

and increase investment in new medicines, diagnostic tools, vaccines and other interventions.

Recent weeks have seen reports of microbial resistance to all known antimicrobial agents.²

In the UK itself, antimicrobial stewardship (a systemwide approach to promoting and monitoring the judicious use of antimicrobials with the aim of preserving their future effectiveness) is rightly currently under scrutiny by NICE (National Institute for Health and Clinical Excellence).

Given the above, you will understand our serious concern at the implications of the letter carried in the *BDJ* on 11 December 2015 (*Improved gum health* – p 514).³

Gingival bleeding clearly responds to mechanical or chemical means to minimise bacterial plaque accumulation. It is absolutely crucial that antimicrobials are only used appropriately and for serious infections: failure to follow such advice will inevitably put the public in serious danger, as emphasised by the Chief Medical Officer.⁴

Furthermore, dealing with the antimicrobial mentioned, clarithromycin is a macrolide metabolised by cytochrome CYP3A4 and which can at least precipitate or aggravate ventricular arrhythmias and the cardiac long QT syndrome as well as interacting with other QT-prolonging medications and with several other drugs (eg anti-retrovirals, calcium channel blockers, carbamazepine, cisapride, colchicine, ergotamine or dihydroergotamine, lovastatin or simvastatin, or pimozide) and it should not be used in people with renal or hepatic disease.^{5,6}

C. Scully, London,

A. N. Robinson, Singapore,

D. Wiesenfeld, Melbourne

1. World Health Organization. Global action plan on antimicrobial resistance. Geneva: World Health Organisation, 2015. Available at: http://apps.who.int/iris/bitstream/10665/193736/1/9789241509763_eng.pdf?ua=1 (accessed December 2015).
2. Liu Y Y, Wang Y, Walsh T R et al. Emergence of plasmid-mediated colistin resistance mechanism MCR-1 in animals and human beings in China: a microbiological and molecular biological study. *Lancet Infect Dis* Published online: 18 November 2015.
3. Stepney R, Zalinski A, Patel K. Case report: Improved gum health. *Br Dent J* 2015; **219**: 514.
4. Davies S C. *The drugs don't work. A global threat*. Penguin Book, 2013.
5. Wikipedia. Clarithromycin. <https://en.wikipedia.org/wiki/Clarithromycin>
6. Scully C. *Scully's medical problems in dentistry*, 7th ed. Edinburgh and London: Elsevier Churchill Livingstone, 2014.

Authors' note: Bacteria resistant to colistin, the antibiotic of last resort, have been discovered in China, followed by findings of similar resistance in parts of Africa and Europe, and now in the UK. Public Health England (PHE) found resistant bacteria in

samples of human infections and on three farms. The strains carry a gene *mcr-1*, which can spread rapidly between species, potentially leading to a super-resistant epidemic. Professor Alan Johnson, from PHE said: 'Our assessment is that the public health risk posed by this gene is currently considered very low, but is subject to ongoing review as more information becomes available (<http://www.independent.co.uk/news/science/bacteria-resistant-to-last-resort-antibiotic-discovered-in-uk-a6782331.html>)'.

DOI: 10.1038/sj.bdj.2016.115

PATIENT SAFETY

Scottish Patient Safety Programme

Sir, I read with interest the article by Bailey on patient safety in dentistry.¹ A recent systematic review calls for a collaborative approach to develop concepts for improving patient safety using common methods and an agreed taxonomy.² In Scotland, improving patient safety is a key objective of the Healthcare Quality Strategy.³ A key aspect of this is the development of a strong and positive safety culture in primary care practice.

NHS Education for Scotland (NES) has researched and developed a validated safety climate questionnaire specially designed for use by primary care teams. This questionnaire is now established within the primary medical care setting, has been adapted for use in community pharmacy and recently too (and piloted for use) in the primary care dental setting. Following evaluation, it will be rolled out to all primary care dental practices in Scotland.⁴

In 2016, Healthcare Improvement Scotland will run a one-year pilot improvement collaborative programme across dentistry in primary care settings and three NHS boards have been recruited to take part.⁵ Each board will receive funding of up to £26,000 to cover the payments to five participating dental practices, the costs of a dental clinical lead and a facilitator to support the collaborative, such as data aggregation. During the collaboration process, participating teams will develop and implement a care bundle in at least one high-risk area and conduct a safety climate survey in their dental practice team.

