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Government promises

Sir, I read with dismay the announcements by Minister for Health Dr John Reid in the summer concerning the plans to resuscitate NHS Dental Care.

The present Government are hell bent on a package that will do nothing for the basic ailments that bedevil the attempts to deliver decent oral health care to the population.

Patients – by stealth and ever increasing charges over the years – fund the greater part of treatment at point of use. This amounts to a massive injection of capital and is an outrageous imposition in a National Health Service purported to deliver the health needs of the population without charge when required.

Why is it that the mouth and oral health care are some totally different deal? Is dentistry rather than being a specialised branch of general healthcare some sort of woodwork procedure akin to jobbing carpentry?

Just imagine what would happen if in an analogous situation the first time some little old lady was asked to pay £370.00 or so towards a necessary hip replacement procedure!

Every tabloid and media outlet would be screaming in a millisecond. Yet the deathly silence when this happens (and is meekly complied with!) in dentistry is so deafening as to be unbelievable. Whilst no one protests this will of course continue despite it being so hugely illogical.

Dr Reid tells us that 'The equivalent (sic) of 1000 dentists will be recruited by October 2005.'

Why? It seems that many from outside the UK will be fast tracked in the desperation to fill manpower needs whilst standards slide even further. What is the justification for this influx of dental professionals?

Dr Reid delivers a pledge to fund 170 extra undergraduate training places from October 2005. Why?

What we really need are dental therapists and hygienists. Dentists are largely over trained to deal with the large amounts of the relatively simple treatment procedures that are needed to stabilise oral health in the population.

Advanced restorative procedures will be in the minority. Dental therapists can be trained in 27 months to do much of the restorative dentistry needed and hygienists in even less time to deal with the important basic periodontics.

What then as an alternative to the above, do the people of the UK deserve? To remove NHS charges, put the mouth back in the body and properly re-integrate dental care into the rest of the NHS, salaries for all NHS dentists and a fair rent from the Department of Health to practice principals for existing and already capitalised practice premises.

Practice teams (the professionals complimentary to dentistry) should have direct salaried contracts with the Department of Health. Registration, accredited training, and continuing professional development programmes should be mandatory to enable this. There should be more therapists and hygienists (especially therapists) trained, not dentists and a revision of the availability of 'luxury items' within NHS regulations should occur.

In the proposed changes outlined by Dr Reid, there is no reason for any newly graduated dental professional to feel confident under such a system, of delivering the quality care that patients deserve and desperately need.

John Reid said 'Dental services will be properly integrated with the rest of the NHS providing better access to services and an improved patient experience'. How, pray is this to happen under such a programme?

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Antibiotic prophylaxis

Sir, in a recent letter (*BDJ* 2004; **197:** 115), Longman *et al* criticise the new recommendations on dental aspects of bacterial endocarditis (BE) prophylaxis, published by the British Cardiac Society (BCS) and the Royal College of Physicians (RCP).[1]

We would like to comment on this topic basing on a review of previous EB guidelines published by the Bristish Society of Antimicrobial Chemotherapy (BSAC), the American Heart Association (AHA), and the European Society of Cardiology (ESC).

Longman *et al* emphasise that these recommendations increase the necessity to prescribe antibiotic prophylaxis, that advise 'the use of prophylaxis for a variety of routine restorative dental procedures', and that 'the cohort of high-risk patients has been greatly increased'.

The ESC affirmed in 1995 that 'the dental procedures are the main risk factors for EB and all should be covered by antibiotic prophylaxis, except for superficial caries and bloodless supragingival prosthetic preparation'.[2]

Previously, the same Committee recommended prophylaxis for 'dental procedures with the risk of gingival/mucosal trauma'.[3] However, Roberts *et al* have demonstrated that 'bleeding at the site of the operative procedure is a poor predictor of odontogenic bacteraemia',[4] and that some dento-gingival manipulative procedures (including rubberdam and matrix band with wedge placement) may result in significant bacteraemia comparable to that from dental extractions .[5]

Longman *et al* stressed that placement of rubberdam, matrix band and wedge and retraction cord placement, have not been reported in the literature as causing BE; however, these represent the first step of some dental procedures including fillings or endodontic treatment which have been involved in BE development.

In addition, all 'at risk' cardiac diseases included in the new BCS–RCP recommendations had been previously gathered in the last BE guidelines from AHA[6] and ESC;[3] only two cardiac conditions previously considered of moderate-risk have been incorporated to the high-risk category: the Gerbode's defect and the mitral valve prolapse with mitral regurgitation or thickened valve leaflets.

Antibiotic prophylaxis is recommended in patients either at high or moderate risk

of developing BE. Moreover, it has been shown that there is an increased BE incidence in patients without previously known underlying heart disease. We found in a retrospective series that this could be as high as 30% of all BE of oral origin[7]. In this sense, the ESC has incorporated in 2004 various non-cardiac conditions for which antibiotic prophylaxis should be administered before dental procedures.[3]

Longman *et al* also point out the unnecessary 'use of intravenous (IV) prophylaxis for certain risk groups', and they support this comment on the AHA guidelines[6] where IV prophylaxis is reserved only for patients who cannot take oral medication.

Although a low compliance of IV BE prophylactic regimes by both patients and practitioners has been reported, paradoxically some practitioners may prefer to use parenteral prophylaxis in high-risk patients of BE.

Moreover, in agreement with the BCS and RCP recommendations,[1] IV prophylactic regimens have been recommended by the BSAC before dental procedures under general anaesthesia and/or in patients who have had a previous BE.[8]

It has been proved that clindamycin is an effective antibiotic in the prevention of experimental streptococcal EB.[9] However, we have recently found that in our environment clindamycin does not prevent bacteraemia following dental extractions.[10] Moreover, we have also detected a high prevalence of bacteraemia caused by erythromycin-resistant streptococci[11].

This is of particular concern, since the lack of erythromycin susceptibility may be associated with resistance to first-line prophylactic antibiotics such as clindamycin and azythromycin.

We have also observed that a single chlorhexidine mouthrinse reduces significantly the prevalence and duration of post-dental extraction bacteraemia.[12] In a survey performed among Spanish GDPs, about 30% of patients undergoing dental extractions were administered antibiotics, and EB prophylaxis represented less than 1% of all the antibiotic prescriptions.

In summary, it seems that the use of BE prophylaxis in dentistry is not a major contributing factor to the world-wide problem of antimicrobial resistance, and we suggest that other topics such as the antibiotic of choice and the use of topical antiseptics should be submitted to deep review.

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