Send your letters to the Editor, British Dental Journal, 64 Wimpole Street, London W1G 8YS
E-mail bdj@bda-dentistry.org.uk
Priority will be given to letters less than 500 words long. Authors must sign the letter, which may be edited for reasons of space.

Payment for CPD Allowances

Sir, - I would like to draw attention to the fact that the allowance paid by the DPB for CPD attendance for associates and assistants may be deducted by the principals in the practice. It now seems that some principals take 50% off the associates and assistants CPD allowances, as the principals claim that the courses were attended during surgery hours. This deduction is to compensate the practice for the loss of income from the associate or assistant while they are away on courses.

However, surely allowances paid for courses that were attended in the evenings or weekends outside surgery working hours should not be deducted from the associates and assistants by the principals.

It would be a better idea if the DPB could pay a separate allowances for courses attended during and out of surgery hours, although this might be difficult logistically to operate. It would also help if an agreement between the principals and associates or assistants could be reached as to how best to manage this problem.

I would be grateful if the BDA or any other colleagues could shed more light or give suggestions on this issue.

V. Egemonye
Tooting

Linda Wallace, Director of the BDA Professional Services directorate suggests the following:
The BDA advises that if the courses are attended in surgery hours, the CPD allowances are shared according to the usual percentage. However, CPD allowances for those courses attended during non-working hours should be retained by the associate.

The efficacy of salt?

Sir, - Through your column I wonder if I can get some input from practice and academic colleagues with regard to oral use of common salt?

I was recently mildly criticised by a periodontist for encouraging patients of mine with periodontal disease to use salt water mouthwashes and/or a salt scrub technique i.e. salt is used as a dentrifice and gently scrubbed into the gingiva.

I have been using this technique for some 20 years and believe I was first taught this by consultants at two different hospitals. In my purely subjective opinion I have seen some really excellent results and patients also comment on the improvement.

It may be argued that the periodontal improvement has been brought about by the scrubbing alone but I do not believe so. I strongly believe salt is beneficial to the point where I consider it is more effective than commercial mouthwashes, and consequently I actively discourage use of these mouthwashes in all but the most acute case. This is especially true for patients with red sore mouths who, having been sold the idea by strong advertising, have over used commercial mouthwashes.

The colleague who criticised me pointed out that there was no clinical evidence for the efficacy of salt (a project for some MSc student perhaps?) and indeed he inferred that what I was doing may be considered unethical despite the apparently good results.

Am I alone in discouraging the use of commercial mouthwashes and encouraging the use of salt? Are there any other dentists who are willing to state they find it most beneficial, or otherwise?

Incidentally, this colleague is a specialist periodontist and his criticism went as far as to state that hot salt water mouthwashes have no proven use after oral surgery either, and that we oral surgeons should stop prescribing it after surgery. Am I wrong? Can anyone enlighten me?

R. Kitchen
Bristol

Irrational Therapies

Sir, - I have some sympathy with the frustrations expressed by dyed-in-the-wool scientist T L P Watts, (*BDJ* 2002; 193: 487), when considering complementary and alternative medicine. Equally, I can understand the attractiveness of such treatments to patients, when conventional medicine apparently fails to offer a cure for their disorders.

There is a defence against intellectual frailty however, to which I regularly return. The University of York's NHS Centre for Reviews and Dissemination publishes a series of bulletins to assist those who have the responsibility of investing scarce public funds in providing health services. In its Effective Health Care bulletin on homeopathy, the Centre recently concluded that there is currently insufficient evidence of effectiveness either to recommend homeopathy as a treatment for any specific condition, or to warrant significant changes in the current provision of homeopathy.

Readers can log on to the website at www2.york.ac.uk/inst/crd/ehc73.htm, to access the full report. Other vexed topics recently covered include the management of chronic fatigue syndrome, and the growing public health problem of childhood obesity. The Centre should help T L P Watts and those of a similar persuasion to sort the scientific wheat from the irrational chaff.

C. Stillman-Lowe
Twyford

Cross Contamination by Amalgam Carriers

Sir,- At a recent BDA section meeting concern was expressed at the possibility of cross infection by means of the amalgam carrier, and that if amalgam carriers were developed that could be autoclaved there was the risk of air pollution by the vaporisation of mercury.

I discovered during a staff absence many years ago that the standard amalgam carrier is not an essential item of equipment. Provided that the striations on the tips of the amalgam plugger are kept clean, it is possible to pick up the necessary small increments of amalgam required to plug the

classic amalgam restoration using the plugger alone.

In order to achieve successful pick up, the amalgam mix should be placed on a paper tissue folded in such a way as to give four to six layers of tissue between amalgam and bracket table. The amalgamator should be adjusted to supply a mix that is not too wet and not too dry but just right, as one does!

It takes a bit of practice to get used to this technique, but I have restored many a tricky buccal cavity on an upper left eight or lingual on lower right six, even on patients whose co-operation left something to be desired, indeed I have filled all my amalgam cavities in this way, and for many years have not even owned an amalgam carrier.

