

**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.**

## Erosion in children

Sir, — As a result of attending a Bristol University Open Learning for Dentists (BUOLD) course I have developed an interest in erosion. The incidence of erosion in young people is increasing rapidly and appears to be replacing caries as the prime cause of tooth substance loss.<sup>1</sup>

Unfortunately, there does not seem at present to be a simple system of classification<sup>2</sup> and I would like to offer the following scheme for consideration based on my clinical observations.

Class 1 — Palatal surface of upper incisors and, or the incisal edges of these teeth eroded. Rounding palatally of the tip of the upper canine. NB enamel lesions only.

Class 2 — As above, plus enamel cupping of the mesiobuccal cusp of the lower first molars.

Class 3 — As above, plus cupping in enamel of all cusps of the lower first molars

Class 4 — As above, but lesions are present on other teeth in addition e.g. upper first molars.

I have deliberately tried to keep the system as simple as is compatible with usefulness. The following quantifiers could also be used:

1. Half the area of enamel is lost from the occlusal surface of a tooth.
2. All enamel is lost from a surface.

Obviously, attrition, abrasion and abfraction have to be eliminated as a cause of enamel loss when using this system but their prevalence is low in the age group we are considering here. I hope the above may be of use in the diagnosis and treatment of erosion and welcome any comments.

**M. Austin**  
**Brighton**

- 1 O'Brien, M. Children's dental health in the United Kingdom, London. HMSO; 1994
- 2 Smith B J N, Knight J K. An index for measuring the wear of teeth. *Br Dent J* 1984, 156, 435-439

## Special care dentistry

Sir, — My impending retirement in 1996 and the consequent vacancy for the lead clinician for the Special Needs Unit at Guys Dental Hospital created a similar problem to that outlined by M. Griffiths.<sup>1</sup>

The late Professor Ashley, and his advi-

sors overcame the status problem by creating a new post of senior lecturer with the possibility of honorary consultant status.

This left open the specialty to the experience and training of the successful candidate. Back in 1994, a working group on specialty status of what is now known as the British Society for Disability and Oral Health, of which I was chair, examined the role of experienced clinicians providing special care dentistry. It immediately became apparent that they were providing a high level of holistic care for a challenging group of people.

To be able to care for patients from 3-100+ years of age, an extensive knowledge and skill was regarded as generalisation not expertise, failing to appreciate that these 'experts' were providing care for the most severely disabled people. If it is so easy and lacking in special skills why do recognised specialists show such little enthusiasm for people with severe disabilities?

As 13 per cent of the UK population is registered as disabled there is a significant gap in the availability of specialist dental services, which should be seen in relation to the Disability Discrimination Act.

The profession is content to leave care of people with special needs to the enthusiasts and, as Griffiths points out, fails to support these clinicians by recognising their hard won expertise with specialty status. Slow progress is being made and is reported in a recent publication.<sup>2</sup> Is it too much to hope that specialty of 'special care dentistry' will be established by 2004 — 10 years after the first moves?

**P. Erridge**  
**East Grinstead**

- 1 Griffiths M. Special needs dentistry. *Br Dent J* 2000; 189: 470
- 2 Woof M. Specialisation in Special Care Dentistry — where from, where now, where to? *J. Disab & Oral Health* 2000; 34-35

## FOCI of infection

Sir, — Given the recent return to vogue of the focal infection theory, and discussion of it in endodontic publications and indeed understanding the continuing research into the relationship between dental health and cardiovascular disease, several queries spring to mind.

This theory effectively stated that micro-organisms, or toxins from them, could disseminate systematically from a localised circumscribed infection and initiate or exacerbate a systematic illness or damage a distant tissue site.

The standard protocol for the treatment of the majority of peridicular areas under non-vital or previously root filled teeth is to non-surgically root fill or re-root fill the tooth and then review the case for up to four

years to assess healing. Healing can be classed broadly as failed; uncertain; partial or complete, depending on what the pattern of bony infill was.

It is unreasonable to suggest that in cases showing uncertain healing or failed cases we have in fact exposed the patient to the risk of further systematic damage over a four year period. Should surgical intervention be exercised quicker in cases of large or persistent areas than is suggested in the protocol?

Perhaps unreasonably, the re-invention of the above theory could cause an alteration in endodontic thinking towards extraction and placement of a single tooth implant in these cases with long standing perapical areas rather than considering protracted re-root canal therapy with a reduced success rate?

**H. Duncan**  
**Belfast**

## Colin Davies

Sir, — I was sad to read the recent obituaries for H Colin Davis in the Journal, but no mention was made on his second career as a Christian broadcaster.

In the 1970's, I found myself listening by chance to the Sunday evening epilogue on Radio 4. This programme was a beautifully crafted episode of music and prose written and performed by David and H Colin Davis. The high standard never failed throughout a long series and I became a regular listener.

Later, they were again united to present an edition of 'With Great Pleasure', another Radio 4 programme in which a well known personality shares their favourite prose and poetry. David Davis was already familiar as the voice which read entrancing stories for children on the Home Service but who was H Colin Davis, his brother? 'At school I read a book on careers, he replied, and I had got to D before I found something I liked the look of and DE for dentist comes before DO for doctor!'

I met H Colin Davis personally at a meeting in Edinburgh some time afterwards when he spoke alongside Father Richard Holloway, now Bishop of Edinburgh. I found a man who was warm, welcoming and of extra-ordinary charm and it was a pleasure to share his company. The dental profession has lost a member who had the rare gift to serve his fellow men with distinction from both within and outside the borders of his calling.

