Send your letters to the Editor, British Dental Journal, 64 Wimpole Street, London W1G 8YS 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.

Misleading assertions

Sir, I am writing to express concerns at the content of the editorial in the *British Dental Journal* of 12 May 2007 (*BDJ* 2007; **202:** 505). The comment that the British Dental Association did not know about the announcement in relation to single use endodontic instruments until they 'heard it on Radio 2' is untrue.

I and a colleague briefed the BDA's Chief Executive and a member of the BDA staff on 2 April. The purpose of that briefing was to enable the BDA to prepare to provide support and accurate information to its members when the announcement was subsequently made. At the end of the meeting, the BDA asked us if we would share the question and answer briefing that we were preparing. We agreed to that request and subsequently provided the BDA with the question and answer briefing several days before the announcement was made.

As regards notifying the BDA of the actual announcement, we were in regular contact during the lead up to the announcement and contacted the BDA a day before, during working hours, as soon as we knew the announcement was going to be made. On the day of the announcement, within 30 minutes of the Written Ministerial Statement being made in the House, we had emailed the BDA the full text of the professional letter and the full text of the Written Ministerial Statement.

As Chief Dental Officer, I kept the BDA as fully informed as I possibly could in order that they could provide the best possible advice and support to their members. I would be grateful if you could make your readers aware that the content of the editorial to which I refer was misleading. It would have been one thing to express frustration that the BDA was not able to use the information provided before the announcement to brief its members in advance but it is another thing altogether to allege that the BDA was not briefed in advance.

I was pleased that the penultimate paragraph of the editorial confirmed that the advice to dentists was based on taking sensible precautions to reduce any risk of vCJD transmission. I was concerned, however, that the earlier part of the editorial, by making an artificial distinction between advice and guidance, seemed to cast doubt on whether dentists are expected to follow these precautions.

B. Cockcroft
Chief Dental Officer – England

The Editor-in-Chief responds: I am grateful to Dr Cockcroft for his letter and I am sorry that he felt that my editorial was misleading. I understand that the CDO had informed the BDA in the manner described in his above letter but that the BDA personnel he had informed, though able to prepare information for members in readiness of the announcement, at the Department's insistence were precluded from briefing or alerting them in advance. This is because of the policy that announcements relating to vCJD must first be made in Parliament before any other communication takes place.

With respect therefore, I believe that the nub of my point remains. Whatever arrangements are made to disseminate the information to all dentists and patients after the 'all clear' from the Department of Health, they can never be as swift as the route through live media such as television, radio and the internet. Thus, while the Government maintains its requirement that all matters concerning vCJD have to be reported to them first and exclusively, the problem will remain. I can only reiterate my question '...can our elected representatives really believe that this is the best way to deal with matters of health care?'

Government's commitment to Parliament, it seems, has caused difficulty and embarrassment not only to its people, its dentists, dental teams, dental industry, and professional bodies but also to its own civil service support staff despite its own best efforts. I believe that there must be a better way of dealing with this and would urge those with the power to make changes to consider doing so as a matter of some urgency.

DOI: 10.1038/bdj.2007.616

Incompetent shambles

Sir, I read with glee the editorial by Stephen Hancocks (*BDJ* 2007; **202:** 505) *It is all about motivation*, asking what the DoH's motive was for explaining the ridiculous guidance about single-use reamers, preventing vCJD transmission. In my opinion, it is not about motivation, 'it is all about incompetence'. The side headline to the same editorial says 'handled logically this could have been a triumph ... instead it is an all too familiar shambles'. I think this sums up policy at DoH. Can anyone suggest a triumph by the DoH? Any decision-making done by this department ends up in failure and displeasing professional medical and dental staff alike.

S. Shah
London
DOI: 10.1038/bdj.2007.617

Projectiles perhaps

Sir, as a person who has had a shotgun pellet in my face for over 20 years I read with interest the paper *Bullets in the mandible over 12 years: a case report* (*BDJ* 2007; **202:** 399-401). At the risk of being pedantic, the pellets or shot from a shotgun are not bullets; projectiles perhaps, or simply lead shot.

R. Reed
Godalming
DOI: 10.1038/bdj.2007.618

The transitional effect

Sir, most dentists will be aware that for some time PCTs have been complaining that the income raised from patient charges, the Patient Charge Revenue (PCR), has not lived up to expectations. I believe that a large part of the revenue shortfall for 06/07 has been caused by a failure to consider the effects of the transitional period when calculating the estimates for PCR.

Transitional cases were those patients who were part way through a course of treatment at the introduction of the nGDS contract on 1 April 2006. For these cases dentists were required to submit two claims for payment. On the first claim the dentist recorded details of that part of the treatment completed

prior to 1 April, together with the patient charge for the entire course of treatment. This claim was then paid by the DPB with a deduction for the patient charge. The second claim recorded the UDAs applicable to that part of the treatment carried out after 1 April. These UDAs were recorded on another schedule; they were paid for by the PCTs and deducted from the dentist's UDA targets. Because patient fees had already been deducted from the first claim the PCTs were unable to raise any revenue against these UDAs. Despite this the PCR forecasts given to PCTs were made against the entirety of dental practitioners' annual UDA targets. This anomaly, which I have named the 'Transitional Effect', could easily account for a large proportion of the PCR shortfall at the PCTs.

