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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

Criteria for CPD

Sir, I was interested in the results of your recent Continuing Professional Development survey (*BDJ* 2005; **199**: 665-669), and most surprised that over 90% of respondents agreed that the articles selected for verifiable CPD were applicable to their needs. This is not my opinion. As a busy GDP, and mother of four children, it is a constant struggle to keep up to speed with postgraduate education. Dental journals and magazines pile up and are often consigned to the recycling bin, unread. I give priority to the *BDJ* articles, especially those which will contribute to the verifiable CPD requirement. It is a source of great frustration when these articles have little relevance to clinical dentistry; the inclusion of your self-congratulatory survey being a classic example.

As a result of reading that thoroughly, I now only have time to skim through the much more relevant article on red and pigmented lesions. I would be most interested to know what criteria you adopt for selection of CPD articles in your esteemed publication.

M. J. Coward
Dorset

The Editor-in-Chief responds: *I thank M. J. Coward for her comments on our CPD programme, which provides the opportunity to clarify several matters. The programme is designed to include a range of papers to meet the needs of all readers and to encourage reading and learning in areas that might not necessarily be in the reader's daily experience or indeed of immediate clinical significance to them; the 'C' in CPD standing for Continuing not Clinical. We see the purpose of lifelong learning as being just that, rather than as a short-term fix and choose papers accordingly across a variety of topics throughout the year.*

The BDJ *programme provides a possible 48 hours a year of verifiable CPD out of a mandatory GDC requirement of the equivalent of 15 hours per year. This means that participants can pick those papers which they wish to read, and on which to answer questions, according to their own planned personal development, which possibly explains the high levels of satisfaction found in the survey.*

Finally, the survey was not intended to be 'self-congratulatory' in either execution or presentation. It was a genuine attempt to discover if we were meeting the needs and expectations of members and readers. It would have been published whatever the outcome and the results are helping us in our continuing work to improve the programme further.

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Potential adverse effects

Sir, I write regarding the News item on the use of a bisphosphonate (Risedronate) in periodontal disease (*BDJ* 2005; **199**: 701).

While many drugs have potential beneficial effects, the question of potential adverse effects should always be considered. Readers may be aware that at least three of the family of bisphosphonates – Pamidronate, Zoledronate, and Alendronate – helpful in osteoporosis have been linked to severe oral adverse effects, especially painful necrosis of the jaw bones, sometimes described as osteochemonecrosis.[1] This has been reported especially after dental extractions, but not invariably,[2] and particularly in cancer patients on chemotherapy,[3] especially intravenously.[4] This adverse effect has been highlighted elsewhere.[5] Mouth ulcers may also occasionally occur.[6]

C. Scully CBE
London

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3. Bagan J V, Murillo J, Jimenez Y, *et al.* Avascular jaw osteonecrosis in association with cancer chemotherapy: series of 10 cases. *J Oral Pathol Med* 2005; **34**: 120-123.
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5. [No authors listed] Alendronate (Fosamax) and risedronate (Actonel) revisited. *Med Lett Drugs Ther* 2005; **47**: 33-35.
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Indirect retention

Sir, with reference to the paper by Crawford and Walmsley (*BDJ* 2005; **199**: 715-719), while I agree with the article almost in its entirety, there is one point I feel I must make.

In the discussion regarding the pre-prosthetic removal of a fibrous ridge they say this 'enhances the stability of the prosthesis'.

The glossary of prosthodontic terms defines stability as the resistance to displacement of a prosthesis in a horizontal direction. If ridges are removed, however flabby, this will decrease the stability of the prosthesis as there are fewer walls to offer resistance to lateral movement.

The authors are referring to increasing the support of the prosthesis which is defined as resistance to displacement towards the tissues and will, as they rightly point out, indirectly aid in retention.

P. Keenan
By email

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