Please note that all letters must be typed. Priority will be given to those that are less than 500 words long. All authors must sign the letter, which may be shortened or edited for reasons of space or clarity. All letters received are acknowledged.

The Odol man

Sir, — I was very interested to see the advert for Odol mouthwash on the *BDJ* cover in the September 26 issue. Readers may be reassured to know that mouthwash made as many millions for their manufacturers at the beginning of this century as at the end. On a visit to Dresden in 1997 I visited the Deutschen Hygiene Museum, opened in 1930 from the profits made from Odol by Dresden industrialist, Karl August Lingner (1861-1916).

Lingner was also responsible for the first International Hygiene Exhibition in 1911 in Dresden which was visited by five million people. The Deutschen Hygiene Museum deserves to be better known in Britain as it provides an excellent health education service, particularly for the young people of Saxony on such subjects as AIDS, drugs and contraception. There is, of course, a dental education section. The museum's most famous exhibits are the glass man and woman which have internal organs that light up at the touch of a button.

As to the efficacy of the mouthwash? We can only speculate.

M Austin
Brighton

A sign of the times?

Sir, — Trauma to the upper central incisors in children has been an all too frequent event in the life of a general dental practitioner. The causative agent of this trauma has varied over the years and passed through the skateboard and rollerblade phases.

Perhaps the most unusual case I had seen is one caused by a fight over a computer joystick. However, yesterday I saw my first case of two fractured incisors due to a yo-yo trick injury. What next?

C H Walker
Barnsley

Safety of adrenaline

Sir, — Dr Padfield makes some interesting suggestions in his recent letter (*BDJ* 1998; **185:** 266). He is critical about the continued use of adrenaline, particularly at a 1:80000 concentration, in dental local anaesthetics. His opinions should not pass without comment. An individual's doubts, after a few clinical observations and without supportive evidence, should not result in a change in practice.

Lignocaine 2% with adrenaline 1:80000 has been used successfully throughout the world for fifty years. Nevertheless, it is sensible to examine our 'usual' and 'time-honoured' practices, but the following should be taken into account:

1. I have responded to many more adverse reactions in 'local anaesthesia' and 'minor oral surgery' departments than Dr Padfield in the last twenty-five years and can confirm that the vast majority of adverse reactions in dental surgery (involving 'collapse', tachycardia etc) are due to anxiety.
2. An intravascular injection of a solution containing adrenaline will cause a tachycardia and is potentially harmful. Dr Padfield comments that 'many dental syringes do not aspirate' — old fashioned, unsatisfactory equipment must be discarded. Aspiration is an essential aspect of the procedure[1] and if a dentist does not use an aspirating system this is a failure to adopt a satisfactory standard of care.[2]
3. There is no substantial evidence that patients with 'cardiac problems' suffer when given lignocaine with adrenaline[3] — for any patient, safe administration requires that the drug is given properly ie the total dose is controlled, aspiration is carried out and the injection is given slowly.[4,5]
4. To achieve a satisfactory level of analgesia, the incorporation of adrenaline 1:80000 with lignocaine does appear to be necessary.[6] However, I share Dr Padfield's disquiet about this and hope that a local anaesthetic is developed which will provide the same depth of analgesia with a lesser concentration of adrenaline but, at present, lignocaine 2% with adrenaline remains our most reliable agent. It is not the speed of onset which is principally improved by adrenaline (it is probably delayed),[7,8] but the depth of dental pulpal analgesia.[8]
5. Dr Padfield offers a potential research project. I am pleased to report that research has been undertaken (soon to be submitted for publication), which confirms that adrenaline does cause neural ischaemia. Indeed, I believe that the anoxic block which results from the application of adrenaline is one of the mechanisms which makes the addition of adrenaline so effective in (dental) local anaesthesia. This may not, however, be without occasional neurotoxic effects.
6. The suggestion that the adoption of prilocaine and octapressin would allow us all to 'relax' must be challenged. Inadequate depth of analgesia could be harmful.[3] Felypressin, unlike adrenaline, causes constriction of coronary arteries.[9] Prilocaine has, unlike lignocaine, been implicated in neurotoxicity after dental injections[10] and is more likely to produce methaemoglobinaemia, which can cause misinterpretation of SaO_2 levels with pulse oximetry.[11]

Lignocaine (with 1:80000 adrenaline) is the most reliable local anaesthetic preparation currently available for dentistry and, when used correctly, is safe.

J P Rood
London

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The advantages of telephone reminders

Sir, — The article by Reekie and Devlin (*BDJ* 1998; **185:** 472-474) reflects my own (*The Dentist* 1985; **2:** 14-17), in which I advocated using telephone reminders, in conjunction with computer generated lists, for regular check-up appointments made six months previously.

