

On placing it on a table a seagull (*Larus argentatus*) promptly swooped down, stole it and flew off!

From a height of 100 feet a lower denture may very well resemble a large prawn or crayfish, an irresistible treat to the avian eye, especially for a hungry seagull. These birds have featured many times in the media, having earned a reputation for increasingly aggressive behaviour to people. (*Postal deliveries in Devon disrupted by seagull attacks; BBC News 23 June 2010; When seagulls attack; Daily Echo 1 February 2009; The birds* by Hitchcock *et al.* 1963). I have encountered patients who have had dentures eaten by dogs on several occasions over the years but this has been a new experience for both of us.

I strongly suggest that on fitting a new denture after giving our patients the usual advice on denture maintenance and hygiene we must warn them never to remove them at the seaside.

R. A. Raeburn

By email

DOI: 10.1038/sj.bdj.2011.631

PEACE OF MIND

Sir, I write in response to the letter of P. Manek (*AED value; BDJ 2011; 210: 501*) on the value of AEDs in the practice setting. In the five-yearly CPD cycle, the GDC¹ recommend at least ten hours of medical emergency training which serves to highlight the importance of managing medical emergencies within the dental setting.

Although this letter suggests only a very small chance of a cardiac arrest occurring in the dental surgery, the benefit of having an AED readily available leads to a certain 'peace of mind' for the dentist, the staff and patients alike should the unlikely occur. Indeed many patients feel reassured if an AED is on display as this indicates a practice that is well equipped and prepared. In addition it is an expectation of the public that AEDs are available in all healthcare environments.²

Whilst the quality and complexity of AEDs vary with price, machines are available from as little as £599 plus VAT with a seven-year warranty.

Consideration should also be given to the fact that most practices contain

more than one dentist; it may be the relative, parent, a member of staff or a passerby who may arrest, which when taken into the equation alter the statistics significantly.

Add in the fear and anxiety exhibited by many patients combined with an element of pain and the odds of a cardiac arrest occurring increase further.

It is indeed correct that the majority of out of hospital cardiac arrests (OHCAs) are shockable but due to the lack of immediate ECG evidence the figures are not accurate. The Resuscitation Council³ suggests that the proportion of OHCAs is around 60% and each minute's delay before shock delivery results in a decreased successful outcome of 10–12%. The overall survival to hospital discharge from a VF/VT (ventricular fibrillation/pulseless ventricular tachycardia) arrest is 21.2%.³ With these statistics in mind and with consideration to ambulance arrival times varying, it would seem prudent to re-evaluate 'cost' implications of these life-saving machines.

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1. General Dental Council. CPD for dentists. Available at: www.gdc-uk.org/Dentalprofessionals/CPD/Pages/CPD-for-dentists.aspx
2. The Resuscitation Council (UK). *Medical emergencies and resuscitation. Standards for clinical practice and training for dental practitioners and dental care professionals in general dental practice.* pp 12–13. London: The Resuscitation Council, 2006.
3. The Resuscitation Council (UK). *Advanced life support.* 6th ed. p 1. London: The Resuscitation Council, 2011.

DOI: 10.1038/sj.bdj.2011.632

MISSES THE POINT

Sir, P. Manek's letter (*AED value; BDJ 2011; 210: 501*) makes interesting reading and his points concerning good quality CPR training and prevention programmes are well made. I would, however, question his reasoning with reference to dentists having AEDs in their practices. While his estimation of the likelihood of use of an AED in his practice is interesting and apparently sound it rather misses the point. We should not consider each individual dental practice in isolation. If defibrillators are widely available in medical and dental surgeries, health centres, chemists etc and in non-health based locations such as stations, car parks,

shopping centres and the like, should any one of us suffer sudden cardiac arrest the likelihood that a defibrillator is readily available allowing rapid defibrillation is greatly increased. Statistically there is something like a 10% reduction in the chances of successful defibrillation for every minute of delay following the arrest.

As healthcare providers and responsible members of the community we should see the deployment of an AED in our dental practice as a measure not just for our patients but as a resource for our local community. Members of the public (not just our own patients) should be able to rely upon any healthcare premises having an AED available in the event that it is needed. It will still be true that most AEDs will never be used other than in training. Looking at it from a different point of view, however, the more AEDs that are deployed the greater will be the chances of early defibrillation being implemented in a cardiac arrest.

I would draw your readers' attention to the Automatic External Defibrillators for Dentist Practices in Walsall – see <http://www.walsall.nhs.uk/communications/news/dentistsdefib.asp>.

R. S. Moore

By email

DOI: 10.1038/sj.bdj.2011.633

INCREASINGLY DIVERGENT

Sir, Tabiat-Pour and colleagues' recent article provides a very useful overview of *Education, regulation, representation and remuneration in dentistry* (*BDJ 2011; 210: 431–438*). However, they've missed several important differences between Wales and England. To highlight a few, the Care Quality Commission's remit stops at Offa's Dyke – as does Monitor's. In Wales the healthcare regulator is Healthcare Inspectorate Wales (HIW), and we have retained Community Health Councils. The system in Wales is increasingly divergent from that in England and the other home countries – we keep a warm 'welcome in the hillside' to readers who'd like to visit us!

Diolch yn fawr.

L. Howells

By email

DOI: 10.1038/sj.bdj.2011.634