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.

'Dr' for dentists

Sir, — I have watched with some surprise the furore within the profession regarding the title 'Dr' for dentists and the ASA and the condemnation of two colleagues for its usage. Sitting down and thinking about it though, I began to understand both sides of the argument. However, I do think there is a solution.

In Holland, a dentist is a 'Tandart'; and in Germany a 'Zahnarze'; both literally meaning 'Tooth Doctor'. In the Scandinavian countries they have the title Dr. Dent., and Dr. Ordont., meaning dental doctor. Why not then propose the style in correspondence of Dr. Dent. but which will naturally contract verbally to 'Dr.' within a very short period of time, which over some years would establish 'custom' for usage. This not only differentiates us from medical 'doctors' but also from PhD holders.

It is a suggestion which may appeal to members of our profession and to 'others'.

Dr. Dent. S. Harrison
Cheshire

Nitrous oxide

Sir, — We support the letter written by Sarrami and Haywood in minimising the exposure of dental staff to nitrous oxide.

Clearly, as we stated in our original paper, it is essential that where nitrous oxide is being used, there must be certain control measures in place, such as access to increased ventilation rates and also the provision of active anaesthetic gas scavenging. Without such measures in place, the exposure to staff will be greatly increased.

These measures are a priority, but once they are implemented, if staff resources permit then further minimisation of staff exposure through staff rotation is clearly advantageous.

K. A. Henderson and I. P. Matthews
Cardiff

Shared world

Sir, — I have just been reading your print of the Wilfred Fish Lecture 2000, given by P. Glantz, and I just had to comment. My letter is not occasioned by the content of the lecture, but by Professor Glantz' opening statement 'during the immediate past century, a dramatic improvement of oral health and dental status occurred on a worldwide basis.' Not true! Improvements in oral health have by and large been made only in the richer half of the world. I do not suggest that this assumption has been made by Professor Glantz, but it is nevertheless a common assumption that only our little corner counts, and that as long as we are okay then everybody else must be. When is our profession going to start sharing its knowledge and resources with the rest of the world?

M. Fugill
Cardiff

NHS discrimination

Sir, — Under the heading 'NHS discrimination?', (*BDJ* 2000; **189**: 238) A. Kosiner urges the NHS to exercise fairness to all general dental practitioners. I would like to support his plea.

I have been working full time in a NHS-based practice as a clinical assistant for nearly a year. Clinical assistants are not entitled to claim for postgraduate education allowance or payment for clinical audits and Peer Review Group studies (although I have myself recently set up a Peer Review Group).

Clinical assistants do not have an NHS number and as such work under the principal's NHS number, having a suffix added. Many assistants are newly qualified dentists and are therefore in real need of postgraduate education and financial support. We are told that it is only the principal, with whom the NHS bears a contract of service, who is entitled to payment. However I currently have nearly 800 NHS patients registered on my list for whom I, not the principal, provide primary care. Without our skills and commitment dental treatment would not be provided for many patients under the NHS.

On behalf of all clinical assistants working for the NHS, I request the NHS to act fairly by encouraging all general dental practitioners, irrespective of their positions in the service, to participate in schemes for lifelong learning and continuing education advocated by the GDC. Clinical assistants would certainly benefit from a change in the present policy and would very much appreciate a fair level of support from the NHS.

D. Tenorio
Petts Wood

Piercing difficulties

Sir, — It was not our intention, in formulating the recommended written advice (*BDJ* 2000; **189**: 235), to offend our colleagues in general dental practice or to perpetuate the myth that dentists only know about teeth. We were concerned, however, that many of these patients present out of hours, and would therefore require the practitioner to open a surgery out of hours, to manage a complication of a procedure not initiated by them. We would, however, have no objection to the advice being modified to 'Go to your family dentist, doctor, or a casualty department'.

P. S. G. F. Hardee and I. Hutchison
London

Special care dentistry

Sir, — We read the comments in relation to services for people with disabilities from M. Griffiths (*BDJ* 2000; **189**: 183) with interest. We share this concern that oral care should be available to all those people needing special care and that it should be provided by well-trained individuals who are empathetic to the needs and desires of people with disabilities.

We are pleased to report that because of these concerns there are now many more opportunities for dentists interested in careers in special care dentistry. For some time community dental services have been developing services for people with special needs within their remit to provide for those who might not seek care within the General Dental Service (HC (97) 2). In many parts of the country these services are comprehensive. Secondary care services have also developed. In this instance, it has usually been around individual clinicians and departments with a commitment to providing care for people with disabilities.