C. A. Yeung, Lanarkshire

1. Bailey E. Contemporary views of dental practitioners on patient safety. *Br Dent J* 2015; **219**: 535–540.
2. Bailey E, Tickle M, Campbell S, O'Malley L. Systematic review of patient safety interventions in dentistry. *BMC Oral Health* 2015; **15**: 152.
3. The Scottish Government. The Healthcare Quality Strategy for NHS Scotland. May 2010. Online information available at <http://www.gov.scot/Publications/2010/05/10102307/0> (accessed December 2015).

4. Scottish Dental Practice Based Research Network. A Safety Climate Evaluation Tool for Primary Care Dental Practice in Scotland. Online information available at <http://www.sdpbrn.org.uk/current-projects-2/patient-safety> (accessed December 2015).
5. Scottish Patient Safety Programme. Dentistry in Primary Care Collaborative. Online information available at <http://www.scottishpatientsafetyprogramme.scot.nhs.uk/programmes/primary-care/dentistry-in-primary-care> (accessed December 2015).

DOI: 10.1038/sj.bdj.2016.116

ORAL HEALTH

Toffee toothpaste

Sir, we are concerned to note that several toothpastes aimed at children have the attractive fragrance and flavour of sweets. Whilst palatable flavours are certainly desirable to improve compliance of child antibiotic and analgesic syrups, it is pertinent to highlight that toothpastes are not meant to be ingested. Children may lack the maturity to distinguish between sweets and colourfully packaged toothpaste that smells and tastes like sweets. Manufacturers diligently test products for safety but the necessity to flavour a toothpaste as toffee or bubble gum is questionable in principle. With phthalates already under the scanner for suspected endocrinal interactions, it is the duty of dental professionals to discourage any practice that may raise the chances of our paediatric patients ingesting toothpaste. Can dental associations coordinate with manufacturers on this one?

N. Uppal, S. R. Uchil, Manipal University, India

DOI: 10.1038/sj.bdj.2016.117

DENTAL EDUCATION

The evolving manikin head

Sir, it was heartening to see an important area of the spectrum of training offered to novice dentists getting some exposure as part of the excellent cover photographic series in the *Journal* (*BDJ* 2015; **219**[10], November 27).

Although a distance from the 1894 setup of the pioneering Oswald Fergus in this respect, we have in most schools and facilities still some way to go to really simulate away from the live patient, the situation that leads to practised and effective close support dentistry delivered by and involving a dentist and nurse/assistant. Most skills rooms feature manikin heads for single operator use.

Leading up to the opening in mid-2015 of the splendid new Education Centre at Morriston Hospital Swansea and as part of the available facilities the decision was made to build a clinical skills simulation

room with 'dual facility' in this respect, in that individual benches would be about 1.8 metres in width to accommodate the appropriate stools for dentist and nurse for all disciplines (Fig. 1).

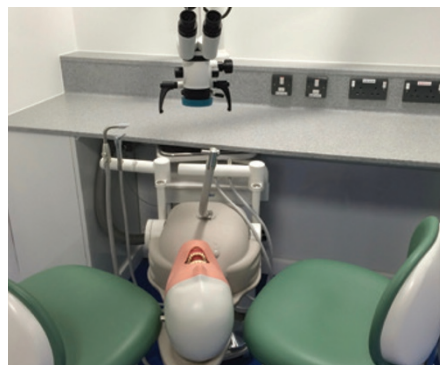


Fig. 1 The dual facility within the clinical skills simulation room at Morrision Hospital Swansea

Since its inception it has been used effectively to teach a spectrum of techniques from routine conservative procedures to more complex endodontics involving microscopy to teams and all including nurse participation.

This has led in the main to some resoundingly positive feedback from participants who have ranged from DF1 status new dentists to hardened practitioners with established 'bad habits'. I have no unequivocal evidence that such training leads to a better patient experience or a hike in quality but I remain convinced that 'on the balance of probabilities' dual training in such a fashion will have a positive impact on the task performance of dentist and close support nurse.

Are there many such facilities in the UK, and if not why not?

K. F. Marshall, by email
DOI: 10.1038/sj.bdj.2016.118

SAFEGUARDING CHILDREN

Was not brought

Sir, safeguarding of children is an issue that should never be taken lightly.

With regards to the recognition of missed dental visits, the term 'did not attend' is commonly used, even with minors. A spin on this has been the introduction of the term 'was not brought' as suggested by Powell *et al.*¹ The terminology, which has been endorsed by consultant paediatric dentists from reputable institutes in the UK, is poignant as failure to attend for healthcare (without reason) is a breach of a child's fundamental rights and thus a child protection issue. The dental team should consider the implementation of this wording as a means of conveying the sincerity of missed appointments to parents.

