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 The length of time the drug should be withdrawn will depend on how effective renal function is, with normal function only requiring withdrawal for 24 hours before the dental procedure.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clearances of between 30-50 ml/min[1] (as opposed to above 80 ml/min in normal kidneys) advise that the drug is withdrawn for 2-3 days (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.

DOI: 10.1038/sj.bdj.2012.936

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

DOI: 10.1038/sj.bdj.2012.937

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.

DOI: 10.1038/sj.bdj.2012.939

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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site that has allowed commercially damaging comments attached to many practices.

I'm keen to hear from anyone who may have similar stories to Dr Hussain and would value their assistance if they could contact me at ecrouch9@btinternet.com.

E. Crouch, Birmingham

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DISLOCATED JAW

Sir, I am a newly qualified dentist and recently experienced a patient dislocating their jaw whilst treating them in practice. This incident has compelled me to write to share my experience to highlight that this unexpected incidence can easily happen when you least expect it.

At university we were taught only briefly about TMJ dislocations with the main emphasis being that it was somewhat a rarity and most likely to occur when extracting wisdom teeth or if using excessive force. The reality of my situation was far from this. I was extirpating a lower premolar, using no force at all, my patient did not have his mouth open wide or for very long, he had no history of dislocating his TMJ and there were no other associated risk factors.

Having not previously seen or managed any TMJ dislocations I felt underprepared for managing this incident. At university we were simply told to 'push back and down' and to be careful that you don't get your thumbs bitten. This sounds rather straightforward but the reality of my situation was not so. Even my experienced VT trainer and an associate – who has previously worked as a MaxFax SHO – were not able to relocate my patient's TMJ.

Although I am sure that this scenario is straightforward for someone with experience in this area, I found managing this incident was not as simple as I had been led to believe in my training at university.

My patient attended our local hospital and successfully had his TMJ relocated by the MaxFax team and has had no subsequent problems. I felt compelled to write to draw the attention to how a seemingly low risk patient can dislocate their TMJ during routine dental procedures, when one may least expect it, and how recent dental graduates have limited experience in this field.

K. Parker, London

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NARROWER SKULLS

Sir, just as autism is being called autistic spectrum disorder, I believe the issue with crowded teeth and a narrow skull should be called 'narrow skull spectrum disorder'. It is indeed multifactorial: chronic inflammation, changing breathing patterns and all the issues with tongue weakness, as well as improper development of the jaw due to lack of 'tough' food which was more stimulating to the growth of the mandible when chewing.

There are also many less talked about issues that relate to chronic inflammatory conditions that lead to poor breathing patterns. Lack of development of the brain due to lack of physicality in youth affects the development of the autonomic system that drives digestion, which then leads to these inflammatory conditions.

The poor vagal tone described above in essence leads to poor blood supply to the gut which leads to poor gut function as it relates to acid and enzyme production from the gut. This then often leads to chronic gut-associated issues such as dysbiosis, and leaky gut syndrome which can then lead to food sensitivities and autoimmune disorders.

There are also issues associated with this mechanism related to processed foods and even environmental chemicals. Since mouth breathing seems to be the common relationship to a narrower skull and teeth crowding then these mechanisms might be the primary epigenetic triggers.

J. Lieurance, Florida

DOI: 10.1038/sj.bdj.942

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