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.

Readers may now comment on letters via the *BDJ* website (www.bdj.co.uk). A 'Readers' Comments' section appears at the end of the full text of each letter online.

FULL COVERAGE CROWNS

Sir, the decision to place a full coverage crown can be difficult. An operator needs to be aware of the potential complications of crown placement, as well as the risks of not providing treatment.

There is little consensus as to how frequently endodontic complications arise in previously vital teeth. Certain cohort studies[1] suggest that 98% of vital pulps will remain free from signs or symptoms of pulpal deterioration after five years, whilst other research suggests a far higher complication rate. One seminal study found that 19% of vital preparations (of unknown age) show evidence of peri-radicular disease.[2]

I would like to present the results of an internal audit in which I have looked at complications arising in crowns over the first five years following placement. The restorations in question were all single unit, full coverage crowns placed in adult patients by an experienced operator between 2003 and 2006 in a general dental practice. I was able to gather data for 510 teeth where the patient had regularly attended routine examination appointments for a minium of five years following crown placement.

In this cohort, only 6 teeth out of 411 which had not previously been endodontically treated (1.5%) went on to show signs or symptoms of pulpal deterioration within five years.

With adequate water cooling, a good knowledge of pulpal anatomy and conservative preparations the evidence from this cohort suggests that it is possible to place crowns with minimal risk of pulpal complications within five years.

S. Haworth, by email

1. Valderhaug J, Jokstad A, Ambjørnsen E, Norheim P W. Assessment of the periapical and clinical status of crowned teeth over 25 years. *J Dent* 1997; **25:** 97–105.
2. Saunders W P, Saunders E M. Prevalence of periradicular periodontitis associated with crowned teeth in an adult Scottish subpopulation. *Br Dent J* 1998; **185:** 137–140.

DOI: 10.1038/sj.bdj.689

YELLOW CARD SCHEME

Sir, in the recent paper by Yip *et al.* (*BDJ* 2013; **214:** E22) concerning the reporting of adverse drug reactions by general dental practitioners, a low level of reporting using the yellow card scheme was noted. The scheme is designed for reporting serious suspected adverse reactions to all medicines and all reactions to new products marked with a black triangle in the BNF. The authors conclude that this low level of reporting by dentists may partly be related to dentists rarely seeing or recognising adverse drug reactions. It could also be related to the fact that dentists prescribe from a well-established list of drugs as part of the dental practitioner's formulary. In addition, dentists would rarely be involved in the prescribing of black triangle medications which are more commonly prescribed by a medical practitioner.

Information on the type and frequency of drugs prescribed by dentists in the community in England are published by the Health and Social Care Information Centre each year. The most recent is for 2012 and makes interesting reading.[1] A total of 5.6 million prescription items written by dentists were dispensed in 2012, representing a 20% increase in prescription items since 2005. Dental prescription items represent 0.6% of the one billion items dispensed overall in the NHS in the community in England in 2012. In broad agreement with the figures found by Yip *et al.*, antimicrobial prescriptions were the most common, accounting for approximately 70% of items prescribed. Antibiotic prescribing in dentistry appears to have been stable since 2005 at between 3,500,000 and 4,000,000 prescriptions per year. The next most common prescription was for preparations containing fluoride at 17% of items (n = 953,000 items) prescribed in 2012. This has increased steadily from a baseline value of less than 0.3% of items (n = 12,000 items) prescribed in 2005, with Duraphat fluoride toothpaste 2,800 ppm and 5,000 ppm being the main drivers of growth since being introduced into the market in 2006.

Dental drug prescribing habits are changing and will continue to change, and with it the potential for new occurrences of adverse drug reactions. The yellow card scheme fulfils a valuable function in helping to identify such reactions when recognised.

J. Taylor, M. N. Pemberton, Manchester

1. Health & Social Care Information Centre. *Prescribing by dentists - England, 2012.* 25 April 2013. Available at: www.hscic.gov.uk/catalogue/PUB10751 (accessed June 2013).

DOI: 10.1038/sj.bdj.2013.690

IMPROVING CANCER CARE

Sir, we write in response to the letter published in the *BDJ* in January 2012 entitled *Unfairness for mouth cancer patients* (**212:** 3). We wholeheartedly agree with this opinion. Treatment of head and neck cancer involves not only removal of the tumour but also restoration of function. The aim of treatment is to prolong life and restore quality of life as far as possible. Head and neck cancer invariably affects vital structures and consequently can have a profound effect on facial appearance and self-image. When the oro- and nasopharynx

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