Letters to the Editor

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Priority will be given to letters less than 500 words long. Authors must sign the letter, which may be edited for reasons of space.

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LETTERS

BANANA ROOT FRACTURE

In the previous issue of the *BDJ*, the letter *Banana root fracture* (*BDJ* 2012; **213:** 263) described a patient who attended as an emergency stating that a tooth had fallen out that morning whilst eating breakfast. Detailed questioning revealed that the tooth-like item was actually dried banana. The illustrations were omitted from the original letter but are shown here (Figs 1-3).

Figs 1–3 Photographs of the suspicious 'tooth'

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ALF'S RESULTS

Sir, may I pay a warm tribute to Lord Morris of Wythenshawe whose death was announced recently?

As plain Alf Morris he was my local MP for many years, Minister for the Disabled and a tireless fighter for the handicapped of all natures.

In the early days of the GDS Eastbourne only accepted a 'one treatment fits all' approach for the correction of Class II malocclusion, namely 'Extract 4/4, retract 3/3 and then retract the upper incisors. Ignore lower arch'. For patients with very severe skeletal or overbite problems this was of course often inappropriate, sometimes damaging. In fairness, the Board's officers were tied by the same rulebook. For families unable to seek a private alternative a detailed letter to Alf often did wonders on the south coast.

Now long retired I still occasionally bump into some of these fortunate patients and enjoy 'Alf's results'.

Long may his memory live on.

H. L. Eirew, Chapel-en-le-Frith

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MY OWN BITTER EXPERIENCE

Sir, I was glad to read Professor Clark's Opinion paper on peer review (*BDJ* 2012; **213:** 153–154). From my own (bitter) experience it is high time to expose an outdated opaque system which purports to pick the most worthy papers for publication, but actually could undermine and prevent papers from being published if the content threatens the standing of the reviewer.

It was my misfortune to select the topic of occlusion for my series of papers, a topic which is rife with differing and conflicting views. This may be one reason why journals like the *BDJ* carry so few papers related to this subject. While I can testify to the enthusiasm and encouragement of the Editor-in-Chief, who personally made helpful suggestions to the layout of the articles, I am not sure if he had the ability to choose reviewers who would have been the most impartial and knowledgeable.

Many months of work and alterations were of no avail, as the reviewer(s) placed obstacles at every stage. The final 'nail in the coffin' came after I had the temerity to contradict one or more of the reviewers' opinions, supplying ample facts and papers to support my statements. Having spent many years of study, mostly in the USA, and taught courses here in the UK, I reckon my understanding of the subject might be good enough to warrant reading.

I did not know the identity of the reviewers. At one stage I was described as an 'enthusiast' in my subject. I suppose this may have been a compliment, but now I wonder.

Had we both been aware of our names one can only think about another outcome.

Dentists, like anybody have their pride, and do not like being contradicted. In the area of peer review I now see that the current process leaves much to be desired. The series was never published in the *BDJ*.

H. Stean
By email

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INCREASE IN REFERRALS

Sir, I read with interest the recent letter by Professor Crispian Scully and Dr Mark Griffiths (*New anticoagulants*; *BDJ* 2012; **213:** 96), advising dental surgeons on the likely rise in the prescription of the new anticoagulants dabigatran (a direct thrombin inhibitor) and rivaroxaban (a Factor Xa inhibitor)

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to eventually replace warfarin. In hospital practice we have certainly seen an increase in the number of referrals for patients taking these anticoagulants who require dental extractions.

It is likely that, as there is no need for routine coagulation monitoring of patients taking these drugs, dental surgeons may feel it is acceptable to advise patients to either continue taking them or to simply withdraw the drug for 24 hours, prior to invasive dental procedures. This is certainly not the advice of the manufacturers who state that 'surgical interventions may require temporary discontinuation of the drug' (Pradaxa) based on calculation of the creatinine clearance (the estimated half life of the drug increasing with poorer renal function). The length of time the drug should be withdrawn will depend on how effective renal function is, with normal function only requiring withdrawal for 24 hours before the dental procedure.

