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.

Diagnosis treatment

Sir, — A four year old boy presented to the Paediatric Department of the Edinburgh Dental Institute with pain, lack of mandibular movement and an anterior open bite. His mother gave a history of having dental extractions carried out under general anaesthetic twenty four hours earlier. On examination, he was found to have pain in his masseter muscles, which were in spasm, with a physical obstruction to closure of his mouth, together with an anterior open bite and lack of lip closure.

The mandibular condyles could be palpated in a position anterior to the glenoid fossa and articular eminence. There was a noticeable depression of the skin overlying the temporomandibular joints. He was unable to talk and masticate and had difficulty with swallowing.

A diagnosis of a bilateral dislocation of the mandible was made. In order to confirm this diagnosis and exclude any bony fracture, an orthopantomograph (OPT) was requested.

When the patient returned, with the radiograph, it was evident that he was suffering less pain and mandibular position and movement were normal. He was able to obtain a good lip seal and could come into centric occlusion. The OPT demonstrated that the mandibular condyles were positioned normally and no bony fracture was seen. Review a few days later revealed a delightful and pain free child.

Dislocation of the mandible is rarely reported in children. Usually the lack of prominence of the articular eminence in children allows mandibular dislocations to reduce spontaneously. Radiographic examination was required to exclude a condylar neck fracture, and because of this change, analgesia and a soft diet was the only treatment prescribed. This case demonstrates an unusual result to a patient posturing to obtain an OPT, which in this case became the treatment.

P. McLaughlin
Edinburgh

Sizing up

Sir, — In your leader[1] expressing concern for the future size of the dental profession you argue the case for a marketing approach to dental practice. In addition you state that 'the principles on basing dental care on need rather than want is actually less ethical an approach.'

Whether such an interpretation of ethics is correct for a profession devoted to dental health care for the adult population of the UK is open to debate.What is unacceptable is the application of such criteria to the child population, particularly to the youngest and most vulnerable in our society.

A recent guest leader in your journal[2] highlighted the difficulties experienced by disadvantaged children in the UK in obtaining adequate dental care. The wants of such children are frequently expressed by tears, their needs have to be addressed by society in general and in this context by the dental profession in particular.

G. B.Winter
Elstree

1 Grace M, Is Need Enough? *Br Dent J* 2000, **188**, 525
2 Naylor M N, Winter G B, The dental care of the disadvantaged child, *Br Dent J* 1999, **186**, 102

Piercing difficulties

Sir, — The case report on a patient with hypotensive collapse as a result of persistant haemorrhage following tongue piercing (*BDJ* 2000; **188**; 12) serves as a timely reminder that such a practice, which seems to be growing in popularity, is not without potentially grave inherent dangers.

I was, however, disappointed to see that the recommended written advice on what action to take should problems arise, made no mention of seeking treatment from the GDP. Indeed, the advice suggested that if there is a possibility the site of piercing may be infected. . . 'Go to your family doctor or a casualty department.'

It is a sad fact that many people still think that all a dentist knows about is 'teeth' — we have all seen patients who have consulted their GP rather than their GDP with an oral problem that is not directly tooth orientated, and I find it a shame when colleagues appear to support this myth.

M. Wilson
Esher

Primary pulpotomies

Sir, — We have followed the correspondence in the *BDJ* on this subject and feel that there are some important issues that have not been addressed. The formocresol pulpotomy was introduced as early as 1932 by Dr Charles Sweet.

Since then, there must have been many millions of pulpotomies carried out with no reported toxic effects. Research specifically to identify any toxic effects have not revealed any (reviewed by Ranly, 1994). The one fifth dilution, now the accepted technique, is indicated for all primary teeth, including incisors, and carries a very high success rate of over 90 per cent (Duggal and Curzon, 1994). Our own audit data over a five year period showed 86 per cent of pulpotomies, carried out by undergraduate dental students, as successful.

