recommend that antimicrobials should only be used as an adjunct to operative treatment, be it incision and drainage, extraction, or opening of the pulp chamber.[1] In addition, excessive use of antimicrobials is contributing to an ever growing concern regarding antibiotic resistance and it is estimated that 25,000 people die annually in the EU as a result of this.

There are significant financial implications with regard to inpatient treatment of odontogenic infection. Hospital episode statistics show that over the past five years there has been an increase in the incidence of admissions for drainage of dental abscesses: 2,281 admissions during 2014–2015 in England alone.[2] Reasons which may prevent treatment in primary care may include limited access to NHS dentists, reluctance of patients to visit a dentist, the cost of treatment or dental phobia. We found that a proportion of patients also favoured initial presentation to their general practitioner rather than their dentist.

As threats to divert and close A&E services loom, we have to be realistic about the impact that these admissions are having on the NHS. The reality is that many dental infections seen are entirely preventable and can be effectively managed in the community. We propose that there should be enhanced education for patients, dentists and medical practitioners, alongside financial incentives and targeted treatment goals which may be a means to encourage appropriate first line treatment in primary care.

E. Bowden, H. Cashman, by email

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Dental radiography

Cherry picking evidence

Sir, we write to respond to the opinion article published in the previous issue of the *BDJ* (In our opinion. *Br Dent J* 2017; **222:** 918–921). We wish to thank David Davies for his continued interest in dental X-rays. His paper does nothing to change our view that these tests remain, on balance, inaccurate, unethical and inappropriate.

We did not enter this debate with an agenda, short of ensuring the best interests of both patients and practitioners. We are not ideologues or dogmatists, we are health professionals.

As an organisation we endeavour to follow the principles of evidence-based policy making. We arrived at our current position following considerable – and sustained – deliberation. We take our cues from the available science, ethical standards and of course with input from practitioners at all levels.

Mr Davies in contrast seems to favour policy-based evidence making. Certainly he has gone to some lengths to source academics that can support his position. Having claimed to have found a magic wand for establishing age – only to be roundly dismissed by both government and healthcare professionals – he has worked backwards to try and lend credence to his call.

Certainly his co-authors include notable 'enthusiasts' for the practice of dental age checks, who have provided 'definitive' evidence that is not quite so clear in wider academic research. We respect dissenting voices. The scientific method demands their presence to challenge and move the debate forward. However we do not set out to cherry pick our evidence with the sole intention of justifying a pre-baked position. We want to be guided by the science, not by ideological commitment.

And on ethics we must again part company with the authors. They have gone to great lengths to state that the risks to the individual of a medically unnecessary and potentially harmful procedure can be weighed against the perceived benefit to society. Frankly, these are not principles we can sign up to. Yes we have made a choice, and we will not be venturing down a path trodden by eugenicists in the name of the 'Greater Good'.

We are conscious that both the current and former Chief Medical Officers for England have raised significant concerns about age test trials co-author Prof Roberts has conducted in the past, which have subjected children to X-rays without ethical approval. We recognise these age tests do have a handful of passionate and highly motivated advocates, but there is a question of judgement here. And that passion can leave us unclear where the science ends and the fan club begins.

As the professional association for dentists, we also have a duty to ensure our members are not placed in what could be compromising positions. And we are heartened by the weight of support our position has generated among colleagues.

From the very start Mr Davies has presented these tests as a silver bullet to establish a migrant's 'true age'. Our contention, again based on the overwhelming weight of scientific evidence, is that such claims of 'precision' cannot be made. Yes the science may evolve. We are open-minded. As for the ethics, it may be time the authors found some new arguments.

M. Armstrong, Chair, BDA
R. Ladwa, Chair, Health and Science Committee, BDA
A. Lockyer, Chair, Education, Ethics and the Dental Team Working Group, BDA

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Oral health

Praise for National Smile Month

Sir, I would like to make a special mention and give some history and background to what is one of the UK's more important campaigns to increase awareness in oral health. It first started back in 1977 under the name Smile '77. During the 1980s and 1990s a few messages were shared with the public such as 'Eat well and stay biting fit' or 'Show your teeth you care!' It was on its 30th birthday when due to an increase in popularity, it started a new era as National Smile Month. We are familiar with its three points as they have been replicated through every campaign: 'Brush your teeth last thing at night and at least on one other occasion with a fluoride toothpaste; cut down on how often you have sugary foods and drinks; visit your dentist regularly, as often as they recommend'. I would like to thank in my name and in that of the profession, everyone who has been part of the campaign. It is rewarding to see again this year social media people sharing lovely pictures and messages raising awareness in oral health. However, as prevention is part of our core standards it would be great to keep the same enthusiasm all year long.

C. Jimenez, by email

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