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Scalers: review advice

Sir, further to G. Balfry's letter on pacemakers and ultrasonic scalers (*BDJ* 2005; **199**: 625), I have recently seen two patients who have had pacemakers inserted. Both had been given cards with the details of the manufacturer and type of pacemakers inserted. A Google search produced the manufacturer's web address. I sent an email to the company stating that I would like to use an ultrasonic scaler (type specified) on a patient, provided it did not interfere with the function of the pacemaker. From the email response received, ultrasonic scaling can be used on these patients. The email correspondence also forms part of the patient's record.

Until a list of pacemakers is available, it would be advisable to email the pacemaker company on a patient specific basis and follow their advice on the use of an ultrasonic scaler. I think the long standing advice not to use an ultrasonic scaler on a patient with a pacemaker is no longer valid and should be reviewed on a patient specific basis.

M. Alexander
London
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Telephone translators

Sir, the *Standards for dental professionals* guidance document,[1] states 'Respect patients' dignity and choices'.

Working at the Liverpool Dental Hospital I have found the use of the National Interpreting Service a valuable tool for patients who do not understand English. The steps to using the service are quick and simple, and for patients this means that they can have emergency treatment on the day.

The call centre is based in America and each institution that uses the service has a specific code that is recognised. Once connected the operator simply asks your name, grade and what language you require. Within minutes the interpreter is selected and able to talk over the phone. The scenario and an outline of what is to be done is explained. The interpreter then speaks to the patient. This allows you to check the patient's medical history and gain consent.

The only time the interpreter will intervene is to seek clarification or to make one aware of cultural implications, which might cause offence. The interpreters are professional and bound by a strict code of confidentiality. The whole process usually takes less than five minutes and is extremely efficient.

I think PCTs should also provide this service for general dental practitioners in the primary care sector.

A. Ahmad
Chester

1. www.gdc-uk.org

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Shortages of LA

Sir, I read with some interest the article on the various local anaesthetics in use in general practice (*BDJ* 2005; **199**: 784-787), this after assigning a member of staff to secure a new supply of any available local anaesthetic for our practice. Our usual supplier was out of stock of all local anaesthetic products when we rang, but we did eventually manage to secure a small delivery from a company based in the extreme south-east of England of its own brand product. Shortages of LA have been a matter of concern here since early 2005 and I understand from a conversation with a dental rep that shortages are expected until at least mid-2006. What use is an evidence base in these circumstances? I have yet to see a comment or statement from the trade on the matter. Is this not absolutely appalling? Why can't these people get their house in order?

D. J. Stobbs
Angus
doi: 10.1038/sj.bdj.4813274

Triage protocols

Sir, I read with interest Dr M. Storey's letter concerning out-of-hours dental treatment in a recent edition of the *BDJ* (2005; **199**: 695). For the last three years I have run a private practice which focuses on the weekend and bank holiday treatment of acute dental pain so I have some personal experience of this problem. Two points present themselves.

Firstly, all of my patients have a genuine need; my clinical time is never wasted. I note that Dr Storey suggests that patients initially call a helpline where treatment can be 'accessed by telephone and subject to established triage-algorithms'. What are these I wonder and who provides them? Does the receiver of the call have the power to provide or deny treatment? If so then I would hope they are registered dental surgeons with a current practising certificate, for if not then are not the providers sponsoring illegal dentistry? Our medical colleagues always have a doctor available to speak to a worried patient and furthermore I believe that GMC guidelines specifically say not to diagnose down the telephone, as in – 'when in doubt, always SEE the patient'. This then will of course raise another moot point in that if we do attempt this practice aren't we placing too much reliance on the patient's self-diagnostic skills? I will give you one example of many I have seen in the last three years.

A man phoned complaining of an intermittent pain and slight swelling under his right jaw. He believed it was definitely coming from his wisdom tooth. The pain did not keep him awake at night and was controlled by paracetamol.

My triage protocols are simple – if the patient thinks they've got an emergency, then so do I. Nobody sits in my chair and parts company with hard cash if they haven't got a problem. This patient's diagnosis? Nine days after I saw him the local maxillofacial consultant to whom I'd referred him confirmed he had a malignant lymphoma with several metastices around his body and that gives him only a 50% five year survival. An emergency?

