

longer suits the clinical situation. The British Dental Formulary reflects this in the small number of medicines available for dental prescription. The NHS Act does not set any limitations upon the number and variety of substances which the dental surgeon may administer to patients in the surgery or may order by private prescription (BNF 2010; 60: 6).

Homeopathic medicines are a valuable tool in the practitioner tool kit. They are not a cure all and should never be described as such. However, this therapeutic approach may be adopted when everything else has been addressed and found wanting. Very often a homeopathic prescription will assist the healing process when other interventions have not. A distinct though limited body of clinical research evidence supports the effectiveness of classical individualised homeopathy over and above placebo.¹ There is a larger research evidence base to support the use of homotoxicological medicines as used in the EU, ie 106 studies relating to controlled human clinical trials, which have demonstrated that homeopathic medicines are superior to placebo.²

Homeopathically trained dentists are no different from any other kind of dentists – they are dentists in the first instance, homeopaths in the second. Homeopathic dental training in the UK is provided by the Faculty of Homeopathy with teaching centres at Glasgow, London and Bristol. A five year modular postgraduate course is available for those dentists wishing to extend their pharmaceutical knowledge.

Perhaps if Mr Shaw (an ethics lecturer not a practising dentist) would like to discuss with us the finer points of the appropriate uses of homeopathic medicine within dentistry, we would like to suggest he does this in person.

S. Farrer
By email

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SEEK TO UNDERSTAND

Sir, the Society of Homeopaths would like to point out a number of inaccuracies in D. Shaw's opinion article *Unethical*

aspects of homeopathic dentistry (BDJ 2010; 209: 493–496).

Most importantly, the article wrongly states that the Society registers dentists. D. Shaw quotes widely from the Society's website, saying that the Society offers no specific information about dentistry which is 'unsurprising as it exists only to register dentists and provide a Code'. In actual fact, although the Society's register of professional homeopaths includes practitioners with backgrounds in law, banking, nursing, science, the armed forces and journalism, it is unsurprising that the website has no information on dentistry in as much as it does not register dentists.

This is only one example of a shocking lack of research on the part of D. Shaw, despite his own sweeping dismissal as flawed 'in one way or another' of all of the research evidence which suggests homeopathic medicine works over and above that of placebo.

The article fails to mention that by the end of 2009, 142 randomised controlled trials comparing homeopathy with placebo or conventional treatment had been published in peer-reviewed journals. In terms of statistically significant results, 74 of these trials were able to draw firm conclusions: 63 were positive for homeopathy and 11 were negative.¹

D. Shaw further fails to mention that 75% of *in vitro* experiments have found that substances as dilute as homeopathic medicines have specific effects.² For example, homeopathically-prepared thyroxine can slow down metamorphosis of tadpoles into frogs.³ These results were replicated by five separate laboratories in Austria and confirmed by the results of similar experiments carried out by an independent team in Brazil.⁴ The homeopathic thyroxine used was so highly diluted that you would not expect any molecules to be present. While more high quality research would be welcomed, it is simply untrue to say that there is no scientific evidence to support the efficacy of homeopathic medicine.

The Society is also concerned that D. Shaw makes serious allegations about practitioners of homeopathy. Firstly, he suggests that 'a routine feature of homeopaths marketing practices is to denigrate mainstream medicine'. He provides no evidence of this apart from the quote

of Ben Goldacre, an anti-homeopathy campaigner.

Further, he states that homeopaths are unethical as, for there to be any benefit to homeopathy, patients must be 'deceived'. As already mentioned, there is a growing body of evidence showing the effectiveness of homeopathic medicine, including clinical outcome studies, the largest of which took place at the Bristol Homeopathic Hospital with 6,500 consecutive patients. In this study, carried out over a six-year period, 70% of patients reported an improvement in their health.⁵

Despite the article's claim that it is seeking to provide a summary of the science of homeopathy, it does no such thing. While it is true to say that scientists cannot yet explain the precise mechanism of action of homeopathic remedies, D. Shaw merely jumps on a bandwagon of dismissing homeopathy out of hand. There are many things that science cannot yet explain – surely it is the job of scientists to seek to understand the mysterious, rather than trample it underfoot.