There has been much discussion in recent years regarding the development of a specialty in special care dentistry. Following wide consultation by the Faculty Development Group for Community Dental Services, the Royal College of Surgeons of England established a working party to consider the way forward and as a result of the deliberations of that group there is now a Joint Advisory Committee for Special Care Dentistry. It has been in existence for only a few months. Its remit is to consider specialist training and career pathways in this field.

There are a growing number of MSc courses being offered in this field e.g. Disability and Oral Health (Newcastle Dental School), Sedation and Special Care Dentistry (GKT Dental Institute of King's College London) and Special Needs Dentistry (Royal College of Surgeons, Edinburgh), will sit the exam in November, and the Royal College of Surgeons of England is presently considering a diploma in Special Care Dentistry. There are also distance learning courses being developed for those looking for modular training, as well as the courses run by the British Society for Disability and Oral Health and other similar organisations. Also, the British Society for Disability and Oral Health launches its new Journalist of Disability and Oral Health in October.

We are therefore optimistic about the future of care for people with disabilities

and hope that our response to Mr Griffiths' letter will allow him a happy retirement in the knowledge that there are others carrying on his crusade.

J. Fiske (Chairperson, Joint Advisory Committee in Special Care Dentistry) and S. Greening (President, British Society for Disability and Oral Health)
London

Antibiotic prescribing

Sir, — The letter from Messrs Smith and Browning (*BDJ* 2000; **189**: 237) is a timely reminder of the need for appropriate prescribing of antibiotics.

In the north west (Mersey) region in 1999/2000, 175 GDPs took part in an audit of antibiotic prescribing, within the National Scheme for Audit and Peer Review. The audit allowed individuals to consider their prescribing habits and review their knowledge of all aspects of prescribing.

The results of the audit showed a wide variation in the doses and duration of antibiotics prescribed, and prolonged courses were often chosen, despite evidence that short courses are usually adequate for dental infections. There was considerable variation in approach to prophylactic prescribing. While the DPF was the most usual reference used, this does not provide sufficient information for specific clinical situations.

This audit did show that following the issuing of guidelines and an educational component, there was a significant improvement in all aspects of antibiotic prescribing leading to a marked reduction (57%) in the number of prescriptions issued for antibiotics.

Clinical audit offers an excellent way for GDPs to address these issues, and to improve their knowledge of this important aspect of general dental practice. Those who took part in this audit found it most stimulating, and many said that they were able to improve the quality of care to their patients as a result.

M. Joscelyne
Mersey

Frank Ashley

Sir, — Your reference to the death of Professor Ashley in the news section (*BDJ* 2000; **189**: 274) made sad reading indeed. His work for the Health Education Council, as a council member and chair of its Dental Health Advisory Panel, showed his determination to be an effective advocate for the dental profession. His strategic direction of the Dental Health Programme demonstrated not only his acute mind, but also his courteous and gentlemanly demeanour.

These qualities made working with him both an intellectual challenge and a pleasure.

C. Stillman-Lowe
Reading

Oral temazepam

Sir, — We read with concern (*BDJ* 2000; **189**: 238) Dr Visavadia's account of how a young girl came to harm while under the influence of a self administered overdose of oral temazepam, which had been prescribed by her dentist as a pre-operative anxiolytic.

In our *BDJ* publication 'A Clinical Guide to Temporomandibular Disorders', we advise prescription of a course of Temazepam Oral Suspension in the treatment of some TMD patients. Benzodiazapines have a recognised pharmacological muscle relaxant effect, and temazepam has a significant therapeutic role in the management of patients with TMJ disc displacement without reduction.

It is difficult to balance the benefits of any drug with the possible damage that can be caused by abuse including single overdose (consider paracetamol). We specifically highlight the danger of possible abuse of temazepam in our book and we still feel this is the drug of choice in the specific circumstances we described. We also advised liaising with the patient's general medical practitioner.

It is, of course, the responsibility of all dispensing clinician to counsel the patient when prescribing any drug and the decision to prescribe a drug will be taken after consideration of not only the diagnosis but also the patients medical and social history.

S. Davies and R. Gray
Manchester

Paediatric dentistry

Sir, — We read with interest the abstract 'Visual pedagogy in dentistry for children with autism' (*BDJ* 2000; **189**: 254).

