

Letters to the editor

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Oral health

The destructive effects of khat

Sir, having worked as a GDP in an area with a very high population of patients regularly chewing the green-leaved plant khat, I have witnessed first-hand the destructive effects it can have upon oral health. Commonly chewed habitually amongst certain communities for its effects of euphoria and heightened alertness, it is often accompanied by tobacco smoking, and the consumption of high sugar drinks and concomitant use of sugar tablets to counteract the bitter taste.¹ I have noticed that due to this concoction, my patients have often presented with severe staining of the dentition as well as multiple carious lesions affecting several tooth surfaces, quite often rendering teeth unrestorable. Some literature has also suggested other possible adverse oral health outcomes, such as oral mucosal white changes, gingival recession, gingival bleeding and periodontal pocketing among others.² As of June 2014 khat became controlled as a class C drug under the Misuse of Drugs Act. I feel that this legislation has and will continue to have a beneficial effect upon the oral health of patients previously accustomed to chewing khat. In my experience, I have noted fewer patients presenting with such problems since the legislation and hope that this trend continues.

R. Marway, London

1. El-Wajeh Y A H, Thornhill M H. Qat and its health effects. *Br Dent J* 2009; **209**: 17–21.
2. Astatkie A, Demissie M, Berhane Y. The association of khat (*Catha edulis*) chewing and orodental health: a systematic review and meta-analysis. *S Afr Med J* 2014; **104**: n11.

DOI: 10.1038/sj.bdj.2016.468

Special care dentistry

Collaborative care

Sir, I was interested to read the recent *BDJ* research article from the Bart's hospital team¹ especially as the Bart's team provided other

medical interventions, with ENT, ophthalmology or other colleagues during the same general anaesthetic as the dental care for people with severe learning disabilities (LD).

Back in 1980 I managed to negotiate a monthly dental care session in main theatres of a local general hospital in Surrey providing dental care for severe LD patients. The dental care was carried out by community dental service personnel but using hospital theatre clinicians and beds as necessary.

I recall working in my local hospital with a podiatry colleague during the same GA procedures, although we never managed to both work at different ends of the patient at the same time, we usually did the podiatry first then the dentistry.

R. Rippon, Henley on Thames

1. Clough S, Shebabi Z, Morgan C. Reducing health inequalities in people with learning disabilities: a multi-disciplinary team approach to care under general anaesthesia. *Br Dent J* 2016; **220**: 533–537.

DOI: 10.1038/sj.bdj.2016.469

Prophylaxis guidelines

Plea to NICE

Sir, Dr Alderson and Professor Baker wrote^{1,2} criticising our opinion piece³ and preceding *Lancet* paper⁴ concerning antibiotic prophylaxis (AP) for infective endocarditis (IE) but failed to disclose that they work for NICE and were involved in the recent review of guideline CG64.

We remain concerned that the strict review criteria used by NICE exclude animal data and contemporary observational studies as providing sufficient evidence to influence guideline change. Despite our exhaustive efforts (and those of others), a definitive randomised controlled trial seems highly unlikely due to cost, complexity, and ethical issues.⁵ As a consequence, the current criteria dictate that NICE guidance addressing this controversial question can never change. In this context, the

original 2008 decision to withdraw antibiotic prophylaxis (even for high-risk patients) in the absence of a randomised controlled trial (and when less observational evidence was available) seems questionable.

Our observational study demonstrated cause for concern and there was a clinical and moral duty to report our findings. In our manuscript, we highlighted the limitations of our data and explored alternative explanations for our findings.⁴

Dr Alderson and Professor Baker remarked that NICE had the *Lancet* data reviewed by an independent statistician who criticised our analysis, but failed to point out that he was commissioned by NICE to provide this critique or that the *Lancet* paper was reviewed by nine independent experts (including three statisticians), none of whom raised similar criticisms. In fact, even the NICE statistician concluded that he could find 'no factual error with the modelling approach used in the [*Lancet*] paper'.⁶ However, by adding two extra change-points to the analysis (June 2004, June 2011), he could reduce the significance of the IE increase that we detected in March 2008. It should be highlighted that the aim of the study was to determine if the fall in AP prescribing caused by the March 2008 NICE guidelines was associated with an increase in IE incidence and that was the change-point we therefore pre-specified. None of the *Lancet* reviewers questioned the use of this single change-point. Furthermore, NICE gave no reason for choosing these extra two change-points. Nevertheless, adding extra change-points inevitably reduces the power to detect a significant change at any one of them.

We acknowledge that NICE responded to a letter of concern we submitted during the public consultation process, but they have failed to address the important issues it raised. Our plea is that NICE engage in open discussion with cardiologists, dentists, researchers and