RAISING STANDARDS

Sir, I was both interested in and saddened by the paper in the *BDJ* (2014; **216:** E22) on apical periodontitis (AP) and the technical quality of root canal treatment in an adult sub-population in London.

Thanks to the Young Dentist Endodontic Award (http://www.roottreatmentuk.com/html/young-dentist) I have been privileged to meet some exceptional young dentists with well-honed endodontic skills. From my experience, the best entries for the award are from graduates who have made a point of practising endodontic treatments while they were students, going above and beyond the requirements of their curriculum, or who have had inspirational support from a trainer during their foundation training.

At an early stage, it's not difficult to identify those dentists who should be doing endodontic treatments and those who might choose instead to refer to more experienced colleagues.

The high percentage of patients in the study who had received poor quality root canal treatment and still had AP were perhaps fortunate to be asymptomatic. Just recently, a 55-year-old teacher presented here in acute pain following root canal treatment by her dentist who had also prescribed three courses of antibiotics. The source of the tooth's problem wasn't infection but the gutta percha extruding from the apices of two roots, by 6 mm through one root and by 10 mm through the other. The tooth had been savable prior to treatment but post-treatment, extraction was the only solution to help the patient become pain-free.

As we all know only too well, more and more patients are suing their dentist or complaining to the GDC, which means that as a profession, we all bear the cost of poor-quality treatments, whether it's meeting the rising costs of defence organisation membership or the rising annual retention fee.

But it's the interest of patients which is the priority and there is no doubt that more could and should be done to raise standards.

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DOI: 10.1038/sj.bdj.2014.710

on orthotropics, the article is based on conjecture with references 'cherry-picked' to support some now historical theories of the aetiology of malocclusion. Furthermore, no scientific evidence is provided as to how orthotropics could resolve any of the 'symptoms' mentioned in the article whilst the text contains much to worry current and former orthodontic patients and parents.

When will the orthotropics proponents provide some scientific evidence for their claims?

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DOI: 10.1038/sj.bdj.2014.709

Eschewing science

Sir, I read with interest the opinion piece in the *BDJ* entitled *Craniofacial dystrophy. A possible syndrome?* by M. Mew (**216:** 555-558).

I have two main issues with this piece which I think are worth mentioning.

Firstly, concluding with the statement, 'Attempts to constructively critique or falsify this hypothesis with quality evidence and sound logic are welcomed', is somewhat misleading. It would suggest that this article has presented a valid, evidence based argument for the existence of the potential syndrome 'Craniofacial dystrophy'.

What you have is the author's opinion on how malocclusion compares to a referenced ideal occlusion/posture described by his father (J. Mew) over 30 years ago, also in this Journal. The article is full of interesting claims regarding 'signs' and 'symptoms' that are almost wholly unsubstantiated by scientific reference. One would hope that given the author belongs to a worldwide elite number of 'master level' orthotropic practitioners[1] practising facial growth guidance, that a substantially higher level of evidence for this syndrome could be provided.

As such, inviting readers to falsify the presented hypothesis seems to eschew the scientific process of initially testing whether or not the hypothesis is valid.

Secondly, when there are opinions given in the *BDJ* regarding potentially controversial patient related issues, it would help if this was done in point/counter-point fashion, similar to the recent pieces on short-term orthodontics.

I fully respect the opinion of M. Mew and his right to voice those opinions. However, I am concerned when patients on public Internet forums are directed to these opinion pieces by the author[2] and then this published work finishes by linking to a website where you can 'learn more' about a potentially serious and common 'syndrome' and its treatment. As it turns out, M. Mew and J. Mew are the sole orthotropists between London and the Ukraine registered with this website.[1]

I feel strongly that where an opinion piece with all the scientific rigour of a Facebook posting is published without an accompanying retort, it may result in damage to the reputation of the *BDJ* as a scientific journal.

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1. The Official Website for International Association of Facial Growth Guidance (Orthotropics). Find an Orthotropist. Available at: http://orthotropics.org/Discover_Orthotropics/find-an-orthotropist/ (accessed 31 July 2014).
2. jawsurgeryforums.com. Available at: http://jaw-surgeryforums.com/index.php/topic,3816.15.html (accessed 31 July 2014).

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ORAL SURGERY

The role of microbiology

Sir, we read with interest the details of the ARONJ masterclass and the seven key messages provided by Moore *et al.*[1] Whilst we support these messages it is important to stress the role of expert clinical microbiology input when managing infectious complications of ARONJ cases. In our experience a team approach between surgical colleagues supplying appropriate clinical specimens and laboratory work up from diagnostic microbiology laboratories is an essential facet of high quality clinical care.[2,3] Selection of appropriate antimicrobial class, route, dose and duration are vital for good clinical outcome and in minimising the risks of antimicrobial resistance.[4] This underlines the importance of the dental profession having access to clinical oral microbiology expertise which is sadly in decline in the UK.

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1. Moore A, Ruggiero S, Rogers S *et al.* ARONJ masterclass. *Br Dent J* 2014; **216:** 488–489.
2. Naik N H, Russo T A. Bisphosphonate-related osteonecrosis of the jaw: the role of actinomyces. *Clin Infect Dis* 2009; **49:** 1729–732.
3. Jackson M, Snall J, McFadzean R, Smith A, Rautemaa-Richardson R. A two-centre retrospective study on the microbiology of bisphosphonate associated osteonecrosis of the jaws. 20th European Congress of Clinical Microbiology and Infectious Diseases, 2010. Available at: http://registration.akm.ch/2010eccmid_einsicht.php?XNABSTRACT_ID=101124&tXNSPRACHE_ID=2&tXNKONGRESS_ID=114&tXNMASKEN_ID=900 (accessed 31 July 2014).
4. World Health Organization. Antimicrobial resistance: global report on surveillance 2014. April 2014. Available at: http://www.who.int/drugresistance/documents/surveillancereport/en/ (accessed 31 July 2014).

DOI: 10.1038/sj.bdj.2014.712