Since the original paper appeared in one of the key specialist paediatric dentistry journals, we were somewhat surprised by the abstract editor's choice of 'specialty' heading. To date, the names of over one hundred specialists in paediatric dentistry appear in the specialist list maintained by the General Dental Council.

It should therefore be recognised that it is these individuals who provide specialist comprehensive and therapeutic oral care for children from birth to adolescence, including care for children who demonstrate intellectual, medical and physical, psychological and emotional problems.

M. L. Hunter and B. Hunter
Edinburgh

Dr Trevor Watts replies:
I thank Drs Hunter and Hunter for their comments. As they will know, 'Paediatric Dentistry' frequently features as a heading in my abstracts.

My headings reflect the contents of the paper, and not necessarily the specialty in which it originates, as witnessed in the immediately preceding abstract, taken from a surgical journal, to which I gave the heading 'Oral Pathology'. The choice for the paper in question lay between 'Paediatric dentistry', 'Behavioural science' and 'Special care dentistry'.

I chose the last because it was briefer, and in my opinion indicated the subject matter more accurately. In passing, there is also an embryo specialty of special care dentistry, in which it is possible to pursue postgraduate studies, and of which behaviour management is an integral part.

Kaiser Bill

Sir, — It was with some surprise I read your explanatory note to the front cover of *BDJ* 2000; **189**: issue 5.

The patient is not French but rather German (see helmet lower left) and is in fact Kaiser Wilhelm II. This is a propaganda cartoon designed to foster in French minds the stirling work done by the British Expeditionary force to draw the teeth of Hun aggression.

R. Baker
Paignton

Mobile telephones

Sir, — I read with interest the letter 'Mobile telephones and lesions of the mouth' (*BDJ* 2000; **189**; 237) in which a patient with mild atrophic lichen planus was 'convinced that the sore mouth was related to the use of his mobile telephone'.

It may interest Dr D.G. Watt and other *BDJ* readers that similar psychological phenomena termed 'impressions' by 19th century clinicians were recorded in relation to orofacial clefting. Mason[1] detailed the testament of a mother of a child with cleft palate, who was convinced that the cleft was a direct result of her longing for a particular fish possessing a huge mouth around six weeks of gestation!

G. T. McIntyre
Blairgowrie

1. Mason F. Harelip and cleft palate. J & A Churchill, London:1877.

Orthodontics on TV

Sir, — Once again, we read another letter raising the concept of dentofacial orthopaedics. The recent one states 'there is much evidence to support a growth directed philosophy in orthodontics' and cites 'cranio' as a source of core articles.

It is helpful to clearly summarise the actual evidence from good studies. Whilst some retrospective studies have shown modest skeleta improvements attributable to orthodontic treatment, in the best studies the skeletal effect is found to be less than 1mm. At the recent British Orthodontic Conference Professor Kevin O'Brien presented the results of an extensive multi-centre randomised clinical trial (RCT) into the effect of Class II treatment. This study, supported by the Medical Research Council over the past five years, has been carried out in 14 orthodontic units throughout the country. The study added to the evidence that has also been obtained from several other RCTs which all concluded that the skeletal change achieved, when treating individuals with Class 2 skeletal pattern with modern functional appliances, was minimal. The majority of the changes, in these successfully treated cases, were due to dentoalveolar remodelling resulting from tipping of the incisors. It is time that we practiced evidence based orthodontics. Now that we are in the possession of high quality scientific evidence we must temper our claims for growth modification with functional appliances in Class II cases.

J. Sandler
London

Sinusitis prescribing

Sir, — I read with interest the letter by A. Smith and G. Browning (*BDJ* 2000; **189**: 237) regarding the above. I agree with their advice to dental surgeons but would like to add there has been a very important reference not included.

The Cochrane review updated in January 2000 looked at antibiotics for acute maxillary sinusitis. Data was collated and analysed from thirty-two trials involving 7,330 subjects. The reviewers' conclusion was that for acute maxillary sinusitis confirmed radiographically or by aspiration, current evidence is limited but supports penicillin or amoxicillin for 7 to 14 days. Clinicians should weigh the moderate benefits of antibiotic treatment against the potential for adverse effects. Regarding topical decongestants at present the results show there was no better outcomes for those subjects prescribed these medicines although more data is required.

M. Kumar
Pinner

1. Williams Jr. J W, Aguilar C, Makela M, Cornell J, Holleman D R, Chiquette E, Simel D L. Antibiotics for acute maxillary sinusitis. Cochrane Review 200: 3, Oxford.