The second matter takes Dr Storey's point about the inadequate training of GMPs to deal with a dental emergency. I would like to take it one stage further and include some GDPs also. Fully 40% of my patients are registered with other GDPs, many in the middle of active treatment. They complain that they could get NO help from them or NHS direct to address

their acute pain. Isn't this a breach of some kind of NHS contract requirement? Not to mention a breach of trust with their patients.

Three months ago I received a complaint from a supervisor in NHS Direct. Apparently an exempt and registered patient phoned his dentist and got my number on the answering machine and no other; there was indication that mine is a private practice. When my receptionist offered him an immediate appointment and told him the fee, he declined and complained to NHS Direct who in turn complained to me. When after 10 minutes I was able to make the lady understand I didn't have an NHS contract, the NHS Direct supervisor asked me what I intended to do about it? I patiently explained that it was her problem and not mine.

The second point: who are these people who might be putting into practice these locally agreed triage-algorithms? Who agrees with them? I certainly don't and I think if you asked all my patients, you wouldn't get a single taker either. And finally, what are they? I've written to six PCTs asking this question and to date have yet to receive a single reply. Perhaps one of your readers could enlighten me?

I know it's easy to knock the system without offering a constructive suggestion so here's my two-pence-worth. Why don't you base any new dental out-of-hours service on that of the GMPs? They at least have had a few years' practice.

I. P. Jeavons
Sutton-in-Ashfield
doi: 10.1038/sj.bdj.4813275

Fag packet policy

Sir, I am writing to add my voice to the concern, which is emanating from the profession, about the new NHS dental contract.

In particular, I think that the means by which money is distributed in the new contract is much too rigid. Money now flows to the practices from the PCT, rather than via the patient as in the old model. This is an obvious and perhaps intended consequence of the new arrangements. The power to 'spend' money has been taken from dentists and given to the state. Yes devolved locally, a local command economy, but ultimately controlled by the treasury.

In our area the downside of this model has come quickly. Our primary care trust has now 'spent' its dental budget for the year. As the great majority of practices joined PDS, the budgetary problem has been caused by a combination of perhaps over generous PDS contracts to retain existing NHS practitioners and a fall in patient charges, which has had to be underwritten by the PCT. Extra NHS provision has been provided with recruitment of foreign dentists and this is welcome.

There is no money for growth in our area. If a practitioner wants to increase their NHS commitment it will not be possible during 2006/7. If a Vocational Dental Practitioner wishes to stay in the area after VT will they get a contract?

I think that the contract is also bad for patients. The money has ceased to flow to practices with the patient. There is no incentive to take on new patients with a fixed contract value, and certainly no incentive to embark on, for example, a molar endodontic treatment, when there are an equal number of units of dental activity available for an extraction. How will a patient with high treatment needs, in an exempt category, but without a dentist be able to get treatment other than emergency care?

I listened with interest to a recent Radio 4 programme discussing the successes and failures of this government. The point was made that good governance had followed wide consultation and lengthy reflection prior to policy launch. When policy was put forward without this proper period of reflection and consultation, and what I would describe as the 'back of a fag packet' mode of administration occurred, poor policy ensued.

I am afraid that the new contract, and especially the late entry of UDAs, shows all the hallmarks of policy written on the back of a fag packet.

K. J. Cottingham
Grimsby
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Cochrane and ozone

Sir, it is notable that that the Quintessence book *Ozone – The revolution in dentistry* also received an extremely positive review in October 2005 in the *Deutsche Zahnaerztliche Zeitschrift*. Professor M. Baumann appreciated the excellent illustration in the chapters 4.6 and 4.7 and recommended this book as a true mine of information. Hundreds of dentists have personally told me how HealOzone has improved the care they can provide for their patients and how they now cannot imagine practising without it. My personal experience with the HealOzone over the past three years has been excellent. Published research led by Professor Beer in Germany has also proven the benefits of HealOzone use.[1,2]

Dentists in practice often do scaling and polishing for aesthetic reasons to remove tooth staining etc. However let us have a closer look at this review out of the Cochrane Library:[3]

Routine scale and polish for periodontal health in adults

The research evidence is of insufficient quality to reach any conclusions regarding the beneficial and adverse effects of routine scaling and polishing for periodontal health and regarding the effects of providing this intervention at different time intervals. High quality clinical trials are required to address the basic questions posed in this review.

