COMMENT

Letters to the editor

Send your letters to the Editor, *British Dental Journal,* 64 Wimpole Street, London, W1G 8YS. 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.

Relationships

Intimacy and ambiguity

Sir, the editorial[1] in Volume 225 number 2, 27 July 2018 entitled '*No sex please, we're dentists*', made me consider that mouths have an important part to play in the more intimate aspect of relationships.

Many of your readers will have come across numerous oral environments that must greatly hamper such intimacy. I suppose as professionals we have a role in such intimacy.

However, I would have to admit that I would feel a tad uncomfortable about having a notice in the waiting room along the lines of 'Dentists can enhance your sex life' – it might lead to some embarrassing ambiguity!

P. Williams, by email

1. Hancocks S. No sex please, we're dentists. *Br Dent J* 2018; **225:** 91.

DOI: 10.1038/sj.bdj.2018.872

HIV/AIDS

Running away?

Sir, your editorial[1] and the paper *People Living with HIV STIGMASurvey UK 2015: Stigmatising experiences and dental care*[2] were saddening and depressing for me.

My experience of risk aversion by my dental colleagues dates back before a Hepatitis B vaccine was available when I discovered that I was the only clinician prepared to treat the unfortunate hepatitis sufferers or carriers.

The whole situation was then repeated when HIV/AIDS came to the fore. It is notable that this degree of aversion applied neither to the dental and medical nursing staff nor to anaesthetists who were willing to help me.

The late Professor Scully and I fought long and hard for universal precautions in the face of opposition from management and, bizarrely, the very same risk averse clinicians. With a breath-taking display of psychological ineptitude, they believed that a simple questionnaire would identify risky sexual practices.

What a pity that we seem not to be able to emulate fire-fighters, ambulance crews and police who run towards trouble, not away from it.

M. Griffiths, by email

1. Hancocks S. No sex please, we're dentists. *Br Dent J* 2018; **225:** 91.
2. Okala S, Doughty J, Watt R G *et al.* The People Living with HIV STIGMASurvey UK 2015: Stigmatising experiences and dental care. *Br Dent J* 2018; **225:** 143–150.

DOI: 10.1038/sj.bdj.2018.873

Out of hours

Someone has to do nights

Sir, whilst reading my wife's copy of the *BDJ* I came across J. White's letter (*BDJ* 2018; **225:** 93) regarding dental core trainees (DCTs) and out of hours (OOH) cover. The tone of the letter and its content were concerning to me as an anaesthetist.

I agree that nobody wants a return to the days of 1:2 cover and 100-hour weeks, but there is a need to balance training and service provision. And, whilst true that nights may be harmful to health in the long term, someone has to do them.

The patients don't stop getting unwell just because it's an anti-social hour. Whilst there may be issues with covering medical complaints, trained dental senior house officers (SHOs) are best placed to provide immediate care for those with dental/maxillofacial trauma and disease OOH.

Nights gave me some of the best experience during my training. I was able to take what I had been taught under direct supervision and apply it without someone standing over my shoulder. I was able to find my own way of doing things but safe in the knowledge that I had senior support as needed. This experience would be essential for those considering a career in OMFS, as many DCTs may be.

Just because someone is not there teaching you, it doesn't mean you're not learning. Developing autonomous practice is vital for any doctor or dentist, especially those that find themselves working the majority of their career alone in practice.

With specific regard to the NG tube call; I hope that the author attended promptly to the ward nurse's concerns and assessed the patient because the 'intra-oesophageal somersaults' referred to in the letter are certainly possible.

I have seen two patients with aspiration pneumonitis because their NG tubes had migrated up the oesophagus after vomiting but appeared unchanged from the outside and feeding had continued. A misplaced NG tube is a Never Event[1] and strict guidelines must exist for the insertion, checking and monitoring of patients with NG tubes.

S. Jones, by email

1. NHS Improvement. Never Events list 2018 (January 2018). Available at https://improvement.nhs.uk/documents/2266/Never_Events_list_2018_FINAL_v5.pdf (accessed on 23 September 2018).

DOI: 10.1038/sj.bdj.2018.874

Antibiotic prophylaxis

Back from the brink

Sir, the Scottish Dental Clinical Effectiveness Programme (SDCEP) are to be congratulated for their advice concerning the implementation of NICE guideline CG64 – prophylaxis to prevent endocarditis[1] and for obtaining the endorsement of NICE, the British Cardiovascular Society and the Royal Colleges. This should help ensure that the advice is implemented UK-wide.

Dentists should now:

(A) Make specific patient groups aware of their increased risk of infective endocarditis (IE)

(B) Discuss the advantages and potential drawbacks of antibiotic prophylaxis (AP)

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(C) Liaise with cardiologists/cardiac surgeons as appropriate
(D) Allow the patient to make the ultimate decision whether or not AP will be used.

This is a significant departure from the NICE 2008 recommendation against antibiotic AP.[2] It essentially mirrors guidelines from the European Society of Cardiology (ESC)[3] and the American Heart Association (AHA)[4] and is in keeping with the legal precedent provided by Montgomery.[5]

However, we have some reservations. SDCEP adopted the ESC and AHA definition of invasive dental procedures, ie procedures requiring manipulation of the gingival or periapical region of the teeth or perforation of the oral mucosa. In their consultation document, they gave the same list of exceptions as ESC/AHA.

In their published advice, however, BPE screening and supragingival scale and polish have been inexplicably added as examples of 'non-invasive procedures'. This is of considerable concern.