The restoration of a pulpotomised tooth requires the stainless steel crown. Just as in permanent teeth root canal therapy, a complete coronal seal is mandatory, so the best possible coronal seal of a pulpotomised primary tooth is needed. We believe this can only be effected by use of the stainless steel crown. Two or three surface amalgams, glass ionomer cements or composite resins do not have sufficient high success rates or integrety to be useful. Far too many of these restorations in primary teeth fail and hence the pulpotomy fails.

The use of the calcium hydroxide pulpotomy requires a very demanding technique. Rubber dam must be used, the coronal pulp tissue must be totally removed. There must be no residual blood clot in the pulp chamber and all radicular pulp haemorrhage must be arrested. If any one of these criteria is not met internal resorption occurs with early loss of the tooth. The formocresol pulpotomy is a more 'forgiving' technique and hence its greater rate of success.

To ensure success with formocresol primary teeth pulpotomies it is essential that local analgesia is used with rubber dam, that there be brisk haemorrhage of the pulp tissue which is easily arrested. The coronal pulp chamber should be cleaned after arresting the haemorrhage, filled with zinc oxide and the tooth be restored with a stainless steel crown (molars) or a strip crown (incisors).

Finally, the formocresol solution is readily available in the British Isles from the pharmacy department of the Huddersfield Royal Infirmary. Requests for the solution should be sent together with a prescription for the use of the formocresol for a general dental practitioner's patients.

The use of the combined techniques of formocresol pulpotomy (90 per cent success) with the stainless steel crown (95 per cent success) ensures the proper retention of the primary dentition for its natural life span.

M. S. J. Curzon, M. S. Duggal, S. A. Fayle, K. J. Toumba
Leeds

1. Duggal M S, Curzon M E J (1994) Restoration of the broken down primary molar: pulpotomy technique. *Dent Update* 16: 26-28
2. Ranly D M, (1994) Pulpotomy therapy in primary teeth: new modalities for old rationals. *Pediatr Dent* **16**: 403-408

Blood donors ban

Sir, — I read with interest the recent paper on the human transmissible spongiform encephalopathies (TSEs) by S. Porter et al.[1] This was followed by another article by I. Douglas[2] dealing with the same issue. Both publications highlighted the important issue of cross infection control with particular reference to dentistry.

May I draw your reader's attention to the new blood donation guidelines in relation to the TSEs. These were launched last year in some countries abroad.

Recently, scientists have considered the issue of new variant Creutzfeldt-Jakob disease and blood donation in depth worldwide. As a result, the Governments of the United States of America and Canada issued guidelines in August 1999 to exclude potential blood donors who have spent six or more cumulative months in the United Kingdom between the 1st January 1980 and the 31st December 1996 from donating blood. New Zealand and Singapore also implemented similar guidelines in November 1999.

It is emphasized that the guidelines were introduced as a precautionary measure to manage the theoretical risk of transmitting nvCJD via blood and blood products. Although there has been so far no concrete scientific evidence to support the transmissibility of nvCJD through blood and blood products, the abnormal nvCJD protein (prion) has been seen in the lymphoid tissues.

On Christmas Eve last year, new operational guidelines to exclude potential blood donors were also introduced in Hong Kong, a former British colony.[3] However, the deferral guidance only applied to those blood donors who are Rhesus positive but not on those who are Rhesus negative; for fear of a drastic reduction of Rhesus negative blood by over 30 per cent according to a local survey.

The deferment of Rhesus positive donors under the guidance would result in a 3.6 per cent reduction of blood donors, which could possibly be compensated by recruiting additional donors.

To further manage the theoretical risk of nvCJD transmission for the Rhesus negative blood, a technique called lecuodepletion could be used to remove the leucocytes from the blood. This is a proxy precautionary measure practised in the United Kingdom as the nvCJD prion protein has been found in the lymphoid tissues but not directly in the blood.

