Send your letters to the editor, British Dental Journal, 64 Wimpole Street, London W1G 8YS
E-ail 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

Conflicting opinions

Sir,- To quote the words of Ian Wylie (*BDJ* 2003; **194:** 469) 'The work the BDA has done over the past two years has put dentistry into the strongest position it has been in for many years.' This statement promotes the BDA as being exclusive agents in attaining the current position of dentistry. It could be argued that GDPs practicing solely within the NHS business model have grounds to disagree with this statement. 'Strong position' implies communication with negotiators of government of the day.

The removal of the inertia which has afflicted government negotiators' willingness to 'deal' with the BDA, it has been suggested, comes from a source distant from the aforementioned parties. Sackfuls of mail from patients complaining to their MPs about the lack of NHS dental practices in their areas has undoubtedly influenced the flow of events. The trend for NHS practice conversion to the independent sector, taken initially at risk by the practitioner, has largely brought this state of affairs about. Recognition of the part played by those at the 'dentine face' is also deserved.

F. Moran
Gloucester
doi: 10.1038/sj.bdj.4810313

Sir,- Ian Wylie asks readers to imagine what might have happened to dentistry without the BDA. No imagination is needed as I can tell him with confidence that GDPs would have been much better off! He needs to go back in time to the mid 1970s when together with a number of colleagues from Wiltshire I spearheaded a national campaign to change the centrally funded GDS. We met fierce opposition from Gilbert Daley and his NHS sympathisers on the BDA GDSC sub-committee.

In 1982 I received a letter from Patrick Jenkin (now Lord Jenkin) soon after he became Secretary of State, informing me that the government was prepared to look at new methods of remuneration for GDPs provided that the BDA supported such a move. We all know the outcome.

We also know the outcome of the referendum and the BDA decision to go against the majority of GDPs in the early 90's who were against the new contract. This of course led to a number of dentists such as myself withdrawing completely from the NHS. Ian Wylie conveniently ignores the fact that the government has been brought to heel and the BDA has changed policy only because so many of my colleagues have withdrawn from their support of nationalised dentistry. As a result and for the first time in my professional life, dentistry has acquired some political clout. He refers to 'current committee chairs have long experience of working effectively at the most senior levels of government and regulation'.

This does not appeal to me as the best qualification needed for looking after the freedoms and independence of full-time GDPs! As a result of our efforts to try to change the oppressive terms of the centralised GDS I was asked to give evidence to Sir Kenneth Bloomfield and also the Parliamentary Working Party on Dentistry. My central theme was to suggest a move towards funding via a local dental trust. The latest move towards Primary Care Trusts should put GDPs on warning that their future independence is seriously threatened by back door nationalisation.

I had hoped that a dental trust concept would protect our autonomy and independence. However dentistry will now be firmly under the control of the local PCT bureaucracy and I doubt very much if private practice will be the flavour of the month in the present political climate.

Having removed the shackles of centralised control I am fearful that GDPs are now threatened by nationalisation at a local level. The BDA would do well to ensure that experienced private practitioners who have run successful businesses are available locally in the critical few months ahead to preserve our independence in the new order.

N. J. Knott
Wiltshire
doi: 10.1038/sj.bdj.4810314

Campaign of terror?

Sir,- I would like to bring your attention to a recent television campaign by the BBC which has, so far, provoked fear of the dentist in two of my patients.

The advert depicts a patient being treated by a dentist in a dental surgery. The radio is tuned to BBC Radio One and the patient is trying desperately hard to listen to the radio. However, the radio is being drowned out by the sound of the drill. The dentist drill depicted in the advert is exceptionally and unrealistically large and noisy and the dentist also appears rather aggressive in her manner of drilling.

One of my patients was a child, who was already slightly nervous about dental treatment. At a subsequent appointment his mother explained to me that the depiction of the dental appointment in the advert had scared him and left him very anxious about this appointment with me.

The child was terrified and before I could even look in his mouth he burst into tears and was totally uncontrollable. I had hoped and believed that by slowly introducing this child to dental procedures, he would have become a cooperative patient. However, I have been left with no choice but to refer him to the community dentist.

The second patient was an adult who commented on how the advert had sent shivers down her spine and left her in some dread over her next appointment. I would be interested to learn if others have experienced a similar response from any of their patients. I have written to the BBC to express my concerns.