There are psychological consequences associated with leaving people with stained teeth. Unfortunately, Cochrane only considered the periodontal health question. When they assessed the HealOzone[4] it is so unfortunate that they did not seem to understand that the vast majority of dentists either immediately seal the caries lesion after applying Ozone or they seal the lesion after one month. Why did Cochrane therefore eliminate all the studies of one-month duration proving the reversal of caries after the use of Ozone? Why did Cochrane and NICE choose a biased approach looking for a minimum of six months' follow up when this is inappropriate for most Ozone uses? Performing the Cochrane and NICE reviews for this recently introduced product, undergoing a great amount of research, was premature. But I do see a big opportunity for the future reviews to present a balanced view, when looking carefully to antecedents in the Cochrane practice regarding 'Enamel matrix derivative (Emdogain®) for periodontal tissue regeneration in intrabony defects', where after a relatively short interval first conclusions were revisited.[5,6]

It is interesting to note how many academics were advising, decades ago, against the use of acid etching enamel, against the use of high speed hand pieces, etc while dentists in practice fortunately proceeded to help their patients with these new concepts. Fortunately, many thousands of dentists have already helped millions of patients using Ozone.

L. Steier
Germany

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Illegal jigs

Sir, recently, a radiotherapy technician contacted the Orthodontic Department at Queen Alexandra Hospital, Portsmouth with a query regarding the construction of oral 'jigs' for the location and targeting of radiotherapy equipment during treatment. This was a practice that had been going on for many years and is an important stage of the treatment process. The radiotherapy department queried whether the construction of oral jigs was a practice restricted to only qualified and registered dentists.

We felt that it could technically be a breach of the Dentists' Act and therefore illegal. A solicitor, the General Dental Council and the Medical Defence Union were involved in the investigation of this dilemma.

Section 37 of the Dentists Act 1984 defines the practice of dentistry as follows: 'The practice of dentistry shall be deemed to include the performances of any such operation and the giving of any such treatment, advice or attendance as is usually given by dentists; and any person who performs any operation or gives any treatment for the purpose of or in connection with the fitting, insertion or fixing of ... dental appliances shall be deemed to have practised dentistry within the meaning of this Act.'

In Section 38 of the Dentists' Act 1984, it states that 'Anyone who is not a registered dentist shall not practise dentistry and will be liable on summary conviction to a fine not exceeding the 5th level on the standard scale.' The General Dental Council and the Medical Defence Union advised that although it may be technically a breach of the legislation, it was unlikely to be pursued as no financial gain was involved.

However, the new Dentists' (Amendment) Order 2005, subsection 1A follows as: 'For the purposes of this Act, the practice of dentistry shall be deemed not to include the performance of any medical task by a person who: a) is qualified to carry out such a task; and b) is a member of a profession regulated by a regulatory body ... listed in Section 25(3) of the National Health Service Reform and Health Care Professions Act 2002.'

Although 'medical task' is not specifically defined, it would perhaps be appropriate to assume that the making and fitting of the oral jig is covered. The technicians are currently seeking an official acknowledgement of the Trust's position.

We feel that this report highlights the problems which can be faced in the medical and dental profession by defining procedures and appliances which should be used by qualified professionals alone. There are often situations which are not clearly defined and fall into a grey area. It is important to pursue such situations so that steps can be taken to further define regulations for the future.

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Referral speed

Sir, we thank Dr Zadik for his interest (*BDJ* 2005; **199**: 355) in our case report demonstrating a missed diagnosis of malignancy presenting in the oral cavity (*BDJ* 2005; **198**: 341). Dr Zadik drew attention to the fact that the case report 'stated that general medical practitioners have been shown to be better at diagnosis and prompt referral of oral malignancies than their dental colleagues', although he felt that other papers came to different conclusions. We made reference to one paper[1] which supported the better diagnosis and prompt referral by general medical practitioners (GMPs) when compared to general dental practitioners (GDPs).

Dr Zadik listed a number of other papers which showed either no difference or the opposite finding. In preparation for the case report we did indeed review the studies but rejected their findings in relation to comparative referral quality for a number of different reasons. One of the papers[2] quoted actually showed GMPs to be slightly quicker and better at requesting urgent appointments than GDPs.