So, is British blood safe? Meanwhile, it does not appear to be in some countries abroad, to say the least of it!

C. A. Yeung
Cardiff

1. Porter S, Scully C, Ridgway G L, Bell J. The human transmissible spongiform encephalopathies (TSEs): implications for dental practitioners. *Br Dent J* 2000; **188**: 432-436.
2. Douglas C W I. Are we facing an invasion of the prions? *The Dentist* 2000; **16**(5): 74-78.
3. Hong Kong Red Cross Blood Transfusion Service. New blood donation guidelines launched as a precautionary measure. Press Release 1999; 24 December.

Changing procedures?

Sir, — I write to express my concern regarding the lack of guidance in the management of transmissible spongiforn encephalopathies (TSEs) in general dental practice.

It is widely accepted that classical CJD has been transmitted from person to person by medical procedures[1] and that the abnormal prion protein may not be inactivated by normal sterilization procedure.[2]

It is apparent therefore that the universal cross infection guidelines, to which we adhere to prevent the spread of HIV and HBV, are ineffective with regard to TSEs.

In view of the difficulty of using dental handpieces and sterilization procedures should a patient with CJD or a related disorder, or a patient recognized at being at risk of developing CJD or a related disorder be treated in general dental practice?

If so, will there be funding to cover the cost of disposal and/or placement of instruments in quarantine?

The Advisory Committee on Dangerous Pathogens and the Spongiform Encephalopathy Advisory Committee (ACDP/SEAC) make it clear that:

1 Instruments used in the case of patients with CJD of any type must be incinerated.
2 Instruments used on patients suspected of having CJD of any type should be quarantined.

In order to comply with the ACDP/SEAC guidelines it seems inevitable that all instruments will need to be traceable. Instruments in general dental practice are not in general organised in such a way. Should such organization become necessary, how will it be funded? Will funding be available to purchase instruments to make up a 'whole set' where at present such instruments are not needed?

The Chief Medical Officer recognizes that endoscopes exposed to positive CJD and destroyed have a large cost attached and that if it is not possible to identify the instruments with certainty and that the relevant instrument cannot be distinguished from identical ones in a pool, then all endoscopes would need to be destroyed. The logistical and financial implications for general dental practice are similarly profound.

Given the throughput of a busy general dental practice, a patient, (unknowingly) at risk of CJD or related disorder could, over the course of over two or three years, prior to diagnosis, have treatment a dozen or more times and encounter each and every instrument in that practice. When the patient subsequently is identified as having CJD or a related disorder, the practice faces ruin whether the instruments are traceable or not.

It is dearly impractical to have one set of instruments per patient which would be the only way of eliminating all risk of transmission of TSEs. Therefore, unlike HIV and HBV the public is at risk, (albeit small) no matter what the profession does.

I believe that the profession needs clear guidelines in the following areas

i Identification of the risk patient and sources of referral for identified patients.
ii Adequate funding to organise and purchase sufficient instruments to make traceability possible.
iii Full and comprehensive compensation where instruments are destroyed and/or quarantined.
iv Patient education — to reassure the public that all that can be done has been done, but there is a risk of transmission (albeit small) that we cannot at present eliminate.

D. Gingell
West Bromwich

1. Variant Creutzfeldt-Jakob Disease (vCJD) minimizing the risk of transmission. *Health Service Circular* HSC 1999; **178**.
2. Transmissible Spongiform Encephalopathy Agents: Safe working and the prevention of infection, April 1998. Full text available on: http//www.official-documents.co.uk/document/doh/spongifm/report. htm

Enlisting readers help!

Sir, — I am trying to track down the supplier of an ingenious advanced piece of dental equipment. This equipment was the subject of publicity over a decade ago when a British inventor developed a revolutionary method of treating dental decay. The device consisted of a hand held 'pen' which delivered an ion stream (charged particle beam) to the area of decay.

