Letters to the Editor

Send your letters to the Editor, British Dental Journal, 64 Wimpole Street, London, W1G 8YS
Email bdj@bda.org

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.

TREATING THE WHOLE PATIENT

Sir, I recently attended a six-week, half-day course in Leeds aimed at creating a new generation of patients empowered to take action of their healthcare needs in partnership with their healthcare professionals (the Expert Patients Programme – EPP) and must recommend it.

It is a lay-led, self-management course for people with long-term health conditions to take an active role in the management of their lives. It covers pain reduction, improved use of medication, managing common symptoms, using your mind, exercise, communication, healthy eating, making treatment decisions and making your wishes known and planning for the future ie advance directives for healthcare – fears and reality.

I am now a certified expert patient and self-manager, and wholeheartedly encourage those practitioners and/or patients living with a long-term health condition to sign up. There is no fee and the free textbook after the course is invaluable. All transport/childcare/healthcare etc can be claimed back in full.

As dentists, we are interested in treating the whole patient and understand the impact that chronic medical conditions can have on our patients' oral needs. Conversely, it may help patients with chronic oro-facial conditions eg pain, ulcers, cancer, to cope better long term, reducing the need for surgery visits and medication.

The EPP originates in the USA and since 2004 has also led a coalition of organisations across the NHS and voluntary sector to develop Stepping Stones to Quality (SS2Q) as a straightforward and practical assurance framework. It is a non-profit organisation and works in partnership with other providers across the NHS, voluntary sector and social care to ensure equitable provision of lay-led self-management across England to all people living with long-term conditions.

Nobody wants to have a long-term illness but if we do, we can learn to live the healthiest and fullest life possible. Dentists can be part of this holistic healthcare. (Contact on: tel: 0113 843 4548; email: epp.account@nhsleeds.nhs.uk.)

H. Tawfik
Leeds

DOI: 10.1038/sj.bdj.2013.744

SCANT EVIDENCE

Sir, I agree with Dr Ghaeminia's commentary on *Coronectomy may be a way of managing impacted third molars* and consider it to be essential reading.[1]

I am concerned coronectomy that can be undertaken by all is possibly being promoted as an alternative to extraction of third molars with scant evidence of patient benefit. NICE guidelines stipulate those impacted third molars suitable for extraction in the UK yet there is no mention of them in the published papers.

Following a coronectomy of an impacted third molar that satisfied NICE criteria for its extraction, would it be deemed a failure of the duty of care if the tooth remnants later became symptomatic? Would the surgery be considered inadequate[2] should a patient suffer inferior dental (ID) nerve damage from the coronectomy surgical technique (undertaken to prevent it)? Should a root that is unnoticed to have been inadvertently loosened in the procedure later become symptomatic soon after the coronectomy also be a failure of the duty of care?

Cone beam CT investigation has been suggested as essential to confirm the third molar root relation to an 'at risk inferior dental nerve'[3] prior to coronectomy. Does this radiation hazard negate any benefit from protection to the ID nerve by the technique? What of the risks to the lingual nerve from the surgical technique? Importantly, should research using the technique be submitted for scrutiny by an ethics committee?

G. D. Wood
By email

1. Ghaeminia H. Coronectomy may be a way of managing impacted third molars. *Evid Based Dent* 2013; **14:** 57–58.
2. Gleeson C F, Patel V, Kwok J, Sproat C. Coronectomy practice. Paper 1. Technique and trouble-shooting. *Br J Oral Maxillofac Surg* 2012; **50:** 739–744.
3. Renton T. Notes on coronectomy. *Br Dent J* 2012; **212:** 323–326.

DOI: 10.1038/sj.bdj.2013.745

ANTICOAGULANT UPDATE

Sir, anticoagulation therapy produces an increased risk of bleeding. The common anticoagulant is the coumarin warfarin – a vitamin K antagonist (VKA). Anticoagulants that may replace warfarin are new oral anticoagulants (NOACs) and include dabigatran etexilate (NICE recommended) and rivaroxaban (US Food and Drug Administration approved).[1,2] Dabigatran and rivaroxaban are quickly absorbed and, in the event of excessive anticoagulant activity, discontinuing the drug is usually sufficient.

Guidelines for dental surgery in patients on NOACs have recently been published in the *BDJ* and elsewhere.[3,4] The guidance is similar to that recommended for patients on treatment with