3. Müller M P, Hänsel M, Stehr S N, Weber S, Koch T. A state-wide survey of medical emergency management in dental practices: incidence of emergencies and training experience. *Emerg Med J* 2008; **25:** 296-300.

DOI: 10.1038/sj.bdj.2012.271

BLOW AWAY THE INERTIA

Sir, in the early 1980s as a dental undergraduate I was taught the huge benefits of water fluoridation. It was, and remains a central plank of teaching on the prevention of dental caries. So why after nearly 30 years has nothing really happened?

As a practitioner working in a city centre practice for almost 30 years I understand the benefits of establishing a preventive philosophy in my practice. I see the results daily of a long campaign on diet and oral hygiene in terms of reduced caries rates and healthier dentitions. I am fully aware though that all of this work would be massively supported and massively dwarfed in impact by the introduction of fluoridation in my area. So why are we still waiting?

Late last year I decided that the time was right to try and blow away the inertia surrounding fluoridation and try to raise the profile of this public dental health measure. The e-petition can be accessed at: http://epetitions.direct.gov.uk/petitions/18219 (Fig. 1).

Fig. 1 Scan this QR code with your smartphone to go directly to the e-petition

The strategy is to gain some serious momentum for fluoridation amongst the dental profession and then to begin looking at how we can engage patients and local stakeholders in order that when a local consultative process on fluoridation is commenced in our individual areas we have a strong local support that can lobby effectively. For too long fluoridation has been derailed by poor communication, misleading information and myth.

The purpose of the petition is simply to demonstrate support. Debates on targeted use can begin later. Let's face it, if the profession cannot endorse fluoridation - how can we expect the public to support it? This is an opportunity to break out of this state of mind and finally work towards establishing fluoridation nationwide. Are we up to the challenge? I hope so. We owe it to future generations to move this forward. If not, why waste time teaching it?

S. Hearnshaw
Chairman Hull and
East Riding Of Yorkshire LDC

DOI: 10.1038/sj.bdj.2012.272

UNRECOGNISABLE WORLD

Sir, in over 40 years as a dentist I have never felt the urge to respond to a letter from a colleague printed in the *BDJ*. That is until reading the letter by P. Mc Crory (*BDJ* 2012; **212:** 103) on antibiotic prescribing in primary care.

Dr Mc Crory suggests that before dentists in a primary care setting prescribe antibiotics to a patient they should first telephone an appointed service specialist to discuss the case and, if both clinicians agree, a code to validate the signature on the prescription would be issued by the support service. If mutual agreement could not be reached then a third clinician's opinion would be sought. All this to take place when one is confronted with a patient with pericoronitis who has been fitted in between a ten o'clock extraction and a ten fifteen filling appointment.

Of course if this were to apply to GDPs, it would have to apply to GPs as well or dentists would be seen as being insufficiently qualified to prescribe without prior permission.

I don't know what world Dr Mc Crory lives in but it's not one I recognise.

M. Wilson, Esher

DOI: 10.1038/sj.bdj.2012.273

INTERPRETATION CONSIDERATION

Sir, I write in response to the paper by S. Critchlow and L. Nanayakkara, *A guide to entry into specialist training* (*BDJ* 2012: **212:** 35-40).

Being a recent graduate currently going through an era of endless application forms, this paper plays particular relevance to myself. Firstly, I would like to acknowledge the authors for the invaluable information provided within this paper, after all every little helps from those that have been through this challenging process. However, I have noted a mistake. The Diploma of Membership of the Faculty Dental Surgery (MFDS) offered by the Royal College of Surgeons of Edinburgh can in fact be awarded after 12 months of postgraduate clinical dental experience, not 24 months. These regulations were adjusted in September 2010.[1] Evidence of 12 months' clinical dentistry experience is a requirement for the MFDS part 2 examinations, meaning that if one passes this exam, they can then at that time be elected and awarded the diploma, and do not require two years' clinical experience.

Furthermore, I would like to question how 'desirable' it is to actually have a prize? The selection panel should be mindful that some dental schools give out prizes like free pens at trade fairs. A prize at school A may be significantly harder to achieve than at school B, so the interpretation of having a prize must be taken with careful consideration.