Oral cancer screening

Sir, — In response to recent letters regarding the use of toluidine blue/tolonium chloride the editors of the occasional paper, Craig and Johnson, raise a number of issues which deserve a reply.

Their response that more primary research is needed and not a systematic review is not justified. We would contend that a systematic review of this area is exactly what was needed. Until the results of this review have been widely disseminated and debated there should be no endorsement/promotion of this test by the profession.

If the efficacy of the test is as poor as the systematic review (in press) suggests and given the rarity of oral cancer (3-4 per 100,000) then the sample size required to test the efficacy of this agent in a primary care setting is very large. It is precisely because of this difficulty that systematic reviews, which bring together the results of many studies, are important. Systematic reviews also remove biases that are often a problem with the traditional literature review.

Drs Zakrewska and Martin make several important points that are not properly addressed in the authors' response. They questioned both the efficacy and cost-effectiveness of this test as well as its effectiveness in picking up dysplastic lesions, points not answered. Yet Craig and Johnson claims it is perfectly satisfactory for practitioners to use it, and should not set limits!

We think that the profession has a moral and ethical duty not to offer a test where there are doubts regarding its efficacy and cost effectiveness. Not to do so we believe raises questions regarding clinical governance. At the very least patients should be fully aware of these issues, otherwise consent is not informed.

We are aware that the company promoting this product offers training but does this include the necessary counselling skills required? Also, is there any emphasis given to the psychological trauma that is inevitable if the initial application is positive (given the two-week gap between test and re-test)? The authors may not be overtly promoting the product but they are indirectly advocating further use and this will undoubtedly lead to an increase in the number of unnecessary biopsies being performed.

This also does not address the issue that those most likely to want the test are the 'worried well' who are likely to be in the lower risk groups at the outset.

We think that Craig and Johnson's call for more primary research on this product is misplaced. We should rightly be concentrating on the proper visual identification of suspect lesions at routine examination. We should be asking about the smoking and drinking habits of our patients, encouraging smoking cessation and improving communication skills among primary care physicians. These are all points raised in the occasional paper.

The other area where there should be more research is on understanding the early stages of oral cancer. Without this information, it is very difficult to screen for oral cancers as we cannot answer the following questions. How often should we screen if we are not going to miss a lesion? How much of a guarantee is the profession going to give a patient that they are disease free, six months, one year, two years or five years?

If a patient were to develop oral cancer between screenings could they sue the dentist? We also know little about the malignant potential of dysplastic lesions which is another area where there is urgent need for a large good quality prospective study.

We agree with Zakrewska, Martin, Gray and Elley that we should not be recommending/endorsing the use of toluidine blue/tolonium chloride in primary care.

Oral cancer is an important issue and the potential for a proper screening programme is being investigated. However, potential screening tests must be both clinically and cost effective before we advocate their widespread use. Not to do so is damaging both to the profession and patients.

D. Richards, A. Lawrence and D. Thomas
Oxford

Sir, — We read with interest the letter from Zakrzewska and Martin (*BDJ* 2000; **189**:124) regarding tolonium chloride screening for oral cancer, as we share many of their concerns.

We are glad to see that a new study is to start soon. We wonder if the study will also look at the implications of this practice on secondary care. Recently we have become aware of two cases referred to oral and maxillofacial surgeons following positive stating of multiple oral sites on two occasions, with no clinically visible lesions.

The surgeons felt obliged to undertake a further rinse procedure with concurrent biopsy of stained areas. These showed normal oral mucosa or mild frictional keratosis on histopathological examination. Other oral conditions such as benign ulceration and lichen planus will also take up tolonium chloride and hence false positives are likely to be generated. The onward referral of many such cases is likely to increase the pressure on secondary care services (both clinical and histopathological) with poten-

tial implications for delays in management for other referred symptomatic patients.

A current dilemma with similar considerations is that of screening the colorectal cancer. Here, where there is good evidence that screening should substantially reduce the death rate from colorectal cancer, there are concerns from the clinicians involved about their capacity to deal with the increase in the number of referrals that would be generated by widespread screening.

In a recent position statement they suggest that screening (faecal occult blood testing) of patients at low risk of colorectal cancer 'should only be offered where there are agreed protocols between primary and secondary care that are backed up by the necessary resources for further investigation of individuals with a positive test.'[1] It is also important that before the use of tolonium chloride is widely advocated in dental practice, such resource implications are considered along with the other issues of efficacy already raised.