The ion stream neutralized the bacteria responsible for the decay and promoted healing of the decayed area all without the need for drilling and filling!

The device was suitable for use where decay could be detected early. Obviously for more advanced cases of decay traditional methods still had to be used.

The advantages of the system were self-evident even if its use to manage dental decay results in more frequent patient checkups.

Does this ring any bells? If so, I am attempting to contact the inventor and would appreciate contact from any dentist able to provide me with information enabling me to do so.

M. J. Clarke
Newcastle Upon Tyne

Better by bike?

Sir, — G Balfry of Bristol (*BDJ* 2000; **188:** 11) adopts a rather cynical view regarding the Avon Health Authority's rate for reimbursement for travelling to postgraduate courses by bicycle. I wonder why!

After each 21 miles a cyclist would get a new bicycle — a penny farthing!!

D. R. McCall
Dalbeattie

Sir, — 'Better by Bike' (*BDJ* 2000; **188**; 11) should really be 'Even Better by Bike'! The 0.062p per mile quoted by G Balfry is I'm sure the £0.062 or 6.2p per mile which is a Whitley (therefore national) travelling expense rate, payable by not only Health Authorities but also Trusts and much of the Health Service to those of us who bother to claim it. However, it gets better still.

In the 1998 Budget, the Chancellor allowed for claimable cycling to be remunerated at 12p per mile (plus a capital proportion of bike purchase may be offset against tax). Under Whitley, we continue to be paid at 6.2p but the rules allow us to claim the 5.8p difference as tax relief.

I think it was the Cyclists Touring Club who once calculated that the real cost of cycling was about 12-15p per mile but if you genuinely want the workforce on bikes, why not pay them at their equivalent Whitley car rate, thereby allowing a real choice?

Facilities and encouragement for those wishing to cycle to work are in many places poor and I did not hesitate to let Mr Milburn know this in his recent consultation exercise.

R. D. B. Dickson
Morpeth

Memory lane

Sir, — Your report of The Eastman Jubilee reminded me of the happy six months I spent as a very junior houseman in the conservation department from 1950–1951 immediately after qualifying under the undisputed gentleman Alan Deverell.

I learnt a lot under the top guidance of Guy Morrant and his more senior housemen King-Horne and Leggett who were very fine and kind clinicians. I remember electing to take my salary in cash and queued up with the charladies every Friday afternoon to collect my £1/day wage less deductions.

R. O. Leavor
Bradford

Mobile telephones and lesions of the mouth

Sir, — I recently referred a patient to Newcastle Dental Hospital, where a suspicious lesion was biopsied. The histological diagnosis was mild atrophic lichen planus.

The interesting aspect is that the patient was convinced that the sore mouth was related to use of his mobile telephone. It was worse on the right side (the hand that he uses) and typically clears up when he is away from work or using a conventional telephone. Have any other of your readers observed any possible connection between pathology and mobile telephones ?

D. G. Watt
Kirkby Stephen

Widow's rights

Sir, — I would like to make colleagues aware of the plight that widows of NHS dentists potentially face: a close friend, and middle aged GDP, recently developed an aggressive inoperable cancer and it quickly became clear that he would not be able to return to work. He was granted early retirement and an enhanced pension on health grounds before he died. He was a devoted family man who had been very happily married for many years and his widow, who is still a young woman, continues to receive a proportion of his pension.

That is fine and how it should be, but the problem will arise that if she ever marries again then she will forfeit her pension. Should her new husband die before her and have no pension then the widow could be left destitute. It seems totally unreasonable that male GDPs having contributed to pension schemes should allow their wives to be faced with this problem. I understand that the Armed Forces are now in the process of rescinding this arrangement and would ask that the British Dental Association make every effort to bring about similar and appropriate changes in widow's rights.

D. Thomas
Wolverhampton

Antibiotic prescribing for sinusitis?

