

mentioned) and more recent articles. Many evidence-based reviews on topics of interest to practitioners (and patients) are available at the Cochrane Oral Health Group Reviews (www.ohg.cochrane.org/reviews.html) – as was mentioned in Newsome P, Smales R, Yip K. Oral diagnosis and treatment planning; part 1. Introduction. *Br Dent J* 2012; 213: 15–19. We hope that such evidence-based reviews will also assist practitioners to move out of the dark!

More specifically, various articles have explored associations between the frequency of patients' attendances and the dental treatments received. Several studies have found that regular attendees have more restorations (mostly replacement restorations) placed because of disease experience and unsatisfactory restorations than do irregular attendees.^{1–3} The average number of restorations placed also increased significantly with a change in dentist.² The lowest survival of restorations was strongly and directly related to the shortest median frequency of attendances, due possibly to the higher occurrence of dental problems in the most frequent attendees.⁴ A three-year study of dentate adults aged less than 35 years at baseline also found that similar percentages of 'dentally successful' people (56%) expected to retain teeth beyond the age of 65, and of 'dentally unsuccessful' people (57%) expected to lose all teeth by the age of 45, had sought General Dental Service care.⁵ And, one other clinical study involving 677 children who attended 50 general dental practitioners on a regular basis reported that similar percentages of deciduous molars having either unrestored caries (18.8%) or a history of restorative care (17.0%) were extracted because of pain or sepsis.⁶ An Australian dental hospital study of 301 adults found that, although 62% claimed to have seen a dentist during the past 12 months, overall 86% attended because of a dental problem – usually toothache, broken teeth and lost fillings and denture problems.⁷ Another Australian private general practitioners' study of 497 adults found that although 64% had attended during the prior 12-month period, overall 54% were now attending because of dental problems.⁸ All of these studies indicate that receiving regular restora-

tive care does not necessarily result in fewer dental problems and, in the latter two clinical studies, the patients also required more periodontal and restorative treatments than just for their immediate dental problems. The reasons for this situation are largely conjectural, such as regular attendees (who retain more teeth) receive more restorations and complex restorative treatments⁹ and, therefore, are also more likely to have increased dental maintenance problems. Finally, most of the statements and supporting references relevant to the mentioned first paragraph on page 112 of Part 5 are contained in additional articles by Elderton.^{10–12}

1. Nuttall N M. General Dental Service treatment received by frequent and infrequent dental attendees in Scotland. *Br Dent J* 1984; 156: 363–366.
2. Elderton R J, Nuttall N M, Eddie S, Davies J A. Dental health services research in Scotland: a review of some 5-year results. *Community Dent Oral Epidemiol* 1985; 13: 249–252.
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4. Burke F J T, Lucarotti P S K, Holder R L. Outcome of direct restorations placed within the general dental services in England and Wales (Part 2): variation by patients' characteristics. *J Dent* 2005; 33: 817–826.
5. Nuttall N M. Characteristics of dentally successful and dentally unsuccessful adults. *Community Dent Oral Epidemiol* 1984; 12: 208–212.
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8. Mount G, Walker B, Roder D. The dental health and treatment needs of middle-aged and older patients attending 21 general dental practitioners in South Australia. *Aust Dent J* 1987; 32: 166–170.
9. Mount G, Walker B, Roder D. Professionally defined dental treatment needs of middle-aged and older patients attending 21 general practitioners, as related to tooth retention. *Aust Dent J* 1988; 33: 129–132.
10. Elderton R J. Implications of recent dental health services research on the future of operative dentistry. *J Pub Health Dent* 1985; 45: 101–105.
11. Elderton R J. Clinical studies concerning re-restoration of teeth. *Adv Dent Res* 1990; 4: 4–9.
12. Elderton R J. Preventive (evidence-based) approach to quality general dental care. *Med Princ Pract* 2003; 12(Suppl 1): 12–21.

