investigation against me that I believe to be grossly inappropriate and totally unrelated to the clinical issues involved. They have made a raft of unpleasant allegations against me and suggested that I am a 'danger to the public' based on these records alone. They have chosen to ignore my unblemished previous history, two immaculate CQC reports and several glowing recommendations from patients and staff.
I have gone to considerable lengths in the last two years to vastly improve my record-keeping (SOE has been installed at the practice, I have had a number of external audits done by an expert at DPS and I have also done much in the way of CPD and remediation and reflective logs) but the GDC has chosen to ignore this and continue to pursue the case. At no point has anyone (including my legal team) made any attempt whatsoever to explore the actual clinical issues involved. My legal team (who I know are doing their best) have pretty much said that I am indefensible because my initial records were poor. This is akin, in my view, to making a definitive diagnosis on a patient based on some old records without even examining them. Frankly, this Kafkaesque procedure has destroyed much of my passion for a profession I once considered noble. If I was of an age and in a position to retire, I would.

It seems to me that the GDC has become an unfit for purpose, bureaucratic behemoth, built and fuelled by parasitic lawyers, that does precious little to protect patients and serves mainly to protect itself and those who profit from it. I think the current legal 'feeding frenzy' in medicine is doing a great disservice to patients and I feel the Government and the profession should be fighting hard to change this culture.

Name supplied

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Antimicrobial resistance

Refresh your memory

Sir, today is 18 November 2016, the European Antibiotic Awareness Day. I sincerely applaud today's eloquent *BDJ* editorial[1] which recapitulates the crucial importance of proper antibiotic management in dentistry and raises awareness of this issue that is so, so important for humankind.

Microbes almost always steal a march on us humans, and the weaponry as well as the armamentarium available to us in defence against these ferociously lethal enemies is rapidly dwindling for a variety of reasons. Shortly we are bound to run out of our weaponry and it is critical we resort to rational prescribing to save our armoury.

The ground rules of rational prescribing of antibiotics are clearly articulated in the recently released Antimicrobial Stewardship Toolkit mentioned in the editorial and at https://www.gov.uk/guidance/dental-antimicrobial-stewardship-toolkit, and elsewhere. I implore all clinicians to visit this site for a few minutes to refresh their memory on strategic and rational antibiotic prescribing.

L. Samaranayake, by email

1. Hancocks S. Antibiotics don't cure toothache. *Br Dent J* 2016; **221**: 595.

DOI: 10.1038/sj.bdj.2017.5

Smoking cessation

The role of e-cigarettes

Sir, I am writing in reference to the *Potential quitters turn to e-cigarettes* Upfront news article[1] that was published in a recent issue of the *British Dental Journal* which seemed to imply that e-cigarettes were undermining smoking cessation attempts. This article was written in reference to a Health and Social Care Information Centre report[2] which described the continued fall in the use of the Stop Smoking Services (SSS) and suggested that this 'may be partly' due to increased use of e-cigarettes.

This publication was very timely, because almost within the same week, a study which addressed this exact topic was published in the *BMJ*.[3] This study, the first of its kind, estimated the population impact of e-cigarettes usage by undertaking a time series analysis to explore an association between use of e-cigarettes and changes in quit attempts at a population level. Some key conclusions of this study were that:

- E-cigarette use by smokers (in England) was positively associated with the success rates of quit attempts
- No clear association was found between e-cigarette use and the rate of quit attempts or the use of quitting aids (except for NRT obtained on prescription, for which there was a negative association with e-cigarette use).

The authors of the *BMJ* paper estimated that in 2015 there were 54,288 additional short- to medium-term quitters compared with no use of e-cigarettes in quit attempts, and on the assumption that approximately two-thirds of these may relapse in the future, that e-cigarettes may have contributed about 18,000 additional long term ex-smokers in 2015. The authors point out that although these numbers are relatively small, they are clinically significant given the huge health gains of stopping smoking.

This is obviously an important area and continued careful surveillance of the data relating to e-cigarette usage, quit attempts, and smoking cessation is required. It is also critically important that we investigate further the oral health effects of e-cigarettes, to contribute to these complex discussions.

R. Holliday (Newcastle), P. Preshaw (Newcastle), L. Bauld (Deputy Director of the UK Centre for Tobacco and Alcohol Studies [UKCTAS])

1. Potential quitters turn to e-cigarettes. *Br Dent J* 2016; **211:** 284.
2. Health and Social Care Information Centre. Statistics on NHS Stop Smoking Services. England, April 2015 to March 2016. Available at: http://content.digital.nhs.uk/catalogue/PUB21162 (accessed December 2016).
3. Beard E, West R, Michie S, Brown J. Association between electronic cigarette use and changes in quit attempts, success of quit attempts, use of smoking cessation pharmacotherapy, and use of stop smoking services in England: time series analysis of population trends. *BMJ* 2016; **354:** i4645.

DOI: 10.1038/sj.bdj.2017.6

Anaesthesia

LA in pregnancy

Sir, the use of local anaesthetics (LA) in the treatment of pregnant women is a difficult area as there is an absence of evidence because of ethical constraints preventing randomised controlled studies. Current advice is to avoid non-essential dental treatment until after pregnancy, and where treatment is required to aim to perform it in the second trimester. The reason for this is that in the first trimester organogenesis occurs and small degrees of insult may lead to significant damage to the developing foetus.

The difficulty with comparing the use of LA as opposed to not using them is further complicated because it is usually an adjunct to carrying out a secondary procedure, so a control group not having treatment under LA would also include the group that did not have actual treatment. Therefore, any complications noted in the mother and child would include some of the complications of lack of treatment of the dental problem (eg caries, dental abscess etc).

A recent article reported a prospective, comparative observational study following 210 pregnancies exposed to dental LA in the first trimester compared with 794