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.

Skeletal changes

Sir, — I have followed with interest both the recent coverage expounding the use of 'dentofacial orthopaedics' and the measured reply by Professor Sandler (*BDJ* 2000; **189**: 468) that you recently published. Professor Sandler is absolutely correct of course to draw attention to the relatively modest skeletal changes obtained by the use of functional appliances. It is however true that such skeletal changes effects as they do exert are positive, albeit minimal, ones.

It is also worth pointing out that although the mean skeletal effect is small, most studies (including the Manchester study that Professor Sandler refers to) demonstrate a very wide variation in the skeletal effect with many patients demonstrating little skeletal change but with some experiencing greater clinically worthwhile change.

In deciding whether these appliances have a useful role to play, it is important to note that the claimed skeletal changes are not the only advantages of this particular appliance type. Indeed use of functional appliances in appropriate cases can rapidly correct a class II molar relationship, correct the angulation of proclined upper incisors, reduce an increased overjet, produce upper arch expansion (where needed) and reduce lip incompetence. Functional appliances can also be used earlier than conventional fixed appliances. This can allow early correction of cases with very severely increased overjets that have been associated with increased risk of incisal trauma. They may enjoy great popularity but we should not forget that they are capable of producing precisely the series of dentoaveolar changes that we require for many class II cases. In this context they often represent a logical and useful component of the overall treatment plan.

M. Bradley
Yeovil

Local anaesthetics

Sir, — May I congratulate Professor Rood on his excellent paper.[1] The author very convincingly tried to dispel confusion and misconception surrounding this issue often raised as suggestions by practitioners, patients and relatives alike based on their encounter to adverse reactions nothing to do with allergy. It is not helpful that from time to time doubtful case reports appear in the literature[2,3] suggesting 'allergic reactions' based on superficial observations about the safety of those local anaesthetics which are used in large quantities in everyday dental and surgical practice.

Professor Rood proved beyond doubt that in 141 patients — specifically referred to be tested because of concerns raised about possible 'allergy' — none actually had such allergy to lignocaine or prilocaine, the most commonly used local anaesthetics in dental practice. I have been using lignocaine not only for dental but also for surgical procedures for a long time. I use the surgical version of 20ml lignocaine 1% with 1:200000 adrenaline diluted to obtain 0.25% lignocaine with 1:800000 adrenaline. This enables me to do large skin excisions with flap repairs under local anaesthetics in an elderly, frail group of patients well into their 80s and 90s. It is very effective and I have certainly observed no allergic reaction over a period of 23 years.

As a practitioner, with interest and experience in this subject[2,4] I repeatedly tried to reassure our colleagues that true allergy to lignocaine and prilocaine are exceedingly rare and they are very safe indeed with proper use. However, all those who administer these local anaesthetics must know their maximum dose and how much they should actually give to a particular patient. It might explain some of the adverse reactions, that in a study[5] only 3% of dentists were able to give the correct dose of lignocaine in a dental cartridge (40mg) which are used most commonly and routinely in everyday practice. It is important to reinforce the message for our colleagues in GDP that local anaesthetics are safe and 'not to suggest that an allergic response has occurred when the clinical events are consistent with well recognised common causes of adverse reactions to dental injection.'

A. Ezsias
Bridgend

1. Rood J P. Adverse reaction to dental local anaesthetic injection — 'allergy' is not the cause. *Br Dent J* 2000; **189**: 380-384
2. Ezsias A. Article title misleading. *Br Dent J* 2000; **189**: 3
3. Ruiz K, Stevens J D and Train J J A, Watkins J. Anaphylactoid reaction to prilocain. *Anaesthesia* 1987; **42**: 1078-1080
4. Ezsias A. Lignocaine and anaesthetic allergy. *Br Dent J* 1998; **185**: 428
5. Preshaw P M, Rowson J E. The use of lignocaine local anaesthetic. *Br Dent J* 1996; **181**: 240

Share of the pie

Sir, — It has come to my attention that commitment payments are being hi-jacked from associates by some practice owners. In one case the associate had only worked at the practice for one year out of the last ten. Although this did not amount to any 'share' of the payment, the principal deducted 50%. There are other cases reported to me personally by the DPB of principals taking the whole of the payment! It is difficult to understand the motivation behind such contemptible treatment, other than sheer greed. In another case the principal employed associates in one NHS practice and operated exclusively privately in another. Not entitled to payment himself he thought it justifiable to share his associates payment to the tune of 50% presumably out of jealousy and self-pity.

Unless the BDA and DOH can make a clear and unequivacol appeal to these principals that their stance is morally and professionally wrong, the only recourse for these unfortunate associates is to go to court. They will then be witnessed squabbling over irrelevant 'contracts' which were not designed to include commitment payments in their remit. Do we need this in the public domain? Over the last two decades I have seen associates treated as if they were some species of parasite, and this latest development seems again to illustrate why associates are thin on the ground.

D. A. Boothman
Chichester

Linda Wallace from the BDA General Practice department responds: *The BDA's view is that the commitment payments are intended as net pay. They have no expenses element and so associates would not normally share them with practice owners. The Review Body's original intention was that the payments would reward loyalty and retain and motivate NHS GSPs; provide for an element of pay progression; reward past and present commitment; be open to all GDP principals (who meet the criteria). They are also fully superannuable, applicable normally only to the net element of gross income and the doctors' equivalent is taken to be net pay.*

It is, however, open to associates and practice owners to negotiate, taking account of the quality of the practice facilities and the overall financial package of the associateship. Many associates maintain the NHS basis of practices. They have little opportunity for private work themselves but enable practice owners to maximise their private earnings. As they reward past, as well as present, commitment, another aspect to consider is how long the associate has been at the practice and whether, if the payments are to be shared, the full amount should be shared. For a guidance note, please contact the BDA's General Practice Department.

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