LETTERS TO THE EDITOR

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MINIMAL INTERVENTION DENTISTRY

1970s glass ionomers

Sir, I was interested to read the paper on minimal intervention dentistry by Ngo and Opsahl-Vital (*BDJ* 2014; **216:** 561–565). The article states that glass ionomers were introduced to the dental profession in 1988. I believe it was much earlier. I still have my 'ticket book' given to all students at Guy's and in which all restorations and materials were recorded. In it I see that on 6.10.1977 as a third year student I did a restoration with ASPA – alumino silicate polyacrylic acid. I believe this was the first commercial GIC material, made by De Trey. On the ticket the demonstrator has noted that underneath it was my first pulp exposure. A cutting edge day for me in several respects.

N. Chandler
Dunedin, New Zealand
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ORAL HEALTH

Antacid toothpaste

Sir, we came across this interesting advertisement (Fig.1) in *The Glasgow Herald* (7 November 1941). In the advertisement, the use of milk of magnesia toothpaste for 'smokers' fur' is advocated to get rid of the woolly feeling in the mouth caused by excess acid formation, and for a clean mouth and fresh breath.

Fig. 1 Advertisement in the *The Glasgow Herald* for the antacid toothpaste (Reproduced with permission from *Glasgow Herald*)

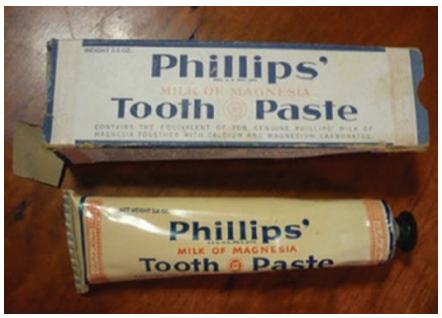

Fig. 2 Phillips Milk of Magnesia toothpaste

Milk of magnesia or magnesium hydroxide is an antacid used to neutralise stomach acid, and a laxative. It is primarily used to alleviate constipation and to relieve indigestion and heartburn. Charles Henry Phillips in 1872 coined the term 'milk of magnesia' which was a white-coloured, aqueous, mildly alkaline suspension of magnesium hydroxide and was sold under the brand name Phillips' Milk of Magnesia for medicinal usage (Fig. 2).

Did the Milk of Magnesia toothpaste really help smokers get rid of stale breath and stains? Did it really make the teeth clean and get rid of the woolly feeling in the mouth due to smoking? Did the woolly feeling in the mouth mean plaque? How would an antacid toothpaste help clean the mouth? All these questions are difficult to answer but this advertisement makes us think about the evolution and advances in oral care products.

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Spit don't rinse

Sir, in Laura Pacey's interview with Tim Elmer on page 13 of the 11 July 2014 issue of the *BDJ* (**217:** 12-14), he says 'including active oral health promotion for recruits, brush twice a day; spit, don't rinse, etc'. I am curious to know where this new advice about not rinsing out after brushing your teeth with a fluoride toothpaste is coming from. I haven't been able to find it on any of the toothpaste boxes that I have checked and I can easily imagine that this might be because – if my memory serves me correctly – one of the toothpaste manufacturers had to make a substantial legal payout to a girl in the United States some years ago because she had damaged her teeth, or her health, by doing exactly this – not rinsing out after she had brushed her teeth.

If this is the case, if somebody in the UK makes a similar claim and it can be shown that they were not rinsing out as a result of advice given to them by their dentist what will the situation be?

J. Hartley
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NHS DENTISTRY

Failed appointments

Sir, since the introduction of the nGDS contract, dentists have been prohibited from charging patients for failed NHS dental appointments. In an effort to gauge the current opinions of colleagues on this matter, a poll was conducted on a UK dental discussion group.

The first question sought to determine the level of support for reintroducing patient charges: 2% (n = 1) of voting members were against failed appointment charges; 77% (n = 50) for all such appointments being chargeable and 22% (n = 14) that charging should be limited to a specified range of unacceptable reasons/excuses. Question 2 asked who should set failed appointment charges if permitted by the NHS: 37% (n = 23) believed NHS, 55% (n = 34) the provider and 8% (n = 5) the performer. Question 3 addressed the division of any fees collected: 20% (n = 12) provider should retain all fees collected, 10% (n = 6) performer should receive all fees and 70% (n = 43) splitting of fees between provider and performer. The fourth question asked if the voter or their practice stopped offering appointments following a maximum of two failed appointments and approximately two thirds were adopting such policies.

In 2011, the BDA reported research which it had conducted into failed dental appointments.[1] It found that failure to attend rates were high, particularly in predominantly NHS practices. In those