However, it would be dangerous to assume that all patients have normal renal function and manufacturers' recommendations for patients with creatinine clearances of between 30-50 ml/min[1] (as opposed to above 80 ml/min in normal kidneys) advise that the drug is withdrawn for 2-3 days (>48 hours). Failure to do this means that levels could be high, resulting in postoperative haemorrhage, which is of particular concern as there is, as yet, no specific antidote or reversal agent for either of these drugs.

The consequence of this requirement will mean hospital referral if dental practitioners are not in a position to calculate renal function. This will also mean inevitable delay in treatment as this investigation will have to be carried out before treatment can take place, unlike most units who now use INR monitoring devices for patients taking warfarin that can provide virtually instant results.

I am rather concerned that over the last 30 years it became apparent that warfarin withdrawal was more of a risk than a benefit and that in future we may achieve the same result with the new anticoagulants.

R. Davies, London

1. Boehringer Ingelheim. Pradaxa Advice Sheet. July 2012.

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USELESS MOUNTAINS OF PAPERWORK

Sir, the (Hampshire) PCT seems to have a vast agenda – reduce contract values, KPIs, criminal records, HTM 01-05, UDAs, IGT, medical status, patient complaints ...on and on... all based on an assumption that dentists are **not** to be trusted! They need to be broken and beaten into submission by useless mountains of paperwork, form filling, box ticking etc.

The sad part is that the PCT and dentists used to work together for the benefit of patients. There was a really good relationship whereby we talked to each other; no really, we physically spoke and problems could be solved without reverting to paperwork, breach notices, or email.

I'm old, I've been in practice for 40 years and the finishing line is in sight. I can escape at any time (hence the letter). I still enjoy dentistry, but someone once told me that when you are no longer prepared to fit in with the system, it's time to go.

The system has grown into a monster – so with regrets farewell.

N. T. Lynn
By email

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TAKING PREVENTION TO THE CHILD

Sir, I write in reference to the opinion article *Child dental neglect: is it a neglected area in the UK?* (*BDJ* 2012; **213:** 103–104). The authors correctly highlight the various factors which contribute to the inequalities in oral health for children. These inequalities contribute to child dental neglect (CDN).

One of the most evidence-based and effective ways of addressing this is by the commissioning of community fluoride varnish schemes. The principle being that prevention is *taken to the child* rather than waiting for the children to be taken to preventive care.

This is particularly effective for those children whose parents do not traditionally access care. An added bonus of this intervention is that children with obvious dental disease can be identified and signposted to local dental services.

The fluoride varnish scheme has been running in Islington for the last three years. Not only have thousands of children received fluoride varnish but also a large number have been signposted to local dental services for ongoing care.

In the absence of school screening, community fluoride varnish schemes can address CDN **both directly and indirectly.**

W. Bellis
Clinical lead for the Islington Fluoride Varnish Programme

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A LIGHTER PREFERENCE

Sir, it was interesting to read the paper by Cooper *et al.*[1] about patient perceptions of aesthetics as it took me back to work we did here in Manchester many years ago on the same topic.[2] We were surprised to find that patients did not necessarily prefer the restorations that they thought looked most natural, and tended to choose the restorations which had a lighter shade. With the more recent emphasis on tooth whitening, I should imagine that this trend would probably be even stronger today.

A. Mellor
By email

1. Cooper G E, Tredwin C J, Cooper N T, Petrie A, Gill D S. The influence of maxillary central incisor height-to-width ration on perceived smile aesthetics. *Br Dent J* 2012; **212:** 589–599.
2. Rimmer S E, Mellor A C. Patients' perceptions of esthetics and technical quality in crowns and fixed partial dentures. *Quintessence Int* 1996; **27:** 155–162.

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COMPLETELY WITHOUT FOUNDATION

Sir, I have read Dr Hussain's letter in the 25 August issue of the *BDJ* (**213:** 147) and have great sympathy in his battles to deal with public comments on the NHS Choices website that is attempting to turn NHS dentistry into a health version of Trip Advisor.

I have been contacted by many colleagues equally affected by such things as anonymous potentially libellous comments with poor moderation of the site and reluctance to remove comments that are completely without foundation.

I am aware of a group of dentists who have a strong legal opinion that may challenge the duty of care of the

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