Letters to the Editor

Send your letters to the Editor,
British Dental Journal,
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Email 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.

OVER-PRESCRIBING

Sir, my daughter, aged 41, visited a dentist in Latin America recently. She had not had a dental inspection for two years but her caries experience was low and she maintains a high standard of oral hygiene. She was told she needed 12 restorations (and also that the practice was to be re-equipped the following week). She rang me to ask for advice. I confirmed that her mouth was comfortable and that bitewing X-rays had not been taken. I suggested she should not return to the practice and that she should seek another dental examination on her return to her home in north America.

She had such an examination some months later and was told that only one molar tooth required treatment, but it would almost certainly require a root canal treatment and the restoration would best be completed with a bonded crown. At that examination the molar tooth had not responded to cold testing, bitewing X-rays had been taken but no periapical views. The estimated cost for the root treatment and crown was more than that for the 12 restorations noted as required at her first inspection. When the dentist was out of the room his nurse advised it would be quite safe to delay the treatment for a few months, when my daughter might again have insurance cover.

I asked her to test the tooth herself with an ice cube from the deep freeze; it gave a normal response. I did a simple examination when visiting her last month and could find no caries on mirror and probe examination. She has subsequently visited a third dentist who, without taking bitewing X-rays, has advised her she is dentally fit.

She has almost certainly been unlucky in her choice of the first two dentists; there can be no excuse for prescribing unnecessary treatment. In the past, when I have been asked for advice as regards joining a dental insurance scheme, or just paying for treatment, I have often advised the latter. Certainly the dentists in my area of England (and Wales) have excellent ethical standards and I have seen no evidence of over prescription or supervised neglect.

However, it would be unreasonable to believe that the United Kingdom is entirely free of these problems and the increasing levels of private practice, and the present recession, may well increase any tendency to over-prescribe or under-prescribe.

I hesitate to equate car maintenance with the maintenance of the dentition but some local authorities have set up car test centres where cars may have the annual MOT test but must be taken elsewhere for remedial work. Would it be unreasonable to offer such a service through local authority clinics, given by dental surgeons with standardised training in diagnosis and treatment planning?

K. F. Ashley, Hereford

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SOMEWHAT AMUSED

Sir, I have followed the several letters to your journal editor relating to two articles which were published in the *Journal of the Canadian Dental Association* (*J Can Dent Assoc* 2005; **71** (10) and 2006; **72** (3)).

I was somewhat amused by one article titled *Persuasive evidence that formocresol use in pediatric dentistry is safe* – it appears he presumpes that the long standing formocresol (FC) controversy was solved by his follow-up letter to Dr Lewis. It seemed quite biased – and acerbic – as he referenced his two articles as proof of FC acceptability. Dr Lewis's strong academic past is well recognised – he is more than well published and versed in the great volume of formaldehyde (FA) and FC literature.

After rereading the 2006 Milnes article and his *BDJ* rebuttal, it reads as though he was attempting to fulfill – in writing – his own bias to support his clinical use of FC. Milnes' literature review covered a number of articles that discussed the dangers of FA, however, his persuasive justification for the paediatric use of FC is a bit weak, especially in light of the overwhelming number of studies reporting the biological dangers of aldehydes. It should be noted that the cresol component of FC is also known to cause irritation to the nose and throat, and has been associated with infant fatality to 20 mg of a 90% cresol solution.

It is a bit mystifying to understand how Milnes computed his measure of Buckley's 1:5 dilution of FC when placing an FC pellet for vital pulpotomy. He seems to have based his computation that 1 mg is equal to 1 ppm. Is not 1 mg a measure of weight and 1 ppm a measure of concentration? A bit like comparing apples to oranges. King reported in 2002 that many clinicians use full strength FC for pulpotomy, and placement of 190,000 ppm of FA on vital tissue would be toxic to the vital tissues – documented in many published studies.

A 2001 study ranked FA fourth on a list of environmental chemicals that produced significant brain damage. A 2004 publication on FA by the Director of Research of Champion Co. cited over 220 references – most of them since 2002 – noting

chronic health effects from long-term low dosage FA exposure to health professionals and wood plant workers. The author cited physical complications ranging from seizures, memory loss, tremors, neurobehavioural impairment and neurotoxic symptoms.

Following recent public health concerns to FA contamination in portable housing trailers following hurricane Katrina, Johns-Manville Co, a major world wide wood construction company, has elected to completely eliminate all FA from all of their construction materials by 2010 – a step to correct their realisation of FA – demonstrating they are a socially concerned company.

