Letters to the Editor

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

COLLATION OF DATA

Sir, I have recently been listening to Professor Steele talking about the impending changes in the NHS regulations. In the midst of a fascinating presentation he seemed to suggest that a requirement of the various pilot schemes about to start is to be the use of one of three computerised practice management programs. Each of these preferred suppliers would then enable the collection and collation of data relating to treatment provided.

What data are these? Whose data are these? Who should be collecting it? Who should be publishing the results and in what form? Does the data set include information about work carried out outside the NHS? If so, by what right would confidential information about patients not involved in an NHS contract be collected on the Department's behalf? Are the data being anonymised, or will the longevity of my MOD amalgams be compared against those of my colleagues down the road? Will that data be published in a league table similar to those into which schools and hospitals are struggling largely in vain to inject some common sense? As we are now recording details of materials and batch numbers, will that data be available to commercial organisations or to independent researchers? There is a huge value there which could be used to the benefit of our patients. Are the data only to be available to the Department of Health and their, let us say, creative statisticians, or will other more objective bodies have equal and, importantly, simultaneous access?

The collection of the data itself is a sensible activity. I cannot for the life of me think why the software companies have not made it easily available to us for years; it is not rocket science. The ownership of the data, its distribution, and the form and timing of that distribution, is a question which I think we, as a profession, should clarify now, whilst we have an opportunity to make a difference to the answer.

S. R. M. Todd
Sussex

Editor-in-Chief's note: The situation as the BDA understands it is that the Department of Health, via the Dental Services Division, is collecting a range of information from the pilots including tooth level data. This is for the purposes of learning from the pilots. Without doubt any new national NHS contract, if based on capitation and a quality framework, will need to collect information. Like all NHS information it will be accessible via Freedom of Information and may also be reported by the NHS. It is too early to say exactly what will be required but it is highly likely that to provide NHS care practices will need to hold clinical information electronically.

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A MEASURED RESPONSE

Sir, I was intrigued to read the case report from Ghafoor *et al.*[1] regarding an apparent reaction to retained amalgam following extraction which led the authors to make certain recommendations for dentists.

The letter describes a unique case where a large area of bone loss was attributed to an intra-osseous foreign body reaction as a result of amalgam displaced into an extraction socket some months previously. These statements left me with a number of questions as to the histology of the lesion, the reason for the earlier extraction and whether the history had been explored in sufficient detail as to exclude the presence of the pathology prior to the extraction.

Whatever the aetiology this is clearly a very rare condition and far more rare I suspect than the inadvertent retention of dental materials or tooth fragments following extractions. Whilst it makes perfect sense to retrieve any retained materials lost into an extraction socket I would question the appropriateness of referral as the authors advise. A more measured and cost-effective response would be to advise the patient of what has happened and to monitor healing of the socket, with periodic X-rays where they can be justified.

G. Scott
Huddersfield

1. Ghafoor M, Halsnad M, Grew N. Restoration fragments. *Br Dent J* 2011; **210:** 558-559.

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CARDIAC FREQUENCY

Sir, in a recent edition of the *BDJ*, Dr Manek attempted to calculate the likely frequency of a dental practitioner being involved in the management of a cardiac arrest (*AED value; BDJ* 2011; **210:** 501). His calculation resulted in an estimate of once in 4,000 years. An alternative approach to calculating this figure can be found by studying the results of a very large survey of emergency medical events reported by UK general dental practitioners.[1] In this survey of 1,500 general dental practitioners (1,000 in England and Wales, 500 in Scotland, 74% response), a cardiac arrest was reported to have a risk of occurring of 0.13 per 40 years of practice in England and Wales and