Practice posters, emails and letters can provide parents with the reminder that the onus of a child's dental attendance lies with them.

Dentists can play an important role in detecting neglect and abuse but for this the child must be regularly attending. However, a lack of regular attendance can also raise an alarm bell.

M. Chand, Northampton General Hospital

1. Powell C, Appleton J V. Children and young people's missed health care appointments: reconceptualising 'Did Not Attend' to 'Was Not Brought' – a review of the evidence for Practice. *J Res Nursing* 2012; **17**: 181–192.

DOI: 10.1038/sj.bdj.2016.119

PHARMACOLOGY

Statins and persistent ulceration

Sir, persistent oral ulceration is a commonly encountered problem in the dental practice. The cause may be difficult to identify and often requires expert input from an oral medicine/oral and maxillofacial specialist. With this letter we would like to remind the readers of the relationship between statins and persistent oral ulceration.

Statins are inhibitors of 3-hydroxy-3-methylglutarylcoenzyme A (HMG-CoA) reductase that have revolutionised the treatment of hypercholesterolemia. Their beneficial effects have been well documented. According to the British Heart Foundation, over 66 million statins prescriptions were written last year, a figure which has trebled in the past ten years.¹

Adverse drug reactions (ADRs) to cardiovascular medication were outlined recently in the literature.^{2,3} The prevalence of oral manifestations of ADRs is not fully known, and the pathophysiological mechanisms for which these occur have yet to be fully elucidated; there have been reports in the literature associating oral ADRs to simvastatin use.

A 62-year-old gentleman recently presented to our clinic with a 12-month history of a recurrent keratotic lesion with areas of small ulceration on the right lateral border of the tongue, which became symptomatic when exposed to acidic or spicy foods. He took regular atorvastatin for hypercholesterolaemia; he was a non-smoker and recorded very occasional alcohol intake.

Histopathological analysis through an incisional biopsy suggested candidiasis with focal ulceration. A two week course of systemic fluconazole and topical nystatin were given; despite this the lesion persisted. Three months later, the patient presented with two additional healing aphthous-type ulcers in the buccal sulcus

adjacent to the upper left canine and lower right second permanent molar.

Statins were suggested as a potential cause for the ulcerations and so were stopped. Six weeks later, the patient reported complete resolution of symptoms and no episodes of ulceration in this time had been noted.

Whilst many patients with oral ulceration have complex polypharmacy, statins are medications that could potentially be stopped without immediate complications and hence a potential causative link could be established or excluded.

D. J. Smith, M. Dillon, J. Russell,
A. Kanatas, Leeds

1. British Heart Foundation. *Statin prescriptions in England rise again*. 9 July 2014. Available at: <https://www.bhf.org.uk/news-from-the-bhf/news-archive/2014/july/statin-prescription> (accessed February 2016).
2. Yuan A, Woo S B. Adverse drug events in the oral cavity. *Oral Surg Oral Med Oral Pathol Oral Radiol* 2015; **119**: 35–47.
3. Kristensen M L, Christensen P M, Hallas J. The effect of statins on average survival in randomised trials, an analysis of end point postponement. *BMJ Open* 2015; **5**: e007118.

DOI: 10.1038/sj.bdj.2016.120

PERIODONTICS

Gingivitis and early labour

Sir, I wished to share with your readership the story of a female patient who attended as a new patient to myself recently. She presented with generally good oral hygiene and minimal inflammation of the gingival tissues with no pocketing present and no loss of bone height radiographically, leading to a diagnosis of mild gingivitis.

During the course of my consultation she happened to mention that the birth of her daughter, now three years old, had taken place two weeks prematurely on the same day that she had attended an appointment for a 'scale and polish' with the hygienist.

The patient enquired as to whether I thought there could be a link. I answered that there has been a relationship established between periodontal disease and early labour due to inflammatory markers (prostaglandins) in the mother's blood but to date I do not know of any research that maintains a link between routine management of mild gingival conditions and labour induction.

I believe that this would be an important area for further study as if this lady's experience is not unique then, as a profession, we need to consider any potential risk of early labour induction in expectant mothers who receive any form of periodontal therapy in the final trimester of their pregnancy.

K. Bell, Bristol
DOI: 10.1038/sj.bdj.2016.121