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AUTOINJECTOR OR VIAL?

Sir, we are medical emergency trainers and it has come to our attention that some practices undergoing CQC inspections in the North of England are receiving confusing information regarding adrenaline preparations that they should have in their medical emergency kits. Some practices have been advised that they should have vials of adrenaline rather than adrenaline in the form of an autoinjector preparation which is

presumably due to that fact that some autoinjector preparations are only available in 300 micrograms (0.3 mL adrenaline injection 1:1000). The Resuscitation Council (UK) states that for a severe life-threatening anaphylactic reaction in an adult, 500 (micrograms (0.5 mL adrenaline injection 1:1000) should be administered into the anterolateral thigh.¹ Appendix (ii),¹ however, suggests that an autoinjector preparation delivering a dose of 300 micrograms ... is an acceptable alternative if immediately available.¹ Those practices that have autoinjector preparations of adrenaline are therefore compliant with national guidelines. As medical emergency events are rare, we suggest that it is easier for dental practitioners to deliver adrenaline via an autoinjector rather than to use adrenaline from a vial.

K. H. Taylor
By email

1. Resuscitation Council (UK). *Medical emergencies and resuscitation: standards for clinical practice and training for dental practitioners and dental care professionals in general dental practice. A statement from The Resuscitation Council (UK)*. July 2006, revised February 2012. Available at: <http://www.resus.org.uk/pages/MEdental.pdf>.

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REAL WORLD EVIDENCE

Sir, this week CQC have commenced another consultation regarding fees for dental practices.

We recently had a visit by two members of the CQC to our LDC meeting. They stressed that CQC was not a 'tick box exercise' but outcome based. When asked about the outcome of CRB checks in dentistry they said that one person had been prevented from working since CRB checks had been instigated.

There were 22,920 dentists working in the NHS in 2011–2012 (www.ic.nhs.uk). Assuming they all work with a nurse and add on approximately 10,000 receptionists this equals 55,840 people requiring CRB checks. The cost is £44 for the CRB plus £20.83 to the post office to process the application. This is therefore at a total cost of £3.6 million in round figures. This doesn't include the cost of my CQC registration to pay for someone to check I have a CRB, or the cost of the time involved in getting it. When asked, the CQC representative said in reply, 'even if it prevents one

person from abuse it is worth it'.

I work in a catchment area for deprived families and patients say, 'You've got to sort out this pain; I can't sleep or eat and I am taking it out on my partner/kids'. Evidence shows that the majority of abuse is carried out by family members. Preventing abuse by removing people from severe pain is the sort of real world evidence-based outcome our practice aims for and wants to spend money on.

In a system which has no additional funding for regulation, the cost of CRB checks is taken directly from patient care. If you are considering outcomes, surely the idealistic view of preventing one person from possibly reoffending at a cost of £3.6 million should be balanced against the benefit of treating 48,000 patients (cost £75/patient x 48,000 = £3.6 million) for dental pain. This has a much better evidence base for reducing abuse within the family and there are considerable spin offs such as fewer hospital admissions for acute care as well!

CRBs are just one small example of this lack of outcome-based thinking; space here limits us from looking at the others. I don't see much evidence for CQC analysing either their original justification or their own outcomes; just reducing dental care by diverting treatment funding. Is this really a good use and how much should we pay them?

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SECONDARY CARE BURDEN

Sir, we are writing with concern regarding the continued increase in the number of odontogenic abscesses presenting to secondary care.

Local and national audits have shown a marked increase in patients presenting to secondary care with odontogenic infection since 1999.^{1,2}

Patient admissions for odontogenic abscesses at Leeds General Infirmary have continued to increase in number since 2006; the number of admissions has increased four fold from 48 in 2006 to 198 in 2011 (Fig. 1).