M. N. Pemberton, P. Sloan and N. Thakker
Manchester

1. British Society of Gastroenterology, the Royal College of Physicians, the Association of Coloproctology of Great Britain and Ireland. Colorectal cancer screening in the UK: Joint Position Paper. *Gut* 2000; **46**:746-748

Special needs dentistry

Sir, — As the only Professor in this area in the UK, I feel that I must respond to the letter by Dr M Griffiths (*BDJ* 2000; **189**: 183). I would agree wholeheartedly with Dr Griffiths that this is a Cinderella area and I have been fascinated that there have been other specialities created that cover areas in which only a handful of dentists work (sometimes only in some of the dental schools).

Yet the area of 'special needs' or 'special care dentistry', which includes many colleagues in the community, hospital and university services as well as general practice, has no speciality status.

Further, I know of one person who, having established the 'special needs' service in one hospital, and having 30 years experience in the field, 20 as a consultant, would now appear ineligible to apply for such a post — not having registration in the speciality of restorative dentistry — the area in which such posts are often placed.

C. Scully
London

Copycat papers

Sir, — I read with interest the recent paper 'Sealing ability of amalgam, Super EBA cement, and MTA when used as retrograde filling materials' by J. Aqrabawi (*BDJ* 2000; **188**: 266-8).

I noted the broad similarity of its content to the paper by Torabinejad (1993) in terms of the experimental method, choice of materials investigated, summary of results and the identical conclusions. His research is just not original but a copycat study. In 1995, Torabinejad and colleagues published a number of papers on the *in vitro* and *in vivo* properties of these materials used for root-end filling, effectively making Aqrabawi's conclusions out of date.

I am sorry to write you a critical letter about acceptance of copycat papers but feel that you should know this information in order to prevent it happening again.

T. R. Pitt Ford
London

The author of the original article was given the opportunity to reply to this letter but chose not to.

Specialist lists

Sir, — The letter from G. Browning (*BDJ* 2000; **189**: 237) in respect of problems relating to recognition as a 'Specialist', does highlight the problems that I forecast in a letter to the dental press when the specialist lists were announced.

At that time I was dealing on behalf of Guardian Health with applications to be recognised for admission on the specialist list, and therefore for those applicants to be able to claim fees from insurers for recognised surgical procedures.

I expressed concern at that time that recognition by the GDC of a specialist qualification, did not mean that this would also be recognised by the major insurers who apply different criteria.

The current policy of Guardian/PPP is that specialist recognition is given to maxillofacial surgeons holding a substantive NHS consultant position and who are on the GMC specialist register.

This means that the holders of these dental specialist qualifications may not only have problems of admittance rights to private hospitals, but perhaps more importantly will be unable to reclaim fees in respect of oro-surgical procedures carried out under permanent medical insurance policies.

A. Halperin
London

Recalled attendance

Sir, — I read with interest the article in BDA News 13:10 'Countering Fraud'. I was particularly interested in the introduction of FP17RA forms which I will have to store for two years.

My practice is already in danger of collapse under the weight of patient record cards and orthodontic models and I do not relish the thought of more paper to store. I could sink without a trace!

On a more serious note, there would be no need for these forms if the payment for recalled attendance was fairer. The intention in the SDR item is to reimburse the GDP for travel to and from the surgery and also to take notice of the fact that he/she is working at less than peak efficiency because the surgery is not staffed as on a normal waiting day.

This is obviously not the case at present and no doubt the DPB suspect that fraudulent claims are being made as GDPs struggle to cover their costs. It would address the activity more accurately if a fee was payable for travel to and from the surgery and a percentage was added to the scale items claimed during this attendance to compensate for the longer treatment times required. It would not normally be necessary to re-attend the surgery more than twice in a day, except in exceptional circumstances, and of course the DPB could continue to telephone patients about their 'out of hours' treatment.

M. B. S. Bradley
Thirsk

Cycling capers

Sir, — Regarding 'Cycling Capers' (*BDJ* 2000; **189**; 288). There is a way for bike riders to achieve equity with car users in attending professional meetings.

Travel claim forms only require applicants to state car type and registration number, and mileage. The actual mode of transport — airplane or lawnmower — does not need to be included.

It is therefore possible to be reimbursed at the higher rate for cars by default — while saving petrol, improving one's health and helping the environment. I would not of course advise anyone to do that!

J. Hogan
London

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