

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

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.

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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

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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).
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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

apparent variation in reporting of dental general anaesthesia which may affect the validity of hospital episode statistics (HES). We addressed this issue quite clearly in our paper and agree that this makes comparison of areas problematic, particularly comparing relatively small individual health economies such as individual NHS Primary Care Trusts or local authorities. Their interpretation of the analyses of HES data published by Robertson, Ni Chaollai *et al.*^{1,2} does not address those studies finding that dental GA provision is substantially under-recorded in HES.

What is more difficult to explain is the difference in rates of hospital admission between larger groupings of areas, such as in our study and, more recently, by Public Health England who found quite dramatic differences between fluoridated and non-fluoridated areas. It seems inherently unlikely that arrangements for reporting dental GA and child hospital admission are systematically different in fluoridated areas compared with non-fluoridated areas, thereby causing a greater degree of under-reporting in the former. If there is, as seems likely, a general degree of under-reporting, then the differences between fluoridated and non-fluoridated populations could be far greater than is currently appreciated.

It is further suggested by Neurath *et al.* that dental care is possibly more extensive in a fluoridated area or that dental professional behaviour is different. It again seems inherently unlikely that dentists in fluoridated areas are behaving systematically differently to those in non-fluoridated areas regarding referral, or have better clinical skills than their peers in non-fluoridated areas with higher levels of decay. The most likely explanation for the slightly higher care index in young children in the West Midlands (10.6% compared with 8.0%) is the lower

prevalence of decay, meaning that what remains is more readily managed by treatment services.

Neurath *et al.* feel that an individual-level randomised controlled trial (RCT) of water fluoridation using bottled water would not be difficult, although they do concede the difficulty of a community-level water fluoridation RCT. It is hard to see how a bottled-water study could be practically achieved or complied with over a number of years to establish effect across all age groups. However, publication of their proposed methodology would enable the practicalities to be assessed.

The potential use of HES data to assess the impact of water fluoridation schemes needs further investigation but variations in reporting, or variations in dentist behaviour seem unlikely reasons for the magnitude of the differences seen between larger communities served by multiple service providers.

T. B. Elmer, J. W. Langford, A. J. Morris

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PRIMARY DENTAL CARE

Simple haemostatic measures

Sir, I am writing as a young dentist who has recently completed an Oral and Maxillofacial Surgery (OMFS) Dental Core training post in a busy central hospital. As part of my duties I was tasked with managing referrals from the Accident and Emergency department. A significant number of these patients were warfarinised individuals who had recently undergone a dental extraction with subsequent prolonged bleeding. Guidelines for the treatment of these patients, including those published by the *BDJ*

in 2007,¹ are now well established and disseminated. The general principles entail a stable INR recently (<72 hours) found to be <4, in addition to local haemostatic measures as required. Suturing should be evaluated on a case-by-case basis depending on the degree of soft tissue trauma.² It is advised that non-selective NSAIDs and COX-2 inhibitors should be avoided as analgesia.

From my experience, warfarinised patients presenting to me and my colleagues with post-extraction bleeding have usually had a recent INR of <4 recorded, although certainly not in all cases. However, only a very small number of these patients had had any form of local haemostat. In A&E the bleeding was usually stopped within a very short period by the placement of a resorbable haemostatic dressing, such as oxidised cellulose or a collagen sponge, in addition to a tight suture. Unfortunately it was often several hours down the line by the time the patient had been triaged and referred to our team, particularly if they had initially presented at a hospital without an OMFS unit.

The purpose of this letter is to raise awareness of the simple haemostatic measures that can be used in primary care following dental extractions for individuals taking anticoagulation therapy. A suture and placement of a resorbable dressing could save the patient several hours in A&E and also avoid a frosty subsequent appointment for the clinician.

A. Trott, London

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