Z. Dymitr

Chairwoman, Society of Homeopaths

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LEARNING LESSONS

Sir, we congratulate Davies and Bridgman (*Br Dent J* 2011; 210: 59–61) for expressing so clearly that the traditional model of (oral) health education for children lacks evidence. Knowledge alone does not lead to significant behaviour change in adults, adolescents or children. However, this outdated and simplistic model of health education is still the basis for many oral health promotion activities worldwide, including many of

those undertaken by national professional organisations, non-governmental organisations and the dental industry. We could not agree more with their conclusion, that 'education alone is a great way to increase health inequalities'.

It is encouraging to learn that in the UK there is a steady realisation of the need to go beyond the concept of just educating children to keep their teeth healthy. The move to more effective and evidence-based approaches such as skills-based learning using a settings-approach, as well as the effective use of fluoride through supervised tooth brushing with a 1,450 ppm-fluoride toothpaste in nursery classes, child centres and other venues, as is the case for the Manchester initiative, is a timely development that needs widespread public support.

While the Manchester initiative works within a well-developed (oral) health care system, the situation on a global level, and particularly in low- and middle-income countries, is very different. Almost all dental decay remains untreated and creates a largely ignored public health problem affecting children in particular.^{1,2} Weak health systems offering unaffordable or no oral care at all for the masses require a dramatic change in professional thinking and political priorities. The WHO and the world's leading oral health organisations recommend jointly that 'exposure to appropriate fluoride, in particular through fluoride toothpaste, will improve quality of life and enhance the achievement of the Millennium Development Goals by reducing the high dental disease burden of entire populations, especially children'.³

In an unprecedented move, the World Bank, the WHO and the United Nations have chosen an innovative school health programme in the Philippines, the 'Fit for School Programme' as best-practice model for innovation in global health.⁴ This horizontal programme consists of simple, evidence-based high impact interventions that integrate daily supervised tooth brushing with an adult-strength fluoride toothpaste with other health interventions such as daily supervised hand washing with soap to prevent gastrointestinal and respiratory diseases. The programme is the national school health flagship programme of the Ministry of

Education and currently covers over 1.5 million children in elementary schools and day-care centres.

While the Manchester initiative is to be highly commended, it might be considered to integrate more general health promoting habits as regular habits within the school setting. Many interventions in school health have good evidence for improving health and education performance,⁵ such as hand washing with soap,^{6,7} physical activity to tackle obesity,⁸ or tobacco use prevention.⁹ For many years the dental profession has been advocating the integration of oral health within general health. The improvement of child health through evidence-based health promotion in a school health programme is an ideal opportunity to make this a reality. More information on the FIT for School programme can be found at: <http://www.fitforschool.ph/>

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BEWARE THE MENTAL FORAMEN

Sir, I read recently with interest the

article by Renton *et al.*¹ regarding trigeminal nerve injuries secondary to mandibular local anaesthesia. Although I found this article interesting I was disappointed that the authors failed to mention damage that potentially can and, in reality, does occur at the site of injection for the mental nerve blockade. Many dental surgeons use mental nerve blocks, including myself, for provision of more limited anaesthesia when working on the lower incisors. Often patients require bilateral mental nerve blockade for scaling of this region to reduce the sensitivity whilst performing this minor but nonetheless uncomfortable task. Recently, I had a rather agitated patient come in to my practice complaining of numbness of several days in the region of distribution of the mental nerve after having had the area anaesthetised. It occurred to me that the mental nerve may have been damaged exiting its foramen by perhaps direct impingement by the needle tip in an attempt to deliver the anaesthetic as close to, or even within, the mental foramen itself by overzealous technique. This had resulted in a nerve compression injury. I reassured the patient that any nerve damage arising in this fashion hopefully ought to resolve itself in a few more days. The importance of careful study of the anatomy of the mental foramen has come into focus these days due to the more frequent use of dental implants in that region of the mouth.² It is useful to note this as mental nerve compression injuries may take up to several months for normal sensation to return.³ Therefore, it ought to be cautioned that, as in the case indicated above coming to my practice, mental nerve injuries can occur even with routine infiltration technique in the area. Particular and careful technique is required to avoid this unpleasant occurrence.

J. Loudon

Sydney

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