A. Maqbool
By email

1. The Royal College of Surgeons of Edinburgh. Dental Surgery Examination Regulations. http://www.rcsed.ac.uk/site/698/default.aspx

DOI: 10.1038/sj.bdj.2012.274

URGENT ATTENTION AND TREATMENT

Sir, a long-standing patient of our practice, a 77-year-old Afro-Caribbean male who suffered from type II diabetes and hypertension, was undergoing a composite filling, when a slow but progressive swelling started developing around the lips, tongue and buccal mucosa (Fig. 1).

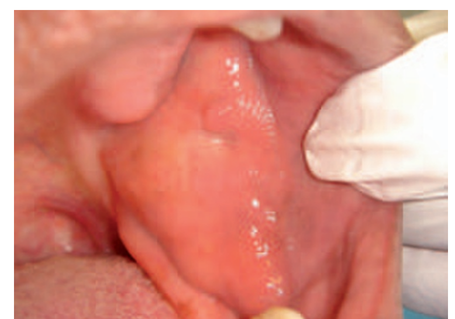

Fig. 1 Swelling developing around the lips, tongue and buccal mucosa

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All treatment was immediately stopped, extra assistance was called and the emergency trolley was deployed. The patient was continually monitored and reassured. We administered chlorpheniramine 20 mg and closely monitored him. The medical history was rechecked and he reported no known allergies or history of any other similar swellings. The medication list comprised of Metformin, Amlodipine, Atenolol, Ramipril and Allopurinol. Apart from this the medical history was unremarkable.

The patient was taken to A&E where he was kept on corticosteroids for a further two hours as the swelling started to subside. He was diagnosed as having angiodema secondary to ACE inhibitors. A report was immediately sent back to his general medical practitioner, asking them to change his ACE inhibitor medication. Following on from this there have been no further swellings.

Angiodema secondary to ACE inhibitors is a serious complication and some deaths have even been reported. This type of angiodema is becoming increasingly common for two reasons. The first being that ACE inhibitors are incredibly successful in the treatment of hypertension and congestive heart failure, and secondly due to the rise of life expectancy in Western societies, which has led to more patients with hypertension and congestive heart failure that have been prescribed these drugs. The swelling can be severe and therefore these drugs must always be considered in the medical history, as well as when investigating swellings around the lips, mouth and tongue as quite often they can mimic anaphylaxis type reactions or food allergies.

The angiotensin converting enzyme metabolises bradykinin, a potent vasodilating substance and converts angiotensin I to angiotensin II. Angiotensin II causes vasoconstriction and increases smooth muscle hypertrophy, both of which can lead to an increase in blood pressure. The ACE inhibitor therefore prevents conversion of angiotensin I to angiotensin II thereby lowering arteriolar resistance and increasing venous capacity. This causes extravasation of fluid into the subcutaneous tissues, which produces angiodema. For an unknown reason people of Afro-Caribbean origin are more at risk.

The acute management in these cases involves securing the patency of the upper airway. The next step, depending on the severity, can be the use of medications such as antihistamines, corticosteroids and if needed, adrenaline. In the secondary care setting intubation and surgical intervention may also be required in extreme cases. Long-term management includes changing medication.

Angiodema of the head and neck is potentially a life threatening condition that could quite easily present to the general dental practitioner and needs urgent attention and treatment.

P. Raval
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DOI: 10.1038/sj.bdj.2012.275

THIRD MOLAR VISION

Sir, as a dentally qualified maxillofacial SHO I was somewhat bemused when a patient calmly asked if I could reassure her about something. 'My mum has told me when your wisdom teeth are pulled out your eyes can get pulled back permanently because of all the blood vessels and nerves being connected, is this true?' Racking my brains of my first year anatomy I felt confident to reassure the patient to the contrary. I wonder if this is a common concern or an urban rumour?

R. Carr
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DOI: 10.1038/sj.bdj.2012.276

WAGGING TONGUES

Sir, your correspondents S. Surendran, E. Thomas and S. Asokan describe a hypermobile tongue in a young patient (*BDJ* 2012; **212:** 55-56).

In a paper that I wrote 42 years ago in your esteemed journal, I described the same phenomenon which I had thought at the time was rare and remarkable (Becker A. Acquired extraordinary movements of a normal tongue. *Br Dent J* 1970; **128:** 396-397). The article generated some lively responses to the editor and a similar case was presented in a lecture given by Prof. William Proffit of the University of North Carolina, USA, in Jerusalem two years ago.

A. Becker
Jerusalem
DOI: 10.1038/sj.bdj.2012.277

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