LETTERS TO THE EDITOR

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Email bdj@bda.org. Priority will be given to letters less than 500 words long. Authors must sign the letter, which may be edited for reasons of space. Readers may now comment on letters via the *BDJ* website (www.bdj.co.uk). A 'Readers' Comments' section appears at the end of the full text of each letter online.

GUIDELINES

Insufficiency concern

Sir, we have seen the recent publication of the commissioning guides for specialist dentistry (Introductory guide and specialist pathways for orthodontics, oral surgery & oral medicine and special care dentistry). The guides are now live on NHS England's website at www.england.nhs.uk/commissioning/primary-care-comm/dental/dental-specialities/

These guides provide aspirational commissioning standard setting for the provision of specialist dental care across all healthcare settings. However, a note of caution, the commissioning based upon these guides will only be successful with local intelligent implementation and with sufficient workforce to deliver this level of care of specialist services.

I remain very concerned, with an inadequate existing workforce in many specialties, about those patients coming to harm whilst a suitable fit-for-purpose workforce to deliver this standard of care is identified and trained.

T. Renton, London
DOI: 10.1038/sj.bdj.2016.3

Oral health guidelines in humanitarian settings

Sir, the humanitarian crisis in Syria has left a high impact on the Syrian people's general health[1,2] including dire consequences to their oral health status and care,[3] and has negatively impacted what was once labelled as the best dental care system in the Arab world. In response to the ongoing crisis and as an alternative to conventional dental clinics, several refugee dental clinics have been established in border regions to provide the Syrian refugees with much needed dental care. These clinics provide the bare essentials with limited resources and are the dental equivalents of field hospitals.[3]

In light of the obviously challenging circumstances faced by ourselves and other dentists when working in the dental clinics for refugees established in the regions bordering Syria, it is evident there is a need for clinical guidelines with standardised protocols for use in areas of conflict. We would like to propose several areas of focus for immediate attention. Foremost, importance should be given to addressing each patient's chief complaint(s) and to prioritising treatment of infection and acute pain. Thereafter, a simple medical screening tool could help categorise patients in terms of suitability for dental work. For instance, one category could include patients who have immediate medical concerns needing attention before receiving any dental work, another may encompass patients having serious but controlled medical conditions who are fit for dental work, and a third category may be reserved for healthy patients with no or non-significant medical issues who are suitable for dental work.

Apart from prioritisation schemes, guidance should be provided for creating:

1. Better protocols for management of war-related maxillofacial traumatic injuries using a step-by-step approach
2. Circumstance-specific infection control strategies (eg sterilisation and disinfection techniques) with substitutes in cases of material unavailability
3. Treatment alternatives in the absence of dental equipment and radiographic X-ray
4. Mechanisms for charting which are simple yet comprehensive enough to assure adequate patient information
5. Decision tools for medication use including contingencies in circumstances where adequate medications are unavailable.

Lastly, we call for more efforts and attention to the continued suffering of Syrian refugees, and for more humanitarian aid efforts from the dental community to help in relieving the medical and dental consequences of this tragedy.

H. Saltaji and H. Alfakir, Edmonton, Canada
O. Shibly, New York, USA
DOI: 10.1038/sj.bdj.2016.4

1. Hurley R. Who cares for the nine million displaced people of Syria? *BMJ* 2013; **347**: 7374.
2. Saltaji H. 4 years of the humanitarian tragedy in Syria: who cares? *Lancet* 2015; **385:** 943.
3. Saltaji H, Alfakir H, Shibly O. Oral health consequences of the crisis in Syria. *Br Dent J* 2015; **219:** 49.

CONTRACTS

No action needed

Sir, the BDA certainly recognises and shares the concerns expressed by Dr Dawoud (*BDJ* 2015; **219:** 560) about the potential impact of changes to junior doctors' and dentists' contracts. The BDA has been feeding into the negotiating process to make sure the views of trainee dentists are heard. We have been making the very same points as those articulated by Dr Dawoud, for example, about the proposed changes to 'banding' and pay protection arrangements. The BDA also joined our medical colleagues in organising a ballot for potential industrial action.

That this is the first such ballot in the BDA's history demonstrates the importance we attach to this issue. Dentists voted overwhelmingly in favour of strike action, and following the disappointing failure in negotiations, will now stand alongside their medical colleagues in taking action. This is not a step that any healthcare professional takes lightly, but the BDA is supporting junior dentists in their fight against the threat of imposed and unwanted changes that will harm clinicians and patients.

M. Woodrow, BDA, London
DOI: 10.1038/sj.bdj.2016.2

ANTIMICROBIAL RESISTANCE

Antibiotics and consultant oral microbiologist posts

Sir, we welcome the review on dentists, antibiotics and *Clostridium difficile*–associated disease highlighting challenges in antimicrobial prescribing and the alarming rise in inappropriate prescribing patterns.[1]

The Association of Clinical Oral Microbiologists (ACOM) is concerned about this negative development and considers

that many of these short comings are associated with the decreasing number of consultant oral microbiologists (COMs). COMs have the necessary training and experience to teach undergraduates and postgraduates the prevention, diagnosis, surveillance and management of oral and maxillofacial infections in addition to the important principles of antimicrobial stewardship. The latter is essential to ensure the appropriate use of antimicrobial agents both in limiting serious side effects and reducing the emergence and spread of antibiotic resistance. The key requirements of 'high calibre skills base' and 'modernising the surveillance of drug resistance' have been recently highlighted in the O'Neill report[2] on the Global Health Crisis caused by antimicrobial resistance.

