

LETTERS TO THE EDITOR

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ANTIMICROBIAL RESISTANCE

The need to train clinical microbiologists

Sir, I was saddened to see the letter by Pankhurst *et al.* (*BDJ* 2016; 220: 2–3) referring to the previous lack of manpower planning in clinical oral microbiology. As postgraduate dental dean from 1998–2013, and then as the lead dean for the additional dental specialties from 2000–2012 and as Chair of COPDEND 2006–2012, I, along with the postgraduate deans, consistently argued for the need to train specialists in clinical oral microbiology. We obtained some NHS funds from the then CDO England, Professor Bedi, for two training posts, one each in Bristol and London; after some initial problems, the Bristol funding was moved to London. I liaised with the Lead Postgraduate Medical Dean for Microbiology about training, and colleagues in oral microbiology developed a curriculum in collaboration with the Royal College of Pathologists (then responsible for medical microbiology training) that was eventually approved by the GDC Education Committee (I believe this committee no longer exists).

Attempts to obtain funding for further training posts, as the number of Consultants in Oral Microbiology (COMs) depleted to the point that there were only a few COMs remaining in the UK (and that there were few such colleagues to advise the DH or, as then, the PCTs), were frustrated by comments by a senior member of the profession, at national committee level, that we were managing alright without such properly trained colleagues. Even then we knew there were problems developing with antimicrobial resistance and that both medical and dental GPs were over-prescribing antibiotics. This has all been brought into sharp focus recently by statements from the Chief Medical Officer for England, Dame Sally Davies, as we enter a post antibiotic era.

Recruitment into clinical oral microbiology was also an issue because potential trainees (and postgraduate deans) were uncertain whether there would be NHS consultant or senior clinical academic posts for those completing training to apply for. In

IMPLANT DENTISTRY

Understanding CBCTs

Sir, over the years I have noticed the number of articles dealing with the provision of implants as a treatment option. These articles mention the types of bone that can be present for implant therapy using a classification system used by Lekholm and Zarb¹ labelling bone from D1–D4 types.

Not to be controversial but this type of classification is a misnomer and the teaching of this only prevents the clinician from truly understanding the complexity and importance of the recipient bone in relation to implant dentistry.

This can be easily evident on the examination of a cone beam computed tomography (CBCT) image which is commonly taken pre-operatively. As one that limits work to dental implants it has been rare to find an area of bone that is described and conforms perfectly to the Lekholm and Zarb bone classification.

I would advise colleagues to get a better understanding in examining and reading CBCTs in detail before implant surgery.² It is far better to take into account the quality and quantity of the

local bone and other specifics such as: the cortical thickness, the marrow spaces within, Hounsfield Units, the density of the spongy bone, the large trabecular radiolucencies etc. All of these factors can influence the primary stability and success rates of an implant and can be deduced pre-operatively, rather than labelling it into a specific class of bone post-operatively.

I would advise colleagues to be aware of the limitations in trying to classify the recipient bone into a specific group and to obtain further training in CBCTs as recommended by the British Society of Dental and Maxillofacial Radiology.³

G. Pynadath, by email

1. Lekholm U, Zarb G A. Patient selection and preparation. In Brånemark P I, Zarb G A, Albrektsson T (eds). *Tissue integrated prostheses: osseointegration in clinical dentistry*. pp 199–209. Chicago, Ill, USA: Quintessence, 1985.
2. Horner K, Islam M, Flygare L, Tsiklakis K, Whaites E. Basic principles for use of dental cone beam computed tomography: consensus guidelines of the European Academy of Dental and Maxillofacial Radiology. *Dentomaxillofac Radiol* 2009; **38**: 187–195.
3. Core curriculum in cone beam computed tomography (CBCT) for dentists and dental care professionals. Produced by the British Society of Dental and Maxillofacial Radiology, December 2009.

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addition, UK dental schools have had to rely on non-clinical colleagues to provide undergraduate teaching in clinical oral microbiology. Whilst I know that these colleagues do a sterling job, first hand experience of prescribing by clinicians is also very important. Colleagues in the medical and dental specialties who need the advice of clinical oral microbiologists have long since had to make do without. I know from my time in Sheffield, when we had such a specialist, that our clinicians benefitted from such advice.

Training in clinical oral microbiology has required the support and input from colleagues in medical microbiology and virology and, at one time and in a number of places, that was willingly given. During the last few years of my chairmanship of COPDEND, and while therefore sitting on

the Postgraduate Medical Deans Committee, I was privy to the discussions on the changes being argued and devised, in conjunction with the GMC, for a new curriculum that would incorporate medical microbiology and virology into the medical training programme for infectious diseases. That new curriculum has now been approved and it does make it more difficult to obtain oral microbiology training. However, with goodwill and helpful colleagues in infectious diseases, we know this can be achieved. Before I retired as postgraduate dean, I had fruitful discussions with local medical colleagues in medical microbiology and virology, about future training in clinical oral microbiology, aided valuably I should say by one of the authors of the recent *BDJ* letter referred to at the beginning of this correspondence,