Regarding biological concerns of carcinogenicity, FA is on the EPA's list of 10% of worst chemicals of overall hazards to human health. FA is one of the initial patch test protocols to confirm an individual's allergy – FA sensitisation is a known antigenic agent causing contact dermatitis, inhalation and asthmatic allergies and should be removed from clinician's treatment regimens around the world.

C. F. Cox, Yokohama, Japan

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CAN YOU HELP?

Sir, I have recently been contacted by the Recovery & Identification Unit of the Royal Netherlands Army with a request to help identify a World War 2 (WW2) soldier, the remains of whom were exhumed in 1995. As yet his body has not been identified.

A major key to his identification now rests on the fact that he wore a partial upper vulcanite denture. The denture was inscribed on the palatal fit surface with two numbers – 183 and 772 (Figs 1-2).

The Dutch team are quite convinced that the denture was made for the soldier

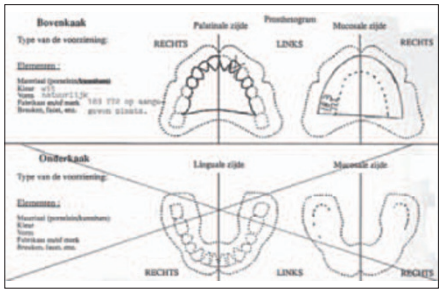

Fig. 1 A diagram of the denture

Fig. 2 The vulcanite denture

following his enlistment into the army.

An extensive search of records in the Royal Army Dental Corps Museum has so far failed to help identify the soldier from his denture.

I would very much like to hear from any dental technician who served in the army dental services during WW2 and who might be able to shed some light on the two numbers inscribed on the fit surface of the denture.

Please contact Colonel (Retd) James Hardy – by telephone on 01252 863264 or email rsme-hq-dental@rsme.mod.uk.

J. Hardy
By email

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A RELIABLE TOOL

Sir, I refer to the editorial *The whole population approach to caries prevention in general dental practice* (*BDJ* 2008; **205:** 521).

NICE clinical guideline 19, issue date 2004 on Dental Recall Interval is an excellent memorandum accepted by both the BDA and DoH. Their checklist of stated modifying factors is certainly an accurate and reliable tool to predict who is high risk and who is low risk. To doubt that a dentist were to get a decision wrong with consequences for a child who converted from caries free to caries active would be to assume that the checklist was not realised and followed.

Delivering better oral health: an evidence based toolkit advocates professional intervention with fluoride varnish containing 2.2% sodium fluoride twice yearly for children aged 3 to 6 years and 3-4 times yearly for children giving concern. This applies also to children aged 7 to young adults. Presently general dental practices are being targeted by PCTs with prompting from the DoH to comply with NICE guidance on recall. There have been public accusations of dentists gaming on the system. To comply with *Delivering better oral health* would be to have much shorter recall intervals, unless of course there were to be a separate attendance for caries prevention in addition to a recall attendance. Apart from the costs of the fluoride, the additional costs in involving valuable surgery time would be pretty expensive. Also more importantly, compliance from patients for an extra attendance for caries prevention would be poor.

There would be implications in making dental nurses apply fluoride varnish. The GDC would only permit dentists, therapists and hygienists to do clinical procedures. If the application of fluoride is permitted for dental nurses, there would be a need for a proper training programme which would require validation. Their contracts of employment would have to be redrawn to include this added duty. There would have to be a mandatory indemnity insurance for them.

I am pleased with the toolkit *Delivering better oral health* and can state that I have gained benefits in oral health education and techniques from it. I would find such a whole population approach difficult to accept in general dental practice. I am in complete agreement to apply fluoride varnish to high risk groups be they a child or an adult of any age.

P. Wee, London

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EXPANDING, IMPROVING

Sir, in his article (*BDJ* 2008; **205:** 475-476) Peter Swiss looked at the historical development of Denplan. As a user of this capitation scheme over the last 15 years I should like to offer my personal comments as a practice principal on its benefits.

I did a practice conversion in January 2000 of a mixed NHS/private practice in the reasonably affluent south east of England to Denplan. This changed my attitude to my profession. For the first time in 28 years I knew how much I was going to earn the next month without the vagaries of patients not turning up and the fee per item system. I could now budget, plan ahead and attend

postgraduate courses without losing fee income. I knew how much I could invest in my practice and could adjust yearly my monthly fees to cover future expenses and inflation. Denplan collects the patients' payments. I had the help of Denplan support staff who provided information, business plans and an arbitration service for any disputes. I had my own key client consultant who visited me regularly to update me on developments, courses and give advice. By my yearly accreditation to Denplan Excel I met all my clinical governance requirements. The Denplan Excel Oral Health Score and Preventive Programme Agreement make our patients dentally aware and interested and encourages them to want to keep on coming in order to increase or maintain their oral health. Copies of both these forms contribute to good record keeping and help identify any oral deterioration. Denplan in our practice provides a framework for patients to improve the aesthetics and function of their mouth, should they wish, via additional cosmetic treatment and implants. Patients have the reassurance of world wide emergency treatment and accidental injury cover.