I postulated that this was the most effective (and only) way to pay for the high cost of a computer system at that time, by ensuring the regular attendance of patients every six months. The advantage of telephone reminders, not stressed by your authors, is that when telephoning someone who cannot attend any particular appointment, it is then possible for the dentist's time to be resold while speaking to the patient. This is

not possible with either written or automated reminders.

A further necessity, of course, is that these telephone calls should always be made on a separate line dedicated for outgoing calls only, the main practice number never being blocked for incoming calls by using such a system.

In my own practice at that time, the same method was also used for long treatment appointments. The whole system was as effective then as your authors have shown it to be now.

M H Rich
Eastbourne

Wide circulation

Sir, — I received a paper in the Effectiveness Matters series from the CRD at the University of York entitled 'Prophylactic removal of impacted third molars: is it justified?' with a covering letter addressed to all members of the BDA. It is evident however that it was circulated far more widely, as not only was there a simultaneous press release, but also my waste bin is filling with copies sent to me by consultants in dental public health, medical and clinical directors, clinical effectiveness committees and clinical audit departments.

This is particularly unfortunate as current practice in the UK follows and as shown by the National Third Molar Audit of the British Association of Oral & Maxillofacial Surgeons[1] has for some time supported the philosophy of 'not routinely removing pathology-free third molars' espoused in the paper. Why then has it been circulated so widely and why does it put such a polarised spin on the quoted figures for the incidence of pathology which are at variance with the 250 or more papers reviewed as a prelude to the publication of guideline documents from the Faculty of Dental Surgery of the Royal College of Surgeons of England?[2,3]

The 'take-home message' is already practiced in consultant-based units throughout the UK, but the general public and managers are repeatedly given the impression that third molars are being inappropriately removed on a wide scale.[4,5] The irony is that we still have no prospective, randomly controlled trial which compares and contrasts the outcome of removal against retention and monitoring of wisdom teeth over an extended period. One is now under way in the USA and it will be interesting to see whether the profession will need to modify its practice in the light of the results.

J Lowry
London

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Carpal tunnel syndrome

Sir, — I am 77, and retired 14 years ago, after 33 years in single-handed general dental practice. I have been diagnosed as having 'fairly severe' carpal tunnel syndrome of both wrists and am about to have surgery to de-compress the nerves.

I do not know if this is a common experience among dentists, but it does seem to me that the physical movements and stress, involved in dentistry, coincide with the WHO criteria for producing the syndrome.

Therefore, I suggest that my younger colleagues could well consider taking any measures that would reduce the likelihood of developing this annoying condition in later life, such as exercises, physiotherapy or improved working position.

R Collinson
Cowes

Encouragement for undergraduates

Sir, — I am sure I am not alone in finding at least one of the suggested solutions by Dr Frain (*BDJ* 1998; **185:** 323) to the shortage of dentists as being unworkable. The suggestion that recent graduates would solve the problem by being directed by the Government to remain within the NHS for at least 5 years is Draconian. This solution may have been a possibility in Stalin's Soviet Union, but is hardly practicable or desirable today.

The real solution to the problem is to resurrect an NHS that is attractive for young (and not so young) dentists to work in. As well as considering an increase in dental undergraduate numbers, two other solutions come to mind. Firstly, it would help young dentists to remain in the NHS if they did not qualify with such a large burden of debt. However, the introduction of university fees look set to increase this debt still further.

In addition, greater effort should be made to retain women dentists in the workforce after qualification. Dundee Dental Hospital and School, supported by The Scottish Postgraduate Medical and Dental Council, have been running 'Back to Dentistry' courses for a number of years and these have proved popular and successful. However, demand is very great and more resources, with national coverage, are now required urgently. With around 50% of UK dental graduates now being women, there is certainly no reason to be complacent about future potential workforce problems.

J R Drummond
Dundee

Patient care project

Sir, — With the imminent inception of the Specialist List in Surgical Dentistry, it was decided to initiate a pilot scheme at East Surrey Hospital, to evaluate both the overall quality of patient care and the financial feasibility of providing the services of such a specialist in a hospital environment, within the primary care sector but under the umbrella of an oral and maxillofacial unit.

The project was launched in January 1998 and the following findings are based on the results obtained in the first four months of the project (involving 178 patient episodes) from ongoing audit and from questionnaires supplied to the patients. Patients were referred by local general dental practitioners for oral surgical procedures that they did not wish to undertake themselves and were treated under local anaesthesia in the out-patient department at times when a surgery would have otherwise been unused.

A significant number of patients treated (17%) had medical problems that affected their surgical management, but the location of their treatment, within the hospital environment, allowed for full evaluation of their problems by means of their hospital records and by direct consultation with other specialist departments within the hospital. A similar number of patients (15%) had surgical problems affecting their management for which 'back-up' expertise and facilities were readily available on site via the consultation unit. In terms of clinical governance, the provision of the service within the hospital environment greatly enhanced the quality of care provided.

