LETTERS TO THE EDITOR

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ANAESTHESIA

Over prescription

Sir, a recent study highlights the most likely reason for a child undergoing general anaesthesia (GA), in the NHS, is for dental extractions.[1] This report was unsurprisingly greeted with shock by both public and media. However, little is mentioned of the continued over prescription of GA for dental extractions in adults, particularly with regard increased GA-related morbidity and mortality in adults.

We continue to prescribe GA rarely for dental surgery (Table 1), and this is achievable with appropriate prescription of IV sedation when indicated. An internal audit confirms that 76% of our patients require sedation for the dental extractions when assessed using the indication for sedation need tool.[2]

Our data supports that with adequate IV sedation provision, GA prescription can be minimised thus improving safety for patients. With the intended commissioning shift of oral surgery to primary care, commissioners must understand that many patients require anxiolysis to undergo often quite difficult and unpleasant surgical procedures. Cost implications for the provision of sedation, including team training and facilities, are significant and not reflected in current NHS remuneration or contracting of services. If this underfunding for sedation in primary care persists, more patients will be referred to secondary care for GA, reversing the positive trend in patient safety reported here.

T. Renton, G. Gerrard, O. Obisesan, I. Jackson, by email

GROSS MISCARRIAGE OF JUSTICE

Sir, I wish to express my growing worries over what I see as the rapid deterioration of justice at the General Dental Council.

The recent PCC hearing concerning a doubly qualified professor doctor/dentist is of particular concern. I would like to bring to your attention three main points that I have gleaned from papers relating to justice that have surfaced from this hearing:

- The registrant being doubly qualified had already been judged by the General Medical Council who dismissed the six index cases against him, removed their conditions and imposed undertakings only. Is the GDC superior to an august body of medical peers?
- The GDC so-called expert witness was not in fact an expert in the registrant's field of dentistry. Does this mean that anyone with a lack of subject knowledge but an equal qualification can put in an opinion?
- The contemporaneous patient notes were disregarded and the word of an esteemed and honourable member of the profession speaking under oath was doubted and he was called a liar as was his expert witness. If that is the case, what chance do any of us have of defending ourselves?

This appears to me to be a gross miscarriage of justice which in some terms could be called a 'witch hunt'. Looking dispassionately at this case one can see the oncoming demise of the GDC through their pressing the self-destruct button and what is worse the public's faith in what is in the main a trustworthy and honourable profession is being challenged. As someone who has served on the GDC for nine years in happier times, I am very worried about the future. Is anyone able to call the GDC to account?

M. Bell, by email [received in November]

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Table 1 Table of anaesthetic prescription for third molar surgery/dental extractions (% patient cases not teeth)

Reference locality, year and n	%LA	%Sedation	Out pt GA	In patient GA
King's 2014 n = 5,158	59	38	3	
Birmingham teaching hospital 2013 n = 151[3] Birmingham General Hospital 2013 n = 151	74.7 42.4	14 19.9	11.3 37.7	
Leeds teaching hospital 2003 n = 883-971[4]			60-53	
Cardiff Dental Hospital 1998 n = 444[5]	40-50	10-20	32	44
France 2008 n = 180[6]				100

1. Manning S. Stop the rot! Why thousands of British children are having their teeth taken out in hospital. *The Independent* Tuesday 21 October 2014.
2. Coulthard P. The indicator of sedation need (IOSN). *Dent Update* 2013; **40:** 466-468, 470–471.
3. Pearson D, Dietrich T. Predicting the choice of anaesthesia for third molar surgery – guideline or the easy-line? *Br Dent J* 2013; **214:** 174–175.
4. Jamileh Y, Pedlar J. Effect of clinical guidelines on practice for extraction of lower third molars: study of referrals in 1997 and 2000. *Br J Oral Maxillofac Surg* 2003; **41:** 371–375.
5. Edwards D J, Brickley M R, Horton J, Edwards M J, Shepherd J P. Choice of anaesthetic and healthcare facility for third molar surgery. *Br J Oral Maxillofac Surg* 1998; **36:** 333–340.
6. Trost O, Kadlub N, Robe N *et al.* Third molar surgery under general anesthesia: a review of 180 patients. *Rev Stomatol Chir Maxillofac* 2008; **109:** 91–95, 95-97.

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SELECTIVE LITERATURE USE

Sir, the article by Paul Batchelor *Is periodontal disease a public health problem?* (*BDJ* 2014; **217:** 405-409) is very interesting and raises a number of key issues. However, the section on 'How effective are current care modalities?' is selective in the literature it uses, some of which is misrepresented and this gives completely the wrong message. I therefore cannot let this lie.

He is led to the conclusion that the 'evidence for care modalities is poor'. I would agree with this statement for professional mechanical plaque removal and routine scaling and polish and the references he has selected to support this evidence. However, I would view these as aspects