

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 The length of time the drug should be withdrawn will depend on how effective renal function is, with normal function only requiring withdrawal for 24 hours before the dental procedure.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clearances of between 30–50 ml/min¹ (as opposed to above 80 ml/min in normal kidneys) advise that the drug is withdrawn for 2–3 days (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