Sir, — A recent study[1] has demonstrated that more than 50 per cent of dental practitioners would prescribe antibiotics for sinusitis. This is of concern since acute sinusitis is difficult to diagnose,[2] usually self limiting and the evidence to support the use of antibiotics is marginal at best.[3] Guidelines in the Dental Practitioners Formulary for the treatment of sinusitis recommend the use of decongestant inhalations or drops. In light of current concerns of antimicrobial resistance due to unnecessary use of antibiotics we suggest a reappraisal of the role of antibiotics for the management of acute sinusitis in dental practice.

At least 70 per cent of bacterial complications of acute sinusitis are caused by *Streptococcus pneumoniae* and *Haemophilus influenzae*, of which some 20 to 30 per cent produce ß-lactamase.[4] Less than 10 per cent of cases of acute maxillary sinusitis result from infection originating from a dental source[5] and are usually caused by anaerobic bacteria. Patients who develop complications of maxillary sinusitis such as orbital cellulitis are rare and usually show the characteristic signs of these infections. Until better evidence to suggest otherwise, general dental practitioners should not prescribe antibiotics for uncomplicated acute sinusitis. We suggest that in patients presenting with symptoms of maxillary toothache, dental practitioners are best placed to examine the oral cavity for prompt treatment of dental disease and referal of unresolving cases once dental disease has been excluded as a source of infection.

In summary, good dental hygiene and prompt treatment of dental infection will help to reduce the incidence of bacterial sinusitis secondary to dental disease, antibiotics are rarely indicated or justified.

A. J. Smith and G. G. Browning
Glasgow

1. Palmer N A O, Pealing R, Ireland R S, Martin M V. A study of therapeutic antibiotic prescribing in National Health Service general dental practice in England. *Br Dent J* 2000; **188**: 554-558.
2. Hansen J G, Schmidt H, Rosborg J, Lund B. Predicting acute maxillary sinusitis in a general practice population. *Br Med J* 1995; **311**: 233-236.
3. Stalman W, van Essen G A, van der Graaf Y, et al. The end of antibiotic treatment in adults with acute sinusitis-like complaints in general practice? A placebo-controlled double-blind randomized doxycycline trial. *Br J Gen Pract* 1997; **47**: 794-9
4. Yonkers A J. Sinusitis — inspecting the causes and treatment. *ENTJ* 1992; **71**: 258-62.
5. Gwaltney J M. Sinusitis. In: Mandell G L, Bennett J E, Dolin R, eds. Mandell, Douglas and Bennett's Principles and Practice of Infectious Diseases. 4th ed. Edinburgh: Churchill Livingstone, 1995: 585.

NHS discrimination?

Sir, — I have been in general practice since 1966. Following the new contract in 1990,

my practice gradually converted to private practice, but still accepting children under 18 on the NHS.

As a result of reducing my NHS turnover, I did not qualify for seniority payments in spite of spending the first 25 years of my professional life working substantially in the Health Service.

In addition, I now find that I am no longer eligible to join and participate in a Peer Review Group study, neither am I entitled to be reimbursed for attending qualifying postgraduate courses, both of which I have enjoyed and valued throughout my working life.

I am however obligated to provide out of hours cover for my limited NHS practice, indeed to the same extent as if I were running a full NHS service.

The GDC have announced 'Lifelong learning and recertification for the dental profession.' This, of course, will be entirely welcomed by every ethical practitioner. It would however appear that long-serving dentists like myself, who have given valuable community service in the past through the NHS are now suffering discrimination and are being actively discouraged from participating in continuing postgraduate education.

I strongly believe in continuing professional education, but surely financial reimbursements must be made payable to all practicing dentists.

A. Kosiner
Wembley

Success against oral cancer?

Sir, — Present epidemiological studies have suggested that there is a rising frequency of oral squamous cell carcinoma in the United Kingdom and other developed countries together with an unchanged survival rate.

