hydrogen peroxide. Amendment of the current law to differentiate between 'general' supply, and 'professional use' would be of considerable assistance to dentists when the option of bleaching might obviate a destructive alternative such as veneer or crown preparation.

It should be borne in mind, however, that the SCCP 2007 report[4] which is often quoted as supporting an increase in the permitted concentration of hydrogen peroxide to 6% in cosmetics supplied for tooth whitening purposes does not, in fact, confirm that any concentration greater than 0.1% is safe for use over long periods, highlighting a need for additional research. If in the future it were to be discovered, for instance, that the long-term use of products containing 0.1-6% hydrogen peroxide had a significant mutagenic effect, the existence of doubt as to safety raised by the SCCP report could render many suppliers, including dentists, vulnerable to claims that this should have been recognised.

I do question the inclusion of the 'in brief' practice point inserted at the head of the article stating that 'The dental profession should consider hydrogen peroxide more often in clinical use'. I do not believe the current article states or supports this point, or even that it set out to do so.

H. Beckett , Waterlooville

1. S.I. 2008 1284.
2. [2001] UKHL 32.
3. Council Directive 76/768/EEC, as amended by 93/35/EEC.
4. Scientific Committee on Consumer Products. *Opinion on Hydrogen peroxide, in its free form or when released, in oral hygiene products and tooth whitening products.* SCCP/1129/07.

DOI: 10.1038/sj.bdj.2010.298

DIFFERING GUIDELINES

Sir, I enjoyed reading the paper *Antibiotic prophylaxis in oral health care – the agreement between Swedish recommendations and evidence* (*BDJ* 2010; **208:** E5). It is a good illustration that guidelines concerning this issue have not always been recently reviewed in all countries, and are not the same throughout the world. It serves as a reminder to dental practitioners moving to new jurisdictions outside of the United Kingdom that they need to be aware of local guidelines which may be different to those they have used here. In the United States of America, interpretation of the same evidence as that considered by NICE has resulted in slightly different guidelines as to the need for antibiotics prophylaxis.[1] The American Heart Association guidelines are influential throughout the world and whilst many countries are now producing less interventional guidelines than previously, many still recommend antibiotic prophylaxis in limited indications, especially where the underlying cardiac condition is associated with the highest risk of adverse outcome from infective endocarditis.[2,3]

M. Pemberton, Manchester

1. Wilson W, Taubert K A, Gewitz M *et al.* Prevention of infective endocarditis: guidelines from the American Heart Association. *J Am Dent Assoc* 2007; **138:** 739-760.
2. Daly C G, Currie B J, Jeyasingham M S *et al.* A change of heart: the new infective endocarditis prophylaxis guidelines. *Aust Dent J* 2008; **53:** 196-200.
3. Delahaye F, Harbaoui B, Cart-Regal V *et al.* Recommendations on prophylaxis for infective endocarditis: Dramatic changes over the past seven years. *Arch Cardiovasc Dis* 2009; **102:** 233-245.

DOI: 10.1038/sj.bdj.2010.299

OIL IN CHEEK

Sir, I was fascinated to read the recent letters in the *BDJ* regarding 'oil pulling' - the process of using cooking oil as a mouthwash, its efficacy apparently proved by the way the oil takes on a milky colour after a few minutes of vigorous swishing. However, it has occurred to me that we are already familiar with a similar process used for many years albeit on an industrial scale rather than intra-orally. We substitute the oil with milk, the process is called churning, and the net result is butter. Just to clarify (pun intended), according to Wikipedia the change of colour is due to the transforming of a fat-in-water emulsion (milk) to a water-in-fat emulsion (butter) rather than any magical healing properties. As regards the research that was reported in one of the letters, the oil was only compared with water, so it could well be that other viscous liquids may give a similar improvement - may I suggest jelly and ice cream as a possibility for further research? (sugar free of course).

R. Nute, Swansea

DOI: 10.1038/sj.bdj.2010.300

INTUBATION LITIGATION

Sir, I was recently asked to see a patient by one of our anaesthetic colleagues. The patient was coming round from a general anaesthetic when the anaesthetist noticed some bleeding around the gingival margin of tooth 11 and was concerned by this appearance.

When I examined the patient that afternoon there was evident periodontal disease with 11 exhibiting grade III mobility. The patient also mentioned that the tooth in question had been sore since he woke up from the general anaesthetic.

Obviously, it was difficult to ascertain if the mobility was caused by the anaesthetist when extubating or whether the mobility was prevalent pre-operatively due to periodontal breakdown.

Recently, I read a statement by the MDU that mentioned over half the claims against anaesthetists were dental damage mainly caused by a laryngoscope. The risks are greater on a tooth with poor prognosis and these should be identified at the anaesthetic assessment and be part of the consenting procedure. The statement went on to mention that damage could occur not solely from difficult intubation but from patients biting onto the endo-tracheal tube or similar devices.

I wonder whether increased training for our medical counterparts is required or an increased awareness for such issues to reduce the litigations in this field.

Z. Esmail, Newcastle

DOI: 10.1038/sj.bdj.2010.301

SECOND DEGREES

Sir, firstly we would like to compliment Pepper and Tabiat-Pour on publishing such a useful paper.[1] We would like to point out a few omissions plus some additional sources of information to your readers.

In their first paragraph they say that whilst many books have been written on applying to medical school, none address the unique position of the dental graduate. Our *Handbook for trainees in oral and maxillofacial surgery* published in 1994 and the subsequent annual updates in 1995-1999 did cover this exact ground. We sent a book to every unit in the UK, plus most postgraduate libraries bought one. From 2000 onwards, the updates were published on the British Association of Oral and Maxillofacial Surgeons (BAOMS) website www.baoms.org.uk. Nabeela Ahmed wrote a similar document in 2002 for the British Association of Oral Medicine (which is also available on the BAOMS website).