The necessity of keeping clean the tips of the amalgam plugger will, I hope, help me to avoid the possibility of early brain degeneration due to poisoning by vaporised mercury when the restorative dentistry kits go through the autoclave.

D. Matheson-Dear
Dundee

Ergonomics Enquiry

Sir, - As President of the European Society of Dental Ergonomics I have contacted different people in the UK to find out who in the dental profession or in dental schools is interested in ergonomics in dentistry, the study of working posture, methods of working, use of equipment, instruments etc and management and organisation of the dental practice.

The only person I sometimes hear mentioned is Dr Ellis Paul, who has now retired.

I cannot imagine that besides Ellis Paul, whom I know personally, nobody else in the profession or in dental schools in the UK is interested in dental ergonomics. But I am not able to find these people.

Contact me for further information by e-mail: o.hokwerda@dentnet.nl

O. Hokwerda
Eelde
The Netherlands

The dentist's role

Sir, - One of the great pleasures of general practice is to see patients on a regular basis, to offer continual care and to maintain their oral health even if we disagree on the timescale for examinations!

I have recently seen a young female patient who had an imitation diamond jewel placed on an upper anterior tooth, six months previously, in a beauty salon. She has attended my practice with a cosmetic concern regarding the dark brown discolouration of the 'glue' that was used around the diamond in its original fixing. When she had returned to the salon, complaining of the poor appearance, she was greeted with the news that they were unable to help her and that she should seek the advice of a dentist.

This impressed upon me the importance of the role we play in planning our patients' dental care - looking to the future, not only to the present moment. Perhaps this is a good example of the old adage, "If you fail to plan, you plan to fail".

Our training as dentists over a five-year University course prepares us for this careful consideration of treatment planning, our skills being honed during a year of Vocational Training.

It is, perhaps, no wonder that a beauty parlour cannot expect to consider the future of a 'dental restoration' beyond the time it takes for the patient/client to leave the shop door and arrive on the pavement.

L. Mudford
Haywards Heath

Student Attitudes

Sir, - Reading the article on 'Assessing attitudes in dental education'[1] called to mind an article published, if I remember correctly, in the late 1970's in the *Journal of Medical Education*. The authors had assessed the attitudes of an intake of medical students at the start, during and at the end of their studies.

They found that most of the group had enrolled with strong charitable attitudes such as wanting to use their soon to be acquired medical expertise for the benefit of underprivileged people. By the end of their course many of the cohort had become self centred and money orientated.

In the discussion section the possible reasons for this strong shift in attitude were analysed without identifying any major reasons for this change. Finally the authors posed the question 'Where did we as teachers go wrong?'

This article influenced my thinking throughout the rest of my teaching years and I hope that most of my students remained patient orientated at the end of their course and have remained so. It is important for the profession, and the individual, that student attitudes are assessed and developed - yet another task for the clinical teacher.

P. Erridge
East Grinstead

1. Brown G, Manogue M, Rohlin M. Assessing attitudes in dental education: Is it worthwhile? *Br Dent J* 2002; **193**: 703-707.

Restoring deciduous teeth

Sir, - Referring to the debate in the letters page on the need or otherwise to restore deciduous teeth, one thing that it reaffirms is that in dentistry, if you wait long enough, your particular dogma will be in vogue.

The wheel of restorative care of deciduous teeth surely turns. I admire Nick Cole having the courage to express a viewpoint. Such temerity is often punished by yards of invective. The gold standard is not, to me, based on much more than 'if this was my child, what would I do'. Anything after that is a compromise however we justify it.

So many aspects have to be taken into account not the least of which is the seeming changing ability of children to have anything more than an examination. Treatment modalities like stainless steel crowns, so robust and successful in withdrawing teeth from the oral environment are now more and more challenged because of their appearance. At the same time changing dental materials offer opportunities and our knowledge of the importance of life styles in oral health is growing.

Statistics matter not a jot if you are that one in a million and that is the way our patients see it as well. Balanced decisions are difficult but we will always have to make them and live with them... usually outside surgery hours, unfortunately!

C. Vaughan Jones
Montgomery

Mandible pain

Sir, - I would like to refer to G A Aristidou's recent letter (*BDJ* 2003; 194: 3).

Other serious conditions as well as acute coronary problems can present as referred to the mandible.

I have seen a pulmonary tumour associated with pain affecting the left side of the body of the mandible. This was an unfortunate case as time was wasted investigating the patient's heart when she developed as haemoptysis leading to the correct diagnosis. Even more unfortunately, the patient was the mother of another member of our hospital staff. I am uncertain about the outcome.

D. J. M. Buddery
Great Yarmouth

Cutaneous Reaction to Carbamazepine

Sir, - We recently encountered this florid reaction to Carbamazepine, prescribedfor a 62 year old gentleman who presented with trigeminal neuralgia. His skin literally fell off, particularly his palmar and plantar surfaces. He made an uneventful recovery after his medication was changed to Dilantin Sodium. He is comfortably maintained on his new medication.

R. Matthews
J. Philip
Norwich