However, where there is no clear demarcation between the roots of adjacent teeth, concrescence is a possibility that should be considered during treatment planning, whether extraction, endodontics or periodontal therapy is being considered.[2]

A. Alshawaf, Canterbury

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ANTICOAGULANT GUIDELINES

Sir, we write further to previous correspondence relating to the dental management of patients who are taking anticoagulant drugs and the lack of relevant guidance for dental practitioners.[1-3] We offer the following observations based upon arrangements in our region.

In early 2012, it became clear that the drugs rivaroxaban (Xarelto) and dabigatran etexilate (Pradaxa) would be more widely prescribed in Tayside for patients living in the community than had previously been the case. It was also clear that dental practitioners, in both community and hospital settings, would have little prior knowledge of these drugs and their potential impact on the provision of dental care. A guideline for local use within the NHS Tayside Health Board Area was therefore drawn up[4] to outline the principles of patient management to be adopted for any dental patient who is taking either of the drugs mentioned above. For ease of use by all dental practitioners, the guidance also incorporates information relating to the coumarins and to anti-platelet medications.

The guidance was compiled by a community based senior dental officer who is on the GDC specialist list for special care dentistry, with input from community and hospital-based colleagues on specialist lists in special care dentistry, oral surgery and oral and maxillofacial surgery. Medical expertise and input was provided by locally-based consultant colleagues in cardiology and haematology.

Our guidance suggests that an atraumatic extraction technique, with a limit of 3-4 teeth being extracted at any one visit, supplemented by local haemostatic measures (sutures, haemostat packs and locally applied pressure) at the time of extraction will allow safe treatment for these patients in a general or community dental practice environment. For coumarin drugs standard advice on pre-operative checking of the INR to ensure a level of <4 is advised. No pre-operative blood testing or dose adjustment is recommended for rivaroxaban or dabigatran.

Advice is also given with regard to the medical conditions which should prompt the dentist to seek advice from a senior dental or medical colleague before a dental procedure likely to cause a haemorrhage is undertaken. These conditions include patients with a recently placed stent, liver or renal impairment, alcohol problems and patients taking cytotoxic drugs or who have any underlying defect of their physiological clotting mechanisms.

In our locality we have been using these drugs (predominantly rivaroxaban) instead of warfarin for selected individuals with atrial fibrillation and for new patients presenting with deep vein thrombosis over the past year and no problems have been reported in relation to the implementation of the principles outlined in the guidance. From our experience, it would seem that those patients with uncomplicated medical histories can be safely treated in general dental practice.

R. Kerr, G. Ogden, Dundee
G. Sime, Perth

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ENGAGING FULLY

Sir, M. Mew's letter *Risking our legitimacy* (*BDJ* 2013; **214:** 143) concerning the aetiology of malocclusion gave views also previously expressed by John Mew. Mike challenges the British Orthodontic Society to engage in a debate on this complex issue, suggesting reluctance on our part to do so.

However:

- In the mid 1990s John Mew was invited to and spoke at a symposium organised by the University of Manchester; his views were listened to and debated
- He also spoke at a seminar at the University of Manchester and his views were debated further. Shortly after this, Professor Kevin O'Brien made an offer to John Mew to provide research support to evaluate the effectiveness of the treatment that John was promoting. Unfortunately, John did not take up that offer
- David DiBiase, Consultant Orthodontist, had a debate with him in Sydney, Australia, at the request of the Australian Orthodontic Society in February 1994
- A further debate took place on 3 November 2005 and was held at Elland Road in Leeds. This debate was entitled 'Traditional orthodontics ruins faces'. The argument was proposed by John Mew and opposed by Simon Littlewood with Professor Bill Shaw as chair. A report of the debate was published in the *BDJ* in 2006 (*BDJ* 2006; **201:** 243–244)
- John and Michael Mew presented for a day at the BOS offices for all the UK orthodontic postgraduates in 2007.

We believe that the British Orthodontic Society has engaged fully in debate on the issues raised, contrary to the opinion of Mike Mew.

S. Rudge
Honorary Secretary,
British Orthodontic Society

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HATCHING A SMILE

Sir, I thought your readers might find this interesting. Whilst visiting a local garden centre, I came across some rather unusual garden decorations (Figs 1-2). I was wondering quite who might want such things in their garden; perhaps these are modern day scarecrows influenced by an experience of dentistry?

