# LETTERS TO THE EDITOR

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## WATER FLUORIDATION

### GA extraction rates

Sir, contrary to the hypothesis presented by Neurath *et al.* (*BDJ* 2014; **217:** 55), variations between hospitals in policies and practices for recording HES data on tooth extractions under a general anaesthetic are unlikely to account for the magnitude of the differences in extraction rates observed by Elmer *et al.* in their comparative study of the mainly fluoridated West Midlands and mainly non-fluoridated north-west (*BDJ* 2014; **216:** E10).

The findings of the Elmer *et al.* study are strengthened by the subsequent larger analysis conducted by Public Health England, whose fluoridation monitoring report (March, 2014) found that there were 45% fewer hospital admissions of 0- to 4-year-olds for dental caries (primarily to have decayed teeth extracted under a GA) in fluoridated local authorities of England compared with non-fluoridated authorities. It is unlikely that all or most hospitals in the fluoridated parts of England – which range geographically from Northumberland to Bedfordshire – are following one set of recording practices whilst all or most hospitals in the non-fluoridated parts are following another.

There can surely be no dispute that water fluoridation reduces dental caries prevalence. Three systematic reviews of the worldwide evidence between 2000 and 2007 found that it does.[1-3] Neurath *et al.* imply that the fluoridation effectiveness studies reviewed by York were of poor quality. However, all the studies included were categorised in the report as Level B or 'moderate' quality.

A recent analysis of studies in ten different countries published since 1990 found significantly lower rates of decay in primary and secondary teeth, including after the application of advanced statistical techniques to adjust for potentially confounding factors.[4]

A finding that GA extraction rates are lower in fluoridated than non-fluoridated areas is therefore logical, unsurprising and of interest to policy-makers seeking to address stubbornly high dental caries rates in parts of England. Further research into this aspect of the benefits of water fluoridation would be helpful.

**D. A. White, K. Coomar, Birmingham**


1. McDonagh M S, Whiting P F, Wilson P M *et al. A systematic review of public water fluoridation.* University of York: NHS Centre for Reviews and Dissemination, University of York, 2000.
2. Truman B I, Gooch B F, Sulemana I *et al.* Reviews of evidence on interventions to prevent dental caries, oral and pharyngeal cancers, and sports-related craniofacial injuries. *Am J Prev Med* 2002; **23:** 21–54.
3. Australian Government National Health and Medical Research Council. *A systematic review of the efficacy and safety of fluoridation.* 2007. Available at: http://www.nhmrc.gov.au/guidelines/publications/eh41 (accessed October 2014).
4. Rugg-Gunn A J, Do L. Effectiveness of water fluoridation in caries prevention. *Community Dent Oral Epidemiol* 2012; **40 (Suppl 2):** 55–64.


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### Unlikely reasons

Sir, the letter of Neurath *et al.* (*BDJ* 2014; **217:** 55) commenting on our paper (*BDJ* 2014; **216:** E10) draws attention to the

## THE DENTAL CINDERELLA

Sir, as a dento-legal expert I am receiving increasing numbers of cases of late diagnosis and treatment of periodontal disease. The latter often appears to be the dental Cinderella: too often colleagues consider the condition untreatable when in fact treatment can achieve great results and be the difference between keeping teeth and losing them.

An accurate and regular BPE, appropriate radiographs and treatment or referral to a specialist will largely avoid a periodontal complaint. The policy document of the British Society of Periodontology, *Parameters of care*, published initially in 2001, forms the basis of mainstream teaching at UK dental schools (www.bsperio.org.uk). It is difficult to defend a litigation/GDC case where this protocol has not been followed. The BPE with its forerunner the CPITN has been in use since the 1980s; it takes one to two minutes to complete and the results provide the required treatment needs.

It is imperative to explain to patients if they have any sign of the disease what treatment is needed, as well as the consequences of no treatment. Patients now place a high priority on being provided with this information; they need to know that the end result of untreated periodontal disease is tooth loss. Associated risk factors such as smoking and diabetes also need to be considered and advice given. In order to defend your actions a written record of discussions as well as treatment, oral hygiene instructions and compliance is mandatory.

Treatment should not be delayed and, although time consuming and painstaking, must be thorough. If progress is poor or the disease is difficult to control a specialist referral is strongly advised. Sadly, these referrals are often not made or can be too late with many dentists presuming implants are the only option. There seems to be a misconception about the nature of periodontal treatment and colleagues should appreciate that treatment can take months to get results but can often mean that teeth are saved.

Patients now frequently expect to have their teeth for life. They are reluctant to consider dentures and although they may want dental implants, how many patients can afford them? In litigation cases, periodontal patients are seeking settlements of tens of thousands of pounds and this sadly seems to be becoming commonplace. Faced with unwanted and unexpected tooth loss it is understandable why patients seek to restore their mouths via this route.

Fee rises will be inevitable if the numbers of complaints keep rising. In caring appropriately for their periodontal patients, dentists will be protecting themselves and avoid the misery of an indefensible complaint.

**E. Roberts-Harry, Specialist Periodontist, Harrogate**

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