education and preventive work not a major feature of the dentist's working day. Furthermore the anatomy of the area where tendons cross muscles with no mechanism of separating and protecting the two conditions suggests that this condition may be triggered by, rather than caused by, work.

M. Cosgrove
Cambridge

1. Howard N J. Peritendinitis crepitans. *J Bone Joint Surg* 1937; **19:** 447–459.
2. Thompson A R, Plewes L W, Shaw E G. Peritendinitis crepitans and simple tenosynovitis; a clinical study of 544 cases in industry. *Br J Ind Med* 1951; **8:** 150–158.

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THE REAL DILEMMA

Sir, I am in full agreement with S. Wilson regarding the *BDJ*'s CPD scheme.[1] In the nine years of its operation I believe that his is one of only three published letters that have been critical of the service. The first,[2] *An easy ride*, was published shortly after its launch and the second,[3] *Accumulating CPD hours*, written by myself, was submitted in response to the last editorial on CPD in 2007,[4] *CPD revisited*. My letter generated only one published reply,[5] which offered some valuable opinions but did not address the central theme of quality assurance.

I would like to make two further contributions that should help to resolve the apparent dilemma facing the journal and its partners. First, does the existing scheme meet the requirements for verifiable CPD? I can obtain a certificate for logging in and selecting any answer. All this verifies is my computer skills. There is no attempt to verify that the learning intervention (reading and comprehending a paper) has occurred.

Second, and most importantly, lifelong learning was not introduced primarily for the benefit of dental professionals but rather for that of the public so that patients can have confidence in those charged with caring for them.[6] Perhaps you should address your question to the letters pages of the national newspapers, media organisations and patient representative groups. I am sure that you will receive an unambiguous response.

The real dilemma faced by the journal and its partners is how the existing CPD scheme can be justified to patients. Accusations of tokenism and rewarding superficial participation in education will be difficult to defend. We have seen public confidence in our bankers and politicians gravely undermined. Most recently school examination boards have been accused of competing to provide the easiest to pass GCSEs: the parallel with the journal's CPD scheme (and others) should be obvious.

The question regarding a scoring system is one of much greater significance than might at first be apparent, as Mr Wilson has identified so ably.

A. Gould
By email

1. Wilson S. Asinine system. *Br Dent J* 2012; **212:** 574.
2. Storrar I. An easy ride? *Br Dent J* 2003; **195:** 230.
3. Gould A. Accumulating CPD hours. *Br Dent J* 2008; **204:** 478.
4. Hancocks S. CPD revisited. *Br Dent J* 2007; **203:** 703–704.
5. Shah S. CPD variety is good. *Br Dent J* 2008; **204:** 658.
6. Grieveson B. Proposals for validation and revalidation of the dental profession: a postgraduate dental dean's perspective. *Dent Update* 2009; **36:** 198–200.

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LOZENGE RISKS

Sir, a 24-year-old female with widespread metastatic disease (multiple peritoneal and liver deposits) from a primary GIST underwent a full clearance of her adult dentition due to rampant caries under general anaesthesia (Fig. 1). Four years previously, she had been started on fentanyl lozenges (Actiq - Cephalon Ltd) for pain control and had a sound dentition.

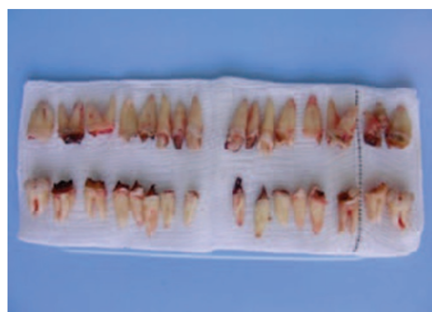

Fig. 1 Full clearance of 24-year-old patient prescribed fentanyl lozenges

The fentanyl lozenges are supplied as the citrate salt and contain hydrated dextrates equivalent to approximately 2 g of glucose per lozenge.[1] A low pH environment combined with fermentable carbohydrates within the oral cavity as a result of the fentanyl lozenge, compounded by the reduced salivary flow associated with opioids,[2] provided an ideal environment for the rapid progression of dental caries.[3] In this case a full dental clearance of 32 teeth was necessary (Fig. 1) due to advanced dental caries.

Oro-mucosal preparations of fentanyl are available as tablets (Abstral, ProStrakan Ltd, and Effentora, Cephalon Ltd). However, faster blood levels are achieved from buccal/sublingual use of a lozenge (Actiq - Cephalon Ltd). The tablets contain mannitol and do not cause caries.[1] The lozenge patient advice leaflet does mention that a dry mouth and dental decay may be caused by the product but only recommends 'normal oral hygiene'.

Fentanyl is demonstrably a highly effective opioid analgesic which has an important role in the management of oncology patients. The rapid delivery of the fentanyl through the buccal mucosa in the form of an oral lozenge further enhances its usefulness. However, it is essential that patients are aware of the risks to their dental health, and that they employ preventative measures such as the use of high fluoride toothpastes and mouth rinses. Ideally, these patients should see their own general dental practitioners before starting fentanyl treatment and have regular dental check ups during the course of treatment.

V. Sharma, M. Miah, M. Cameron
Cambridge

1. Electronic Medicines Compendium. Search on 'fentanyl'. www.medicines.org.uk/emc
2. Carver A; Federman D D, Nabel E G (eds). *Pharmacologic management of pain.* New York: ACP Medicine, 2010.
3. Kidd E A M. *Essentials of dental caries*, 3rd ed. Oxford University Press, 2005.

DOI: 10.1038/sj.bdj.2012.788

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