COMMENT

Letters to the editor

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Orthodontics

Unacceptable scaremongering

Sir, I remain very concerned that Nicky Stanford continues his misleading and scaremongering tactics, including through the letters of the *BDJ*.[1] He knows full well that the Advertising Standard Authority (ASA) refuse to even consider the proper best practice evidence-based medicine (EBM) criteria in their deliberations. The ASA will now only consider very clear orthodontic results from randomised clinical trials (RCTs) – it means nothing to the ASA even if one has a hundred consecutive good fast ortho cases as a clinician; no RCTs = no claims/possibilities are now allowed to benefit others on informative websites or adverts, basically.

That is very narrow and punitive ASA criteria for those clinicians achieving great clinical results on a very regular EBM basis. It could now mean almost all 'current practice' claims/possibilities in dentistry may not be made publicly, including orthodontics improving intra-oral health, at all. So ironically Nicky Stanford (and his small group of co-conspirators?) may well be making a bigger rod for their own UK orthodontic colleagues' backs.[2]

I also note straight after his 11 March 2016 BDJ letter was published[3] it was critiqued heavily upon social media in the following days. Nicky Stanford only then sets out looking for other victims many weeks after this, prosecuting his campaign again and complaining afresh to the ASA on 23 April 2016.[4] Thus there was no overlap of his ASA complaints/outcomes and his 2017 excuse for not responding/apologising for his original misleading and scaremongering tactics in 2016, just compound errors and now looks manipulative, vindictive or potentially abusive.[5]

A non-academic may not know what EBM multiple-criteria actually are (best practice), but to mislead *BDJ* readers without making this aspect clear, then scaremongering with partial information and implied threats to registrants, is simply unacceptable.[3] Nicky Stanford now owes myself, our profession and readers of the *BDJ* a double-apology after a double-dose of reflection, otherwise he is in danger of remaining double-blind vengefully, I fear.

T. Kilcoyne, by email

1. Stanford N. Orthodontics: Falling foul of standards. *Br Dent J* 2017; **222:** 498.
2. Millett D T, Cunningham S J, O'Brien K D, Benson P, Williams A, de Oliveira C M. Orthodontic treatment for deep bite and retroclined upper front teeth in children. *Cochrane Database Syst Rev* 2006; CD005972.
3. Stanford N. Orthodontics: Fast removal of claims. *Br Dent J* 2016; **220:** 220.
4. ASA Ruling on IGDP Ltd. 8 March 2017. Available at: http://www.asa.org.uk/rulings/igdp-ltd-a16-348854.html (accessed 15 May 2017).
5. Kilcoyne T. Orthodontics: monopolistic behaviours. *Br Dent J* 2016; **220**: 558.

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Referrals

We must work together

Sir, regarding Mr Raftery's letter,[1] the British Association of Oral Surgeons (BAOS) share the author's concerns regarding provision of potentially substandard apicectomies and we agree that in an ideal world all these procedures should follow the national guidelines. The guidelines for this procedure by RCSEng (which our president, Professor Renton, was involved in writing) demonstrate the importance magnification and ultrasonic preparation have in achieving higher success rates. We are disappointed to learn some of Mr Raftery's local colleagues do not have access to the equipment required to comply with guidelines.

Periapical surgery appears on the specialist training curriculum of both oral surgery and endodontics and indeed, many of our oral surgery trainees undertake this training with guidance from both oral surgeons and endodontists in a hospital setting. We of course agree that in line with recommendations for commissioning of dentistry, the procedure should be completed in the most appropriate setting, by the professional with the required skill set and at best value for money.

Unfortunately, the reality is that many patients are not able to access routine RCT and trends in NHS dentistry demonstrate a reduction in complex treatments, such as root canal treatments (45% according to Health Committee Enquiry), and an increase in extractions, since the introduction of the contract in April 2006. As we're sure Mr Raftery agrees, we must work together to achieve the best possible outcomes for patients using the available evidence in the environment of the National Health Service and within the remit of both specialties. Hopefully, the future will provide access for all NHS patients to evolving endodontic therapies, thus reducing the need for RCT and subsequent periapical surgery and unnecessary extractions.

S. McKernon, by email

1. Raftery P. Referrals: Apicectomy. *Br Dent J* 2017; **222:** 2.

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Dental practice

Deep satisfaction

Sir, I enjoyed 'First impressions':[1] it never does any harm to put yourself in your patients' shoes. But I was reminded of the time I was lolling on a popular beach in Corfu when a couple of larrikins on mopeds turned up. One of them yelled, 'Oi, SPIRO!' About half of the men on the beach jumped up and looked around while the pair made their escape bent double with laughter.

Where I currently work, if I went into the waiting room and asked for Mr Macdonald