P. Gill
Grimsby
doi: 10.1038/sj.bdj.4810315

The great warfarin debate

Following the letters published from D. K. Mehta and R. B. Lloyd (*BDJ* 2003 **194:** 530) I must first apologise for causing offence to D. K. Mehta *et al* BNF/DPF. We are all, I am sure, very grateful for having such a publication devoted to the

profession. The work that goes into its production must be immense. I do think the interest recently in this area reflects its complexity. The suggestion that advice be sought from haematologists I find interesting, as the majority of higher target International Normalised Ratio (INR) patients I see are mechanical valve patients under a cardiologist. Here is a portion of written advice given to me by a cardiology colleague. 'Those who have a mechanical prosthetic valve are those for whom we would say there was an absolute need to continue with warfarin treatment'.

The implication is clear to me that the serious complications that could ensue from dropping the INR in these patients far outweighs the problems (usually local) that can be produced by the extraction of teeth. I would, as stated previously, suggest a postoperative INR is obtained at 3-5 days which: 1. Protects the patient: Extractions under antibiotic cover may in some cases trigger an over-anticoagulation exposing the patient to an increased risk of serious internal haemorrhage. 2. Protects the dentist: Patients maintained on high INR targets could at any time suffer a serious internal haemorrhage and if this occurs shortly after dental extractions, questions as to the prepost INR might be asked. 3. Might provide valuable research data: The affects of such dental treatment on the INR would benefit from further investigation. For the patient in the lower INR target group (range 2-3) the DPFI haematologists from the North West and Simon Carruthers, Chairman BDA Formulary Committee could possibly be brought into some form of consensus. (This is a low risk group of patients anyway). For the higher group? Well at the present time I could not blame a GDP for wanting to refer these cases on.

N. Malden
Edinburgh

Dinesh Mehta (Executive Editor, BNF/DPF) and Simon Carruthers (Chairman, BDA Formulary Committee) respond:–

The Dental Practitioners' Formulary (DPF) 2002-2004 states (at p. D8) that the INR should be assessed up to 24 hours before the dental procedure. It goes on to say that the dose of warfarin does not need to be adjusted for minor dental surgery in patients whose INR is below 3.0.

For patients requiring dental surgery and who are receiving long-term anticoagulation, the DPF recommends that the advice of a haematologist should be sought if the INR is greater than 3.0. As Dr Malden points out, these patients may be at greater risk of bleeding because of their high target INRs; so seeking the advice of a haematologist (the specialist most often involved with managing anticoagulation) would seem prudent. The advice might well be that the dental procedure could proceed without altering the warfarin dose.

As mentioned previously (Dental surgery in the anticoagulated patient. BDJ 2003 ***194:*** *530), changes to the DPF resulted from extensive advice provided to the Dental Formulary Subcommittee of the Joint Formulary Committee. As with the rest of the advice in the DPF, recommendations on treating anticoagulated patients are kept under regular review.*

doi: 10.1038/sj.bdj.4810316

Orthodontic extractions

Sir,- I was very pleased to read the article on guidelines for referring children for extraction under general anaesthetic (*BDJ* 2003 **194:** 557) and note that orthodontic extractions of sound teeth under general anaesthesia can only be justified for intellectually impaired patients. I would like to suggest adding the extraction of all four first molars for orthodontic reasons for a patient below the age of 11 to the list of those eligible for general anaesthesia.

K. G. Isaacson
Hampshire
doi: 10.1038/sj.bdj.4810317

Hot salt water mouth baths

Sir,- R. Kitchen of Bristol (*BDJ* 2003, **192:** 119) asked for clarification regarding the use of hot salt water mouth baths after oral surgery. At the recommended prescription of one teaspoonful of common salt in a domestic tumbler of hot water at a temperature as would be taken for a fresh cup of tea, produces a heated solution roughly isotonic with body tissues (2nd BDS Physiology!). This prevents destruction of the cells migrating into the area that are trying to repair the wound.

When an intraoral surgical site is so bathed, the heat of the solution produces a therapeutic increase in blood flow to the affected area that promotes wound healing. This is a basic homeopathic principle that was widely adopted before today's use and overuse of antibiotics became available. Common salt as a management protocol for periodontal disease – no comment.

R. W. Matthews
Bristol
doi: 10.1038/sj.bdj.4810318

The above letter has been reprinted. It was previously attributed to an incorrect author in BDJ 2003 ***194:*** *584.*