**J. R. Pilley**  
**Kilmarnock**

## Student activity

Sir, — It was with some dismay and shock that I read the findings from the research carried out in a UK dental school on drugs

and alcohol usage (*BDJ* 2000; 189: 314-417). Though one must naturally be cautious about extrapolating these results across to all other UK dental schools the facts are sufficiently serious to warrant further investigation and practice intervention. Binge drinking by 56 per cent of male undergraduate and 58.5 per cent of females is worrying enough as is the use of cannabis by 55 per cent of undergraduates at some time during their course of study.

The deleterious effects of cannabis on hand to eye co-ordination and fine perceptual discrimination, even three to four days after usage, makes an ostensibly recreational (but illegal) drug dangerous in the hands of a dental student with a drill.

Current research being undertaken seems to suggest that this pattern of drinking does not abate post qualification as it does after other university courses and continues into vocational training. A pattern of drinking may already have developed in dental school. If 71 per cent reported their alcohol intake to be less prior to becoming a dental undergraduate then clearly dental school is where it starts and continues.

An undergraduate programme that recognises this and teaches about the effects for alcohol and substance abuse is an urgent consideration. As a profession we need to recognise the causes of this problem and prevent it ruining the lives of young dentists, their families and potentially their patients.

**L. D'Cruz**  
**Essex**

## Changing procedures

Sir, — The recent letter by Dr Gingell (*BDJ* 2000; 189: 236) regarding his concerns of the management of patients with transmissible spongiform encephalopathies (TSEs) raises a number of interesting points.<sup>1</sup>

Clearly there are aspects of funding which we tried to overcome by suggesting that patients with, or known to be at risk of TSEs be managed in appropriate hospital clinics and indeed it is hoped that the expected monies for the clinical care of patients with TSEs will include funds for relevant dental care even though the present epidemiological studies continue to suggest that an epidemic of variant CJD (vCJD) is unlikely in the UK<sup>2</sup> and elsewhere, and that person-to-person transmission of any acquired TSE has yet to be demonstrated.

Transmission of BSE via blood between sheep has been demonstrated<sup>3</sup> and infectious prions may be present in the white cells or animals experimentally infected with scrapie or CJD, but there is no evidence of blood to blood transmission of prions in naturally-infected animals, and

### Recommended physical processes for the use against TSE agents

Porous load (high vacuum) steam steriliser 134–137°C for a single cycle of 18 minutes, or 6 successive cycles of 3 minutes each.\*†

\* but known not to be completely effective

† downward or upward displacement autoclaves must not be used

patients who have received large quantities of blood or blood products are not liable to TSEs.<sup>4</sup>

In the absence of any evidence of health care staff being liable to vCJD,<sup>5</sup> and the current evidence of low transmissibility of prion disease via blood and blood products, we would suggest that dental health care staff are not at increased risk of TSE, particularly if the current Department of Health guidelines are followed.<sup>1,6</sup>

Many concerns of the medical and dental professions mirror those put forward 20 years ago with regards to hepatitis B, HIV and more recently, hepatitis C virus infection. Excellent up-to-date guidance for health care workers is available from the Department of Health.<sup>7</sup>

Finally we would like to apologise that our published table contained an error at the time of its recent publication in the *Journal*, hence this is now reproduced (above).

**S. R. Porter, J. Bell, G. Ridgway and C. Scully**

- 1 Porter D R, Scully C, Ridgway G L, Bell J. The human spongiform encephalopathies (TSEs): implications for dental practitioners. *Br Dent J* 2000; 188: 432
- 2 Ghani A C, Ferguson N M, Donnelly C A, Anderson R M. Predicted vCJD mortality in Great Britain. *Nature* 2000; 406: 583-84
- 3 Houston F, Foster J D, Chong A, Hunter N, Bostock C J. Transmission of BSE by blood transfusion in sheep. *The Lancet* 2000; 356: 999
- 4 Brown P. BSE and transmission through blood. *The Lancet* 2000; 356: 955
- 5 [www.doh.gov.uk/cjd/unitreport.htm](http://www.doh.gov.uk/cjd/unitreport.htm)
- 6 Advisory Committee on Dangerous Pathogens, Spongiform Encephalopathy Advisory Committee Transmissible Spongiform Encephalopathy Agents: Safe Working and the Prevention of Infection HMSO 1998
- 7 [www.doh.gov.uk/cjd/cjdguidance.htm](http://www.doh.gov.uk/cjd/cjdguidance.htm)

## Allergic reactions

Sir, — We read with interest the useful and sensible paper by Professor Rood (*BDJ* 2000; 189: 380) demonstrating the rarity of allergic reactions to local anaesthetics agents.

We were pleased to see that his findings so closely reproduced our own which were published in 1993, but not referenced in his paper. In that study we compared scratch and intra-dermal challenge with a variety of local anaesthetics in 90 patients referred to

us with adverse reactions and suspected allergy, with those in 45 seconds.<sup>1</sup>

Scratch testing failed to discriminate between patients and controls, while intra-dermal testing, however, did. We found that three of the 90 patients produced positive reactions to prilocaine, lignocaine and mepivacaine. In the other 87 subjects, we concluded that negative skin reactions to at least one of the agents allowed intra-buccal challenge and subsequent recommendation of an agent for future use.

Skin testing does not provide formal proof of allergy but does provide a useful test to indicate local anaesthetics which may be used for future procedures.

We concur with Professor Rood that true allergy to local anaesthetic is extremely rare and likely to be less than 3 per cent of those showing adverse reactions. The majority are either psychosomatic or as a consequence of intravenous administration.

**S. J. Challacombe, T. Hodgson and P. J. Shirlaw**  
**London**

- 1 Hodgson T A, Shirlaw P J, Challacombe S J. Skin testing after anaphylactoid reactions to dental local anaesthetics; a comparison with controls. *Oral Surg, Oral Med, Oral Path* 1993; 75: 706-711

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