Some of the criteria I would suggest for a successful (both for patients and practice) Denplan practice are carefully placing patients in the appropriate fee category and being flexible in moving them up or down according to any long term changes in their treatment needs. Having sufficient patients to prime the pumps and taking the long term view of both the practice's future and one's patients' needs are important.

Eight years later, I am independent of the health service and our practice is expanding and improving. I am doing a clinical master's degree and despite the recession, I have confidence for the future. I am enjoying general practice even more than when I started 36 years ago.

M. Austin, Hove
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UNDESIRABLE RHYTHMS

Sir, I read with interest the article about atrial fibrillation (*BDJ* 2008; **205:** 539). For many years including when I was secretary of SAAD, I said that the ECG was an under used piece of monitoring in the dental surgery and that it would be only a matter of time before somebody found out why. My own anecdotal evidence is that a variety of undesirable rhythms can readily be seen before anybody even touches the patient.

Then I read a letter by some of the same authors where they criticise G. Manley *et al*. Later in the same letter, they say that it 'seems odd to be concerned about preoperative fasting where the loss of consciousness must be avoided'.

I sat back ... I thought I had read that the unexpected cardiac rhythm could occur in a nervous patient. I felt there could be an allusion to a more serious rhythm occurring unexpectedly. I thought it might not be that unusual for that type of patient to lose consciousness? Maybe? We sedate nervous patients. Nervous patients can vomit unexpectedly and I think you can assume that an empty stomach would be a help. I personally found that very very nervous patients are best advised to present with empty stomachs, bladders and bowels!

I think sometimes you can only walk away shaking your head realising that some people just don't get it!

W. A. D. Jack
By email
DOI: 10.1038/sj.bdj.2009.65

BEST ANTIBIOTIC

Sir, with regard to the letter *A single dose* (*BDJ* 2008; **205:** 525) I recall reading that the best antibiotic cover for dental surgical procedures is 2 g Tinidazole 12 hours pre-operatively.

As this is not in the formulary, I have not had a chance to research this.

G. Simmons, Barking
DOI: 10.1038/sj.bdj.2009.66

SOMEWHAT DISTRESSING

Sir, more than 40 years ago I attended a memorable lecture delivered by Dr James Murdoch of Edinburgh, one of the original members of the 'Dunlop Committee' which, I understand, is the forebear of today's NICE. I recollect that he advised the delegates that while about 15% of antibiotics prescribed could be shown to be beneficial, about 5% were potentially dangerous and that the other 80% were neither beneficial nor harmful to the individual but potentially harmful as their prescription could lead to the development of sensitivity and resistance.

It was, therefore, somewhat distressing to read the well informed paper by Professor Michael Lewis (*BDJ* 2008; **205:** 537), a highly regarded clinician, warning that we appear to have learned nothing since then and that, by inference, previously fairly innocuous infections could now become life threatening. Everyone, patient and clinician alike, should be grateful to him. Hopefully some attention will now be paid to such cautionary words. I worry that otherwise the value of these wonderful drugs may be rendered useless less than a century after penicillin's discovery.

In the middle 1950s undergraduate medical and dental students were warned of the dangers of prescribing inadequate doses of antibiotics and of the necessity for patients to complete any prescribed course if the development of both resistance and sensitivity in the community was to be prevented. I wonder, after reading the letter from Dr P. R. Williams (*BDJ* 2008; **205:** 525), if there has been a change of thinking about this advice, if previously unacceptable dosages are now considered to be adequate and without risk. Incidentally, I and my contemporaries were taught at all stages of our education also to warn every patient of the dangers of consuming alcohol after any dental extraction, especially the probability of unwanted, worrying bleeding, no matter which day of the week it was.

S. Blair, Ponteland
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WIKIPEDIA USE

Sir, regarding the letter *Wikipedia comes second* (*BDJ* 2008; **205:** 525), I believe that Wikipedia should not come second. I believe that Wikipedia shouldn't be used as a reference at all in a scientific paper. Wikipedia may be useful to gain a general understanding of a subject, and if the author is truly in a quandary, s/he may quickly scroll down to the references used in the Wikipedia article and then read them themselves.

E. Shawkat
By email
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