5-10% of professional life should be so allocated to achieve this.[4,5]

Clinicians need solutions to be most effectively applied at the time clinical problems occur, or at least very soon after. The priorities for such information can vary from solutions needed at the time to guide a particular decision or action, through solutions needed before seeing the next patient with a similar problem, to the solutions that may interest us but have no active clinical implications in our practice. Under pressure, it is usually only the first category that is addressed.

How to achieve this? Professionally derived literature packs, for instance, on various topics intended specifically to increase understanding and knowledge of certain procedures techniques or management have been shown often to have little or no effect and fail to influence treatment decisions and practice in healthcare professionals.[5]

There are many such questions that need consideration with regard to the overall process and hopefully the upcoming GDC revalidation proposals will be a beginning in addressing the larger picture. Martin Kelleher's suggestions of a completed multiple choice follow up would go some way towards stimulating reflective learning on the topics delivered at the very least, and perhaps these methods will influence behaviour.

A matter of especial concern in a profession such as ours that has hugely varied levels of CPD among those who belong, with – despite everything – some having no commitment at all, but nevertheless considering they can 'get by' and largely still using knowledge and techniques obtained during their early training. Evolution and culture change will perhaps be difficult in many areas!

K. F. Marshall
By email

1. Hancocks S. Does D put the dilemma in CPD? *Br Dent J* 2012; **212:** 461.
2. Kelleher M. The difficulties of making 'CPD verifiability' a legitimate measure of learning outcomes. *Br Dent J* 2012; **213:** 383–384.
3. Wyatt J C. Use and sources of medical knowledge. *Lancet* 1991; **338:** 1368–1373.
4. Wyatt J C. Keeping up: continuing education or life long learning? *J R Soc Med* 2000; **93:** 369–372.
5. Marshall K F. CPD learning. *Br Dent J* 2000; **189:** 287.
6. Evans C E, Haynes R B, Birkett N J *et al.* Does a mailed continuing education package improve physician performance? *JAMA* 1986; **226:** 501–504.

DOI: 10.1038/sj.bdj.2013.65

ACCLIMATISING CHILD PATIENTS

Sir, I read with interest the interview with Prof Tim Newton (*BDJ* 2012; **213:** 423–425) and was especially interested in his top five tips for the dental team in dealing with patients' anxiety. The fifth tip was concerned with the treatment of children and Prof. Newton recommended getting children into the surgery to acclimatise them. I wonder whether I might be permitted to offer a couple of additional suggestions based upon over a quarter of a century of experience in treating children?

If it should ever become necessary to provide operative treatment for a child then I have found it invaluable to explain the entire procedure at the diagnostic appointment and then to get the child back for a second operative appointment (preferably in the morning when they are less tired). It is a very useful technique to desensitise the child by allowing them to handle the instruments which will be used on the second visit. I allow them to lick the end of a cotton wool bud which has been coated with flavoured surface anaesthetic and to feel the sensation of a needleless syringe pressing against their gum. I always use a Vibraject when giving locals and I always turn it on and let the child feel the buzzing sensation against their gum. If they are allowed to play with the syringe and Vibraject at the diagnostic visit then they will not be tempted to look when you repeat the procedure with a needle attached at the operative appointment. An injection given using Vibraject is virtually undetectable so the tooth can always be uneventfully anaesthetised and the child will not notice that second time round they actually had an injection. I also find it useful to demonstrate the slow and fast handpieces. If a large rosehead bur is placed in a slow handpiece the child can touch the rotating bur with the ball of their finger without feeling anything more than a tickle (try it on your own finger if you don't believe me!). The air rota can be safely demonstrated by touching the ball of the child's finger with either the side of a tissue-protecting end-cutting bur or alternatively the tip of a safe-ended endodontic access bur.

The two or three minutes spent doing these simple demonstrations can save many minutes and a lot of stress at the operative visit. One last tip – when talking to a child always kneel down so that you are at their eye level. This makes you much less threatening.

M. W. M. Hawkins, Gillingham

DOI: 10.1038/sj.bdj.2013.66

FAT FACES AND SWELLINGS

Sir, there has been much in the literature and indeed national press recently that has raised serious concerns about the overuse and misuse of antibiotics. In fact the BDA has produced a very useful booklet on that subject but may I be bold enough to suggest another area where we might be using them unnecessarily.

A couple of weekends ago I was doing a three-hour, on-call session for my local NHS Trust. I find this interesting as I get to see acute emergencies that I don't see very often which I put down to the fact I have been at the same practice for 35 years and the majority of my patients have very good dental health.

On this occasion I saw a male in his twenties presenting with a fat face with a fluctuant swelling around a grossly carious lower right first molar. The normal treatment would be antibiotics followed by review and extraction at a later date. All my practising life this has not been my view so once again I gave the patient an ID block very slowly followed by an even slower intra-ligamental injection around the swollen tooth. Complete anaesthesia was achieved, the tooth elevated with a Couplands, a large amount of pus was released and aspirated away and the patient left very happy, had no post-operative problems and was given no antibiotics. Though this may go against traditional teaching, it has always worked well throughout the whole of my practising life and I have seen some spectacular fat faces and swellings in that time!

P. R. Williams, Lowestoft

DOI: 10.1038/sj.bdj.2013.67