BPE screening involves periodontal-probing of all teeth to identify the deepest pocket in each sextant. Several studies have shown that periodontal probing can cause significant bacteraemia with organisms that cause IE.

Most supragingival calculus accumulates at the gingival margin and causes gingival inflammation. Instrumentation to remove this often results in gingival manipulation and bleeding.

Numerous studies have shown that scaling (including supragingival scaling and polishing) can cause significant bacteraemia with IE-related organisms. We are unaware of evidence demonstrating the safety of these procedures and dentists and hygienists following ESC and AHA guidelines normally provide AP cover for these procedures (as did UK dentists prior to the 2008 NICE guidelines).

We agree with SDCEP that patients at 'increased risk' of IE should have this level of risk explained to them. However, the illustrative figure provided by SDCEP (1/10,000/year) relates to the general population and is much lower than the actual level for those at increased (34/10,000/year) or high-risk (50/10,000/year) – called the 'special consideration sub-group' by SDCEP – as shown in a recent study referenced within the SDCEP document.[6]

It would be misleading, therefore, to use a figure 30-50 times too low to illustrate the level of risk for these patients. Similarly, whilst SDCEP described the 'special consideration sub-group' as representing a small fraction of those at 'increased-risk', the same study identified 365,875 individuals at 'increased-risk' in England (2000-2008) with 96,021 (26%) in the 'special consideration sub-group'.[6]

Furthermore, the number at high-risk is growing inexorably as those at moderate-risk undergo cardiac interventions that convert them into high-risk ('special consideration sub-group') cases.

We hope these issues are quickly addressed so that clinicians can confidently adopt the SDCEP advice nationwide.

M. H. Thornhill, J. B. Chambers, B. D. Prendergast, M. Dayer, T. J. Cahill, P. B. Lockhart, and L. M. Baddour, by email

1. National Institute for Health and Care Excellence (NICE). Prophylaxis against infective endocarditis 2016 [NICE Clinical Guideline No 64]. Available at http://www.nice.org.uk/guidance/cg64/chapter/Recommendations (accessed 23 September 2018).
2. National Institute for Health and Care Excellence (NICE). Prophylaxis against infective endocarditis 2008 [NICE Clinical Guideline No 64]. Available at http://www.nice.org.uk/guidance/cg64 (accessed on 23 September 2018).
3. Habib G *et al.* ESC Guidelines for the management of infective endocarditis. *Eur Heart J* 2015; **36**: 3075–3128.
4. Wilson W *et al.* Prevention of infective endocarditis: guidelines from the American Heart Association. *Circulation* 2007; **116:** 1736–1754.
5. Montgomery v Lanarkshire Health Board (Scotland). 2015. Available at https://www.supremecourt.uk/decided-cases/docs/UKSC_2013_0136_Judgment.pdf. (accessed 23 September 2018).
6. Thornhill M H, Jones S, Prendergast B *et al.* Quantifying infective endocarditis risk in patients with predisposing cardiac conditions. *Eur Heart J* 2018; **39:** 586–595.

DOI: 10.1038/sj.bdj.2018.875

Malocclusion

Modern clinical research

Sir, I must protest at the contents of John Mew's letter (*BDJ* 2018; **225:** 95–96).

What he says is untrue. His licence to practice was not removed by the GDC for promoting 'orthotropics' but for other very good reasons concerning his professional conduct. His two hearings can be reviewed on line at https://olr.gdc-uk.org/hearings?name=MEW,%20John%20Roland%20Chandley#filterresults.

It is also quite untrue that his erasure has prevented him from providing the evidence that his treatment methods are effective.

Before his licence to practice was removed, he had 30 years in which he could have attempted to do so. Instead he tried to convince me and my academic colleagues that it was our responsibility to undertake this!

Not only myself, but also the late Professors Houston and Moss spent a great deal of time trying to persuade Mr Mew that, in an age of prospective randomised clinical trials, any retrospective analysis of selected cases which Mr Mew believed he had treated successfully by his methods was pointless and did not conform to contemporary standards of clinical research, all to no avail.

C. Stephens, by email

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British National Formulary

Instant interactions online

Sir, it has come to my attention that there is a surprising lack of awareness amongst general dental practitioners that the British National Formulary (BNF) is no longer issued to dental practices free of charge.

The BNF can be accessed at no cost through an app and the Internet.

At first, I was deeply sceptical and somewhat cynical with regard to this migration away from print copies to a digitised version of the text.

However, having used the online version, I can immediately see a number of potential benefits for our patients.

On the homepage, there is a clear submenu to the left entitled 'Interactions – Browse the list of drug interactions, arranged alphabetically'. I would emphasise that similar information has always been available in the print copy. However, it does appear more accessible and clear in the digital version.

A recent *BDJ* paper detailed the potential for serious harm and death in prescribing miconazole oral gel to patients on warfarin.[1] A simple search of the drug miconazole in the interactions tab would quickly produce a red box, explaining that the anticoagulant effect of warfarin is increased by the antifungal, that the reaction is 'severe' and that the MHRA 'advises avoid'.

Dental practices can still purchase an individual print copy of the BNF (£57.50) but I would question the wisdom of this when the online version is updated monthly and the print copy is only updated biannually.

I would implore all dentists involved in prescribing to make full use of this valuable resource so that we can work towards reducing prescribing errors.

A. Mehdizadeh, by email

1. Pemberton M N. Morbidity and mortality associated with the interaction of miconazole oral gel and warfarin. *Br Dent J* 2018; **225:** 129–132.

DOI: 10.1038/sj.bdj.2018.877