lack of funding, and one is forced to wonder whether they serve any purpose other than to allow GDP's to attain their verifiable CPD quota.

Obviously funding is limited, but the disbursement of any funds should be dictated by merit and value. Using these criteria it is reasonable to feel that study group funding should not be withdrawn without a more thorough overview of local CPD provision. It would be interesting to hear from any other study groups who may be facing similar difficulties.

R. Campbell

D. English

P. Waldron

D. Earp

Norwich

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S. Tucker

M. Wise

A. Gibson

H. Smith

NVQ training

Sir,- I am writing in response to the letter from Dr J F Aitken regarding the National Vocational Qualification (NVQ) in dental nursing (*BDJ* 2003; **195**: 230). On behalf of the BDA Professionals Complementary to Dentistry Committee, I would like to thank Dr Aitken for his comments and reassure him that the dental nursing NVQ is continuing to be developed and enhanced. The BDA is engaged in a

continuing dialogue with Skills for Health about the future development of both the NVQ and the Occupational Standards for Dental Nurses.

Consequently, any feedback that Dr Aitken, or any other BDA member could pass on to us would be most helpful to our efforts at ensuring that the system is improved. Comments can be sent to David Turner in the Policy Directorate at BDA headquarters, 64 Wimpole Street, London W1G 8YS (e-mail: d.turner@bda.org).

G. Watkins

**(Chairman, BDA Professionals
Complementary to Dentistry Committee)
Norfolk**

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Atkins diet

Sir,- I am writing in response to B. Skinner's letter (*BDJ* 2003; **195**: 231) concerning the accumulation of calculus in patients on the Atkins diet. The Atkins diet is low in carbohydrate and results in weight loss because in carbohydrate deficiency, the level of Krebs's cycle intermediates is too low to enable dietary intermediates to be completely oxidised to carbon dioxide and water. This results in the accumulation of the partially oxidised intermediate acetyl-CoA, which is converted to ketone bodies (acetoacetate, β -hydroxybutyrate and acetone) which are then excreted.

The first two of these are acidic and in order to maintain the pH of the body at about 7.4, the body's reserve of buffering capacity, i.e. phosphate in the skeleton, is likely to be drawn upon. It is therefore hardly surprising that the Atkins diet is associated with an increased excretion of urinary calcium.

Is it possible that this is associated with a concomitant increase in salivary calcium concentration? An alternative explanation for the calculus accumulation could arise from changes in oral flora associated with this diet. When on a low carbohydrate diet, oral bacteria will also be carbohydrate deficient. Bacteria which can metabolise amino acids from dietary proteins as an energy source will therefore be at a biological advantage. They will proliferate at the expense of organisms which metabolise carbohydrate which has acidic end products. One end product of amino acid metabolism is ammonia which causes an increase in pH. This too would favour deposition of calculus. Whilst the Atkins diet may well be less cariogenic than the average diet, in terms of general health, it should be discouraged strongly.

J. A. Beeley

Glasgow

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Sir,- In response to the letter of B. Skinner (*BDJ* 2003; **195**: 231) I have also noted the increase in calculus formation in patients on high protein diets such as the Atkins diet. I have a relatively high proportion of vegetarians in my practice and in contrast these patients produce little if any calculus.

Part of my clinical examination includes the measurement of saliva pH and as a generalisation vegetarians have an alkaline pH of 7-8.5 whilst the patients on high protein diets are around the 6-6.5 range unless they are taking supplements to compensate for the stress of a high protein diet. I suspect that the answer to this lies in the body's reaction to acidaemia.

If the body becomes acidic it will bring into action the buffering systems, one of which is the phosphate system. To make phosphate available the body will break down bone and release both calcium and phosphate. If the blood has an increased concentration of free calcium and phosphate then so will the saliva. A combination of free calcium, phosphate and a pH of 6-6.5 in the saliva will encourage calculus formation.

J. F. Ahearne

Poole

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Overbrushing

Sir,- I happen to agree with E. Harrison (*BDJ* 2003, **195**: 360. Overbrushing is not the problem. In my view the problem, I believe, is 'overpaste-ing' (too much toothpaste on the brush with abrasive dentifrices on the market today). Place too much paste on the brush and add force with hand pressure and you will get worn cervical and other areas. Night time bruxism and lateral jaw movements may also cause defects in these areas - abfraction.

N. A. Patterson,

Germany

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Increased chance of death?

Sir,- I enjoyed reading the leader by M. Grace in *BDJ* 2003, **195**: 229. Written with the true zeal of a born-again non-smoker I am sure.

I would like to point out though, that 'if people want to increase their chance of dying' by smoking, they are wasting their time (and money). As far as I am aware one's chance of dying in this world is 100 per cent, regardless.

C. Carter

Essex

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