Within my own practice I have carried out an audit looking at all those transitional cases where fees would normally have been payable. This showed that I have obtained 706 UDAs towards my annual target from transitional cases, which should have raised £10,600.30 in PCR: a figure which fits almost exactly with the PCT estimate of the shortfall for my practice.

I have not lost this money – my PCT has – but they will have less money to invest in dental services and there may well be problems when contracts come up for renegotiation.

P. Martin
Leicester
DOI: 10.1038/bdj.2007.619

Bizarre assumptions

Sir, the letter from J. F. Sharp (*BDJ* 2007; **202:** 369) brings to the fore the issues relating to the flawed UDA calculations. I, too, have raised this matter both directly with the CDO and via the Implementation Review Group with similar results.

In addition to the flaws he raises are the bizarre assumptions made in the calculations that each child has been seen during the 'Test Year' on two occasions and therefore the UDAs included in each practitioner's target will reflect this regardless of whether history shows this to be untrue. This was the instruction given to PCTs in Fact Sheet No. 8.

L. Ellman
By email
DOI: 10.1038/bdj.2007.620

Better than cavitation

Sir, in relation to H. Keanie's letter (*BDJ* 2007; **202:** 507-508) regarding one of his/her patient's potential fluoride allergy, I would also be very cynical at first. Over the last 40 years there have been a few documented cases of claimed potential fluoride allergy from toothpastes/gel, if searching with MEDLINE.[1] Being a common enough agent, I presume that the potential for the body to produce an allergy to it is possible.

Personally I have not come across any patients in dental practice with this problem. But if I did, what I would recommend for improving oral hygiene and reducing the risk of dental caries would be a combination of chlorohexidine gel (to reduce the plaque load) and a toothpaste containing CPP-ACP (to help with remineralisation) in the absence of fluoride.

CPP-ACP, or *casein phosphopeptide with amorphous calcium phosphate*, is sold in the UK as 'Tooth Mousse' or as 'MI Paste' in USA and Japan. If some readers are not aware of this product, it consists of dissolved calcium and phosphate, bound to a cow's milk derivative called casein phosphopeptide, which acts like a carrier.[2] CPP has the ability of keeping calcium and phosphate in the soluble form, but also has the ability to bind to tooth surfaces and the bacterial/plaque biofilm. This latter property allows high levels of calcium and phosphate to re-penetrate the biofilm following demineralisation to encourage active remineralisation. This may not be as good as fluoroapatite forming, but it's better than cavitation!

This product can also be used for dentine hypersensitivity in people with xerostomia and following bleaching of teeth. It can be applied in a tray, with toothbrush or finger. Leave in the mouth for one to two minutes, rinse gently and do not drink for 30 minutes.

M. Lloyd Hughes
North Wales

1. Mummery R V. Claimed fluoride allergy. *Br Dent J* 1984; **157:** 48.
2. Cross K J, Huq N L, Reynolds E C. Casein phosphopeptides in oral health – chemistry and clinical applications. *Curr Pharm Des* 2007; **13:** 793-800.

DOI: 10.1038/bdj.2007.621

Constituent of toothpastes

Sir, in response to H. Keanie's letter, I too have a patient who presented claiming fluoride allergy. Her 'allergic' reaction is basically a sore throat and she has many early carious lesions. I tried to arrange allergy testing through her GMP to no avail. I advised her of the dangers of frequent sugar consumption; she freely admitted she was not good at managing that. My assumption was that it was not the fluoride ion itself, but a constituent of toothpastes which may be associated with the fluoride. Therefore we recently tried Colgate's Duraphat varnish (assuming radically different ingredients). She has had no reaction to this so far, so with luck regular application may prove useful. I am hopeful that Colgate may provide useful information. For a little professional amusement, I suggest a Google search of 'fluoride allergy'.

R. Lilleker
East Grinstead
DOI: 10.1038/bdj.2007.622

Deprecating the role

Sir, at the end of May 2007, members of the University and College Union (UCU) voted at their annual conference to urge a boycott of academic institutions of Israel.

In my opinion this decision is outrageous and unjustified. It deprecates the role of academic institutions, especially universities, to act as custodians of free speech, scientific inquiry and debate. Further, I understand that the decision may even breach the code of conduct of the International Council for Science, which rejects academic boycotts as a matter of principle.

Israel is a democratic country, with a government which may be – indeed frequently is – changed as a result of free voting by its citizens, who comprise many races, creeds and religions. Whilst criticism of this government is legitimate, to boycott academics because of their government's policies is abhorrent and unfair.

The *BDJ* recently detailed an initiative between the Hebrew University of Jerusalem, Israel and the Al-Quds University of Palestine.[1] Initially a symposium was held jointly and further cooperation will ensue. It was reported that according to the institutions, the programme carried a further expression of the joint statement issued last year in London, by the presidents of both universities, for continuing efforts *'to work together in the pursuit of knowledge for the benefit of our peoples and to oppose academic boycotts or discrimination'*.

From events such as this symposium and other joint cooperation over the coming months and years peace may spread and eventually be established across the region. Academic boycotts will do nothing to promote such a peace or understanding.

I call upon colleagues in dental academia to ignore this boycott – indeed to work actively within the UCU to have this decision overturned.

A. S. Kravitz OBE
London

1. Israeli-Palestinian partnership in dentistry. *Br Dent J* 2007; **202:** 7.

DOI: 10.1038/bdj.2007.623