Nearly all the patients treated (95%) were from within the immediate catchment area of the hospital (ie within a 10 mile radius) and results from questionnaires indicate that the patients were happy that the service was provided at a sufficiently local level to equate to a 'high street' facility. A large majority of patients, although not presently charged for their treatment in this pilot scheme, said that they would have been pre-

pared to pay for their treatment. Costing for the project has been carried out and has demonstrated, taking into account the potential fees payable, that a modest operating profit could be generated for the health authority.

In summary, the results so far obtained indicate that patients benefit from the enhanced facilities and expertise available in the hospital, that the provision of treatment is at a sufficiently 'local' level to meet with patient requirements and that this increased quality of service can be provided at no greater cost to National Health Services resources.

An important additional point which should be borne in mind when considering the location of provision of dento-alveolar surgery is that it is crucial to differentiate between the 'simple' surgery which may be carried out in the primary care sector with limited additional support, to the 'routine' surgery which should be provided in an environment where there is full medical and surgical support, should complications arise.

The General Dental Council's recent revised guidance for the use of general anaesthesia in the community highlights the need for exemplary standards. As a result of the revised guidance, one may speculate that the use of sedation techniques may increase. However, the term 'sedation' is a poorly defined entity, thus raising the question of whether sedation techniques are best carried out within the safety of a hospital environment.

J K A Parker
Redhill

Name of the game

Sir, — Readers may recall that I wrote a similar letter to this one some years ago, where I noted I had a Mrs Seamen followed by a Mr Overy booked in. Quite by chance, I was designing a chrome denture for two separate patients and as the two models lay side by side, to her great amusement, my nurse noted the names were Mrs Salts and Pepper!

As far as I know, I have as yet neither a Mr Bread nor a Mr Butter on my patient list!

P Williams
Lowestoft

Pursuit of evidence

Sir, — While there is general acceptance that dental practice should be grounded in research based evidence, in some areas the evidence does not exist. Dr Lamb (*BDJ* 1998; **185:** 323) suggested that careful clinical technique rather than the use of complex articulators may increase patient satisfaction with complete dentures. Various textbooks on the subject of complete denture prosthodontics agree with this sentiinent.[1,2,3] However, Berg suggested that there was no evidence in the research literature to support any factor as a predictor of success in complete denture treatments.[4] Many investigators have been unable to relate denture quality to patient satisfaction.[5-11] Indeed van Waas found an inverse relationship between quality of retruded jaw relation registration and patient satisfaction.[12,13] Only Yoshizumi found a significant association between complete denture quality and outcome.[14] This is an area were there is little research-based evidence to support clinical practice and much of what exists is compromised by small sample size and problems with the method of analysis. We believe that there is a need to investigate accepted clinical method in order to produce valid and worthwhile evidence on which to base future practice.

In response to Dr Lamb's allusion to indirect quotation, one of us (LBC) owes an apology. The use of a review reference was with the best of intentions. The original article, published in *Odontologisk Tidskrift*, was not written in English. We now append the required reference for Dr Lamb's perusal.[15]

M R Fenlon
L B Cabot
London

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Evidence-based success

Sir, — Both Alan Lawrence and Derek Richards must be congratulated on the launch of the first issue of *Evidence-Based Dentistry*. I would also like to thank the *British Dental Journal* for having the vision to publish this journal. I found the resume of the articles interesting and useful. As the associate editor with responsibility for review and leaders at the *Journal of Dentistry* I read with interest Derek Richards article 'Which Journals Should You Read To Keep Up To Date'. As an academic, such citation lists become more important as minds become focused on the upcoming research selectivity exercise. There is pressure to publish a research article in a leading journal which is high on the list. This increases the impact on your paper portfolio when you submit to the research exercise and enriches your CV. However, the disadvantages of such citation lists are well known and often imprecise, but in the absence of other indicators, it is the one that tends to be used. I think that this article opens the way for further research and debate on this subject matter.

The publication of systemic reviews is useful but as an editor, the canvassing of these works from researchers is often difficult. It is a demanding task requiring much time and takes you away from valuable time for research, papers and grant writing. However, many good literature reviews do exist within MSc and PhD theses and higher degree advisors who supervise such work should encourage their research workers to submit their work to appropriate journals for peer review.

Another way forward is that the relevant granting bodies should make extra monies available for the support of research workers to undertake such systematic reviews.

Such publications will always remain a valuable aid to both the busy academic and the general dental practitioner who wishes to keep up to date within their appropriate subject area.

Once again, many thanks to the *British Dental Journal* for leading the way.

A D Walmsley
Birmingham