The dental profession has relied too long on the assumptions that the microbiology of oral and maxillofacial infections is readily predictable, pathogens are always susceptible to first line antimicrobial agents and that oral and maxillofacial infections are associated with negligible adverse patient outcomes. Today, there is evidence to suggest that even metronidazole may be losing its effectiveness for some species of anaerobes.[3]

At present, ACOM is engaged with the Department of Health in the drafting of a guide for commissioners for the supporting specialties. This is a critical opportunity to recruit and train the next generation of dentally qualified COMs. Two of the biggest challenges to the dental profession over the last decade have included instrument decontamination and antimicrobial stewardship. There are currently too few COMs to adequately address these issues. ACOM proposes that a network of increased numbers of COMs is established as soon as possible to provide leadership in the management of these and other issues.

The need for COMs will increase further with the greater use of implantable biotechnologies and an ageing population with multiple co-morbidities predisposed to infection with more unusual and pan-resistant microorganisms. Advances in diagnostic technologies that increase our understanding of the oral microbiome will be accompanied by a need for clinical skills that integrate clinical microbiology and in-depth knowledge of the complexity of the oral microflora and its increasingly apparent role in systemic diseases. COMs are ideally placed to provide their expertise and leadership through further training at a specialist level but this requires the creation of the appropriate number of training and consultant posts.

C. Pankhurst, R. Rautemaa-Richardson, N. Seoudi, A. Smith, M. Wilson, by email

DOI: 10.1038/sj.bdj.2016.5

1. Beacher, N, Sweeney M P, Bagg J. Dentists, antibiotics and *Clostidium difficle*-associated disease. *Br Dent J* 2015; **219:** 275–279.
2. Tackling a Global Health Crisis: initial steps. The review on Antimicrobial Resistance chaired by Jim O'Neill. February 2015. Available online at: www.amr-review.org/sites/default/files/RARJ3003_Global_health_crisis_report_20.03.15_OUTLINED.pdf (Accessed January 2016).
3. Veloo A C M, Boiten K E, Wekema-Mulder G J *et al.*, Antibiotic susceptibility profiles of Prevotella species in the Netherlands. *Int J Antimicrob Agents* 2015; **45**: 554–556.

RIGHT OF REPLY

A proud contribution

Sir, we read with concern the recent Opinion article regarding our arginine dentifrice research programme (Shaw *et al. BDJ* 2015; **219:** 567–569). As a company dedicated to improving oral health globally, we strongly disagree with the opinions expressed and the conclusions and implications drawn in the article. We are proud of the contribution we have made to caries prevention and the research programme supporting it. The company's detailed response to the opinion article can be viewed at www.colgateprofessionaluk.co.uk/Full-commentary-re-BDJ-18-12-2015-opinion-article.html.

We especially want to call out three important facts:

1. The suggestion by the reviewers that claims of efficacy are unfounded and misleading is completely unsupported and based on a limited number of the published studies. The studies sponsored by Colgate and conducted by respected clinical researchers demonstrate that fluoride toothpaste with 1.5% arginine represents a new standard of care and a step change in caries prevention from conventional fluoride toothpaste. The concerns raised by the reviewers regarding a lack of detail presented in study reports are not evidence of errors in study design. The research programme consists of nine clinical efficacy studies, published in four peer-reviewed journals, conducted in collaboration with leading dental universities around the world and involved more than 16,000 participants. They demonstrate that the arginine formula, compared to regular fluoride toothpaste, reduces new cavities by up to 20% at two years.[1,2] In addition, the clinical programme has shown that brushing with arginine toothpastes contributes to four times greater remineralisation than a conventional fluoride toothpaste and reverses early caries lesions by approximately half in six months. Furthermore, a community-based study conducted in Thailand demonstrated up to 40% reductions in dental decay when arginine toothpaste was incorporated into a school based oral health programme[3]
2. For the two studies that the reviewers questioned the use of non-fluoride toothpaste, the protocols and their ethics were reviewed by the Institutional Review Board (Ethics Committee) of Sichuan University, home to one of China's leading dental schools. It is this review board that is best qualified to judge the ethics of a research rogramme in China. The review recognised the compelling reason to include a non-fluoride control group in the study, to gather direct evidence of fluoride toothpaste's efficacy in the Chinese setting and thereby increase acceptance of fluoride as the standard of care in China. Given this compelling rationale and the robust measures taken to ensure all study participants enjoyed equal long-term oral health benefits, the Institutional Review Board judged that a non-fluoride control was justified under Article 33 of the Helsinki Declaration
3. Contrary to what is suggested in the Opinion article, all authors with an affiliation to the Colgate-Palmolive Company were acknowledged and sponsorship by the company was made clear. We recognise that the potential for bias exists in industry-sponsored research, as it does for academic research. In all cases, we should rely on established processes, including publication in peer reviewed journals, to ensure the validity and reliability of research results.

Colgate-Palmolive believes in robust criticism that is based on facts and conducted with the goal of improving research outcomes. With such review, industry will maintain its ability to prove and publish on innovative technologies that benefit the public's oral health particularly those that impact children.

W. DeVizio and R. Ellwood
Colgate-Palmolive Company, New Jersey, USA

DOI: 10.1038/sj.bdj.2016.6

1. Kraivaphan *et al.* Two-year caries clinical study of the efficacy of novel dentifrices containing 1.5% arginine, an insoluble calcium compound and 1,450 ppm fluoride. *Caries Res* 2013; **47:** 582–590.
2. Li *et al.* Arginine promotes fluoride uptake into artificial carious lesions *in vitro*. *Aust Dent J* 2015; **60:** 104–111.
3. Petersen *et al.*, School-based intervention for improving the oral health of children in southern Thailand. 2015; **32:** 44–50.