Both stones seem to be 'hatching' a smile and perhaps the rudest has been influenced by a Rolling Stones album cover? (Although these stones were still!)

Figs 1–2 Garden centre art

It is good to see that such unzipped stones are demonstrating a good oral hygiene example.

R. M. Graham, by email

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CONTRARY TO ASPIRATION

Sir, I am writing to share some comments recently circulated by me as chair of a local professional network (LPN), the Teesside Sedation Network Group (TSNG), regarding the current procurement process for NHS sedation services in our region. LPNs are being heralded as a great opportunity to improve outcomes for patients across the country and make the best use of skilled professionals who meet many patients every day in their communities.

The TSNG is a group of interested sedation providers who have formed links between sedation performers, providers, referrers, commissioners and contract managers since 2009. I am one of the partners of the service which has delivered safe and effective evidence based conscious sedation for the last 14 years, so clearly have a personal interest in this process.

Teesside is a unique region as it has some of the highest levels of dental disease in the country, but low levels of dental general anaesthetics (DGAs). This is largely due to the advanced sedation (Tier 2) service in the region, which has been a gatekeeper for anxious children and adults, thereby reducing direct referral to hospital for DGAs, if simple sedation (Tier 1) techniques are inadequate.

It is interesting that **none** of the current sedation providers or members of the TSNG are involved in the potential new sedation contract delivery in our region. I believe this is due to the following issues:

- The online application process was cumbersome and labour intensive
- The service design was influenced by fund holders and not clinicians
- The service design favoured a low cost model for Tier 1 or simple sedation, which does not support the management of the advanced dental disease we have to deal with in Teesside
- The overall service design is flawed with split sites for Tier 1 and Tier 2 sedation and this is likely to increase patient ping-pong
- The model for KPIs on any new provider is punative and does not encourage best practice
- Heavy dependence on referring dentists to make the correct decision on appropriate sedation techniques for anxious children and adults is not realistic
- Experienced dental sedationists are not prepared to compromise their professional standards for a low treatment cost envelope.

High standards of patient safety and quality of care are essential in a modern and progressive NHS service. These are fundamental aspects of well governanced NHS service delivery, and have been clearly highlighted by the recent Mid-Staffordshire report, showing that ill-conceived budget cuts and cost saving schemes can have a negative impact on both patient care and outcomes.

The reality of this NHS commissioning process for sedation appears to be contrary to the aspiration of forming the NHS Commissioning Board and establishment of Local Professional Networks. This new NHS commissioning format has set out to ensure the highest standards of quality and safety are maintained across the NHS. Sadly, our recent experience in Teesside does not match the aspiration of these new proposals for LPNs.

I. Lane, Teesside

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DENTAL GUIDANCE FOR ALL

Sir, I would like to draw your readers' attention to new guidance entitled *Management of acute dental problems* (www.sdcep.org.uk/?o=3158). This is intended for use by staff in any healthcare setting who may be asked to advise or manage patients with acute dental problems. This includes non-dental professionals, such as general medical practice, emergency department and pharmacy staff, as well as members of the dental team. The guidance is applicable to patients of all ages in all population groups, irrespective of the healthcare setting or whether they are attending their dentist regularly.

Recognising the diverse manner in which patients requiring unscheduled clinical care are managed,[1-3] the Scottish Dental Clinical Effectiveness Programme (SDCEP) convened a guidance development group to support the delivery of safe and effective patient care by providing clinical guidance on best practice for the management of acute dental problems. This new guidance builds on the dental clinical guidance *Emergency Dental Care*[4] published by the SDCEP in 2007.

Based on the main presenting symptoms, this guidance provides decision support flowcharts, which can be used to identify any immediate attention or advice to give to the patient and to determine the appropriate provider of subsequent care. An interactive electronic decision support tool is also available in web app format. This can be accessed on the Internet via a personal computer, tablet or smartphone at http://madp.sdcep.org.uk. A separate Quick Reference Guide that includes the decision support flowcharts only is also provided.

In 2003 the World Health Organisation suggested a range of oral health targets for 2020.[5] These include an increase in the number of healthcare providers who