LETTERS TO THE EDITOR

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IN PRACTICE

Bad posture

Sir, Shiraz Khan is a remarkable young man to have achieved so much at such a young age (*BDJ* 2015; **219:** 6), but his working life is likely to be severely compromised if he continues to work with his neck bent at right-angles as shown in the picture. Regrettably, this is a common posture. Later in his career Shiraz will quite likely be part of the millions of pounds the sickness companies pay out as claims for occupational back pain. My adage for decades has always been to adapt the patient's head position to the dentist, not the other way round. Here the mannequin head is far too low so the dentist has to severely over flex his neck to allow him to work at his close focal distance.

The solution is so simple: raise the patient's chair so the mouth is at the dentist's mid-sternal level so allowing the dentist to work with a straight back and normal neck flexion. Such appalling posture is due to the lack of teaching on correct posture to students and VDPs. I simply can't understand why they still fail to do so.

E. Paul, Edgware

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BOOK REVIEW

Reviewing the review

Sir, it was with such considerable amazement when reading the penultimate paragraph of your *Clinical negligence expert witness* book review (*BDJ* 2015; **219:** 55) that I thought there must have a typographical error.

The paragraph ending '...should we ever become involved within a case representing a defendant or claimant it could make the journey a much less arduous one' is grossly misleading. Notwithstanding your reviewer admitting that she is relatively new to the field, I think she should be made aware of Part 35 of the Civil Procedure Rules. This states unequivocally that an expert has an overriding duty to the court over any obligation to the party from whom they have received instructions or by whom they are being paid.

A clinical negligence expert witness does not represent anybody.

E. Gordon, Finchley

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CLINICAL GUIDANCE

Guidance on guidance

Sir, we read with interest the opinion piece on endocarditis.[1] Dentists are faced with a number of diverse medical problems that can influence the oral healthcare that they provide for their patients, but the evidence for healthcare recommendations very often does not have a reliably solid evidence base.[2] Nevertheless, clinical guidance has been developing in many areas.[3,4]

The changes in the NICE (National Institute for Health and Care Excellence) endocarditis guidelines have not been without consequences, not only in clinical outcomes,[5] but in our experience and opinion, contribute to a lack of clarity for both patients and healthcare providers. We consider that clear unambiguous guidance rather than several variants in guidance such as have appeared in the UK (eg NICE, SIGN) would be more welcome for practitioners and patients; variances between international guidelines hardly help.

Adherence to guidance, though not mandatory,[6] may well in practice be seen as such, because failure to adhere needs justification by the clinician[7] to resist challenge. Non-adherence may arise, amongst other reasons, due to guidelines being based on low-level evidence with weak recommendations and the notion that using such guidance could result in more harm to the patient.[8]

Clinical guidelines are just that, they offer guidance, which is not necessarily applicable to each and every situation and patient. In this respect, it should be stressed that fundamental to sound patient care is good clinical judgment, which involves more than simply the consideration of best current evidence, it requires consideration of patients' expectations, values and preferences to permit patients and clinicians to make informed choices.[7]

C. Scully, London
A. N. Robinson, Singapore
J. A. D. Cameron, Edinburgh

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ORTHODONTICS

A traumatic cause of a ranula

Sir, a ranula is a mucus extravasation 'pseudocyst' that frequently occurs within the body of the sublingual salivary gland or ducts, and less frequently from minor salivary glands in the floor of the mouth.[1] We are seeing increasing numbers of ranulae which appear to be related to traumatic causes attributable to radiograph holders for bitewings or periapicals, and in the younger patient, removable orthodontic appliances. A recent clinical example of a 13-year-old female highlights this. She developed a large painful swelling in the floor of her mouth (Figs 1 and 2) after wearing a functional appliance.

The risks of fixed and removable orthodontic appliances to the hard and soft tissues of the oral cavity are well documented.

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