The authors of another study[4] cast doubt on their findings when comparing GMPs and GDPs due to the small numbers involved. The authors of a further study[5] speculated that the similar length of delays in both groups of referrers was specific to the unique way patients were referred in the country where it was carried out. It was unclear with a further study[9] as to whether the physicians who were compared to GDPs included just general medical practitioners or other specialists. Other publications[3,5,7] made comments which were not backed up in their results, did not look at delay in referrals,[8] and had imbalances in numbers of GDPs and GMPs.[9,10]

Several publications[3,8,10,11] referred to differences in the stage of tumours referred by both groups which is not necessarily a reflection of delayed diagnosis, but may demonstrate the differences in the kind of patients who attend both groups of referrers. None of the papers[2-12] reported how often GDPs correctly diagnosed malignancy when compared to GMPs. The paper by Schnetler[1] does show this, which is the reason it was included in our case report.

We would largely agree with the comment that 'the dental profession is the only profession capable and dedicated to the diagnosis and treatment of diseases of the oral cavity', especially as dentists are one of the few groups of health care professionals who examine the oral cavity at regular intervals. Clearly, GMPs also have a role to play in referrals, and as the references show are also responsible for a considerable number of referrals to secondary care referral centres. Improving the speed of referral by both groups of practitioners should be a priority issue.

G. St George
R. D. Welfare
V. J. Lund
London

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Use it or lose it

The advice from the Department of Health concerning oral health in their new booklet[1] has a glaring omission, which is the lack of specific advice or recommendation for gingival/periodontal care. Given the incidence of tooth support loss and subsequent tooth loss this omission is puzzling. Our patients, quite rightly, expect us to provide them with advice, so what can be offered which is both reasoned and reasonable?

Load bearing improves bone density. Tendons and muscles strengthen with work. Keratinised tissue responds to abrasion/wear by thickening. My own observation of both human and animal dentitions has convinced me that the 'use it or lose it' phrase applies to the hard and soft tissues more than may be acknowledged.

For example, there is a well documented difference between the periodontal condition of feral and domestic cats, in which diet plays a major part. The former have to get what they can catch or pick up and the killing, skinning and chewing all help to toughen up the periodontal and alveolar apparatus. The latter often get tinned or packaged 'meat' which requires little effort to eat resulting in heavy calculus deposits and acute periodontal disease. So, in this context the lifestyle of the feral cat seems to promote a healthy mouth.

If we all adopted the 'don't brush too hard or you will damage your gums' philosophy and applied it to the rest of the body, many sports and hobbies would never be taken up because of some initial discomfort – try playing a steel string guitar for the first time – it hurts. But, of course, the body adapts, within limits. So is 'gentle brushing' of the gums a good idea? Is it enough? I was taught that gum shrinkage with no associated pathology was caused by inappropriate or excessive brushing. Now I am not so sure.

I have yet to see a patient destroy their gums by brushing too much but I have seen plenty of patients improve their gum condition by vigorous brushing. The gums rely on the bone for support so strong bone is an advantage. Bruxists have very tough dental support tissues presumably because the increased loading on the bone builds it up. The bone is strong – so are the gums.

Although popular marketing for mouthwashes and certain sonic brushes emphasises the removal of bacteria as essential, perhaps it is approaching the problem from the wrong direction. Could it be that if the gums are strong then the bacteria will be 'shrugged off'? Therefore, stimulation of the gums should arguably be the first goal of oral hygiene, with 'tooth' cleaning a close second, because I believe that the two are not necessarily inseparable.

Some bruxists that I have seen have poor oral hygiene yet admirably strong dental support. On the other hand, many patients of Oriental ancestry that I have seen, who have good oral hygiene, nevertheless also seem to have a predisposition for periodontal collapse. Their diet often consists of very small pieces of food that require no chewing. Is there a connection?

If it is accepted that the aim of our advice is to encourage the patient to adopt a care programme that strengthens support then, perhaps, we should not only promote gum care but some kind of chewing/clenching exercises.

By adapting some simple and short 'jaw exercises' particularly those involving firm chewing/clenching it is possible to noticeably increase the strength of the main 'chewing' muscles within two to three weeks: the occlusion feels more 'even' and 'more efficient'. These are findings from my patients – purely anecdotal, of course, but fitting in with what I would hope and expect to happen.

I wonder whether some TMJ problems could be prevented by simply 'tightening up' the TMJ area in this fashion particularly if, from childhood, the diet and/or lifestyle encourage it. Unfortunately twenty-first century existence seems to be making us 'soft' – I now hear that it is possible to buy bread without crusts. Use it or lose it?

C. Jeffrey

1. Choosing better oral health. Section 74 'Individuals'. p 32. London: Department of Health, 2005.

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