A new study from the US suggests that these trends may change for the better, albeit slightly. The National Cancer Institute's Surveillance Epidemiology and End Results Programme examined the incidence, five year survival and mortality rates between 1950 and 1995.[1]

There was a 10 per cent increase in the five year survival of patients with oral cancer, survival rising from 46 per cent to 56 per cent. During the same period, there was a 37 per cent fall in the mortality rate (number of deaths per 100,000 people) and 38 per cent fall of incidence (number of new cases per 100,000 people) of oral cancer. Thus there is data suggesting some improvement in survival and mortality associated with oral cancer.

The precise reasons for these changes remain unclear. The fall in mortality rate may affect the possible earlier diagnosis, more effective treatment of the disease and better post-treatment care, and/or general improvements in oral health care.

While the present data is encouraging, in this same time period there was an increase in the five year survival of 20 different solid tumours. While the five year survival rate of oral cancer increased, 10 per cent the survival rate of prostatic malignancy increased 50 per cent — despite a significant rise in the incidence of this disease. Survival rates for breast and colonic malignancy increased by 26 per cent and 21 per cent respectively.

Thus the present evidence would suggest that while the survival rate, mortality rate and incidence of malignancy of the mouth may be improving, these changes are not as encouraging as those of other solid tumours.

Survival is ultimately bettered by the diagnosis at an early stage, hence UK dentists are encouraged to refer patients with premalignant lesions in an effective and timely manner to specialist services.

S. Porter

1. Gilbert Welch H, Schwartz L M, Woloshin S. Are increasing five year survival rates evidence of success against cancer?

Tobacco addiction

Sir, — I was interested to receive the excellent BDA manual on addiction management recently. It is helpful to everyone, not least to find out if you qualify as an addict in the first place. I can see why non-drug addictions and obsessions like gambling were not included, but I would have liked to have seen something substantial on the common addiction to tobacco, which was given the very briefest mention.

In view of the significant adverse effects this substance may have on the smoker's body and behaviour and on other people through passive smoking, and the synergistic carcinogenic effect with alcohol, I think it should merit inclusion in a future edition of the manual.

A few years ago, I attended a reunion of dental school colleagues (we were all around the age of 50), and I noticed that the only person who had retired early did so because of a smoking related condition.

T. Watts
London

Slipshod approach?

Sir, — Oh dear. In the *BDJ* 2000 **189** issue in which you admit to rendering 'Allergy to local anaesthetic? The importance of a good history' as 'Allergy to local anaesthetic: the importance of a thorough investigation' (a slight difference) you also invent a new speciality: 'pediatric dentistry'. Still it could be worse.

I have seen many bizarre references in articles discussing health inequalities to 'depraved' rather than 'deprived') communities. Clearly, it must be the sins of the lower orders that bring upon them the ravages of dental disease, rather than their relative property.

C. Stillman-Lowe
Reading

Temazepam dangers

Sir, — I am currently working as an orthopaedic SHO and would like to bring to your notice a case involving a 16 year-old female patient who was prescribed Temazepam for needle phobia by her dentist.

This patient had successive appointments booked with her dentist and was prescribed ten tablets each of 20mg strength. She was advised to take one tablet at night and one an hour before her appointment.

Unfortunately, following a disagreement with her carer, she took an overdose of seven tablets (140mg). She then tried to run away by climbing out of her bedroom window on the first floor and fell awkwardly sustaining a severe spinal injury. This will require prolonged treatment in hospital.

My reason for writing was to inform my colleagues of the dangers of oral sedation, particularly Temazepam, which is a controlled drug and as such demands the respect of this classification.

Its use should be restricted to short-term anxiolysis only, using the minimal doses necessary.

Temazepam has a considerable abuse potential and should not be readily available in multiple doses to any patient.

B. G. Visavadia
London

Please send your letters to:
The Editor
British Dental Journal
64 Wimpole Street
London
W1M 8AL