The distribution of those presenting with odontogenic abscesses pre and post the introduction of the 2006 NHS dental contract is statistically significant,

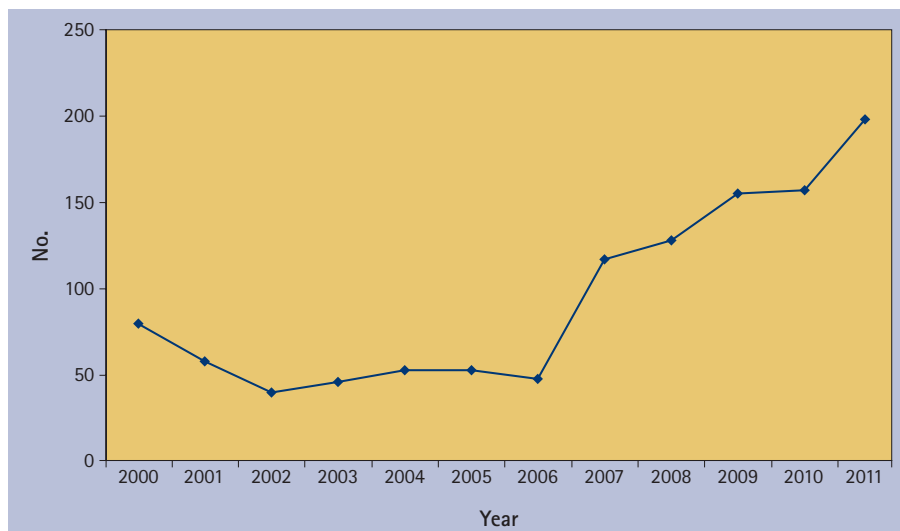


Fig. 1 Odontogenic abscess admissions over time

$\chi^2 = 85.86$, $df = 5$, $p < 0.0001$, with this trend continuing to rise.

This rise will only result in more pressure on the already stretched secondary care system, with an increasing workload for Accident and Emergency departments and on emergency theatre facilities.¹

Explanations for the continuing increase in admissions are varied and complex. Further work is clearly required to identify the main reasons but difficulty of access to NHS or emergency dental care is still widely described. Reduction in initial operative intervention for dental abscesses in primary dental care is also implicated. These issues are potentially due to changes in remuneration upon introduction of the new contract in 2006 causing a reduction in the amount of NHS treatment carried out by GPs.³

In this time of austerity and reduction in hospital bed numbers, the avoidable increase in admissions for odontogenic abscesses is causing an ever-increasing demand on already limited resources. This trend shows the importance of enhanced communication between the primary and secondary care settings, and an increase in emergency funding for our GDP colleagues to reduce the burden on secondary care.

S. King, A. Kanatas, L. M. Carter
Leeds

1. Carter L, Starr D. Alarming increase in dental sepsis. *Br Dent J* 2006; **200**: 243.
2. Thomas S J, Atkinson C, Revington P. Is there an epidemic of admissions for surgical treatment of dental abscesses in the UK? *BMJ* 2008; **336**: 1219–1220.
3. Carter L M, Layton S. Cervicofacial infection of dental origin presenting to maxillofacial surgery

units in the United Kingdom: a national audit. *Br Dent J* 2009; **206**: 73–78.

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CATASTROPHIC INJURIES

Sir, the publication *Oral Health Report* which arrived with our *BDJ* today, although of useful content, was disappointing in its choice of an inappropriate cover photograph used to illustrate a 'typical' dental team. The picture shows a dentist and close support nurse with turbine in full flow, working on a highly vulnerable, supine patient, but without protective eyewear being worn.

Every training programme for dentists, therapists, hygienists and nurses instils the essential and mandatory nature of eye protection. As educators frequently teaching the whole dental team at all levels, of this we are sure. Catastrophic injuries may easily occur to the patient and/or dentist and nurse, and do, resulting in irreversible ocular damage.

Perhaps the journal should be a tad more careful to cast an eye (pun intended) over such literature distributed within its umbrella.

K. Marshall, K. Marshall
By email

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