Send your letters to the editor, British Dental Journal, 64 Wimpole Street, London W1G 8YS or by email to bdj@bda.org
Priority will be given to letters less than 500 words long. Letters should be typed. Authors must sign the letter which may be edited for reasons of space

Public service values

Sir,- Just over a year ago colleagues at the University Dental Hospital of Manchester reported that their students appeared to lack motivation towards public service values but instead were driven by 'considerations of personal and financial gain' (*BDJ* 2002, **193**:471-3). Presenting the same questionnaire to fourth year undergraduates at Sheffield provided an interesting result. Sheffield students were much more likely to be motivated by public service values. This was most pronounced in the dimension of patient care and working with people where over 9 out of 10 students cited these as factors.

High income was less than half as likely to be a motivator, professional status and regular working hours were less important. More likely to be cited as motivators were security, a challenging career with diverse career opportunities, interest in science and opportunity to interact with people which Sheffield students cited more than twice as often. The reasons for this difference between students are unclear. However, these data may reassure those east of the Pennines supporting dentistry's public service dimension who were dismayed by the earlier findings.

M. Crossley, Liverpool

M. Smith, Sheffield

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Salivary calculi

Sir,- I feel I have to write in response to the letter of J. F. Sharp (*BDJ* 2003, **195**: 551) on the subject of salivary calculi. This is not because I wish to claim a further superior sized stone but to challenge the methods used by the author. I applaud the use of a distally positioned suture to prevent the calculus disappearing back down the duct into the gland; it is a shortcut one will only do once to omit this stage as you explain red-faced to the patient that the stone has 'disappeared'.

I would strongly advise against closing the resultant incision with sutures as there is a very real risk of causing occlusion of the submandibular duct. It is better

practice to leave the wound without suturing and simply remove the distal suture. A new opening from an essentially shortened duct is likely to form further back in the floor of the mouth which will be of no consequence to the patient.

Additionally, I would caution readers from trying to remove calculi positioned further back in the floor of the mouth than the segment of duct that is immediately visible behind the lower incisors. Too many times I have had to intervene for 'have a go heroes' trying to remove calculi deep in the floor of the mouth in the third molar area. I would advise such cases are dealt with by experienced surgeons when a general anaesthetic is often required for their removal. If such a patient continues to suffer recurrent submandibular gland swelling after removal of a calculus, it is likely there has been glandular damage. In such instances referral is advised when a sialogram is indicated to examine the residual functional lobules and assess damage. In some cases subsequent removal of the gland is indicated.

R. Oliver

Manchester

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Do dentists read journals?

Sir,- The assumption that dentists do not read journals and have to be tested to prove they have read them, I find counter productive and vaguely insulting.

Increasingly I am reading articles with a view to answering the CPD questions. I used to read them because I was interested in the subject.

D. R. Woolley

Bedfordshire

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Dental health educators

Sir, - The paper by Blinkhorn *et al* entitled 'A cluster randomised, controlled trial of the value of dental health educators in general dental practice' (*BDJ* 2003, **195**: 395-400) is timely and the subject will be of great interest to those who fund the provision of dental services. In view of this, may I use the courtesy of your letters column to ask the researchers some

specific questions?

1. The sample size calculation was based on caries increment. In the event many more children were enrolled, but caries prevalence had to be used as the outcome measure. If the statistician had known this would happen, would the number enrolled have been different?

2. Why did the oral health educator do the baseline examination? It appears this forced the change of analysis of caries from increment to prevalence.

3. A condition for enrolment in the study was that the child should, 'have some caries experience', but in discussion it is noted that, 'several of the children recruited were free of caries at the beginning of the study.' How many, and does this affect the power of the study?

4. Presumably bitewing radiographs would have been available in this high risk population where much of the caries would be on mesial surfaces of B's and distal surfaces of D's. However, radiographs are not mentioned. Were they used?

5. There is no mention of the restorative care the children received. It would be interesting to see dmft data presented individually and by surface. I wonder how many cavitated approximal lesions were present at baseline? If these were not restored, I would expect them to progress as toothbrushing could not access the plaque.

6. The control group had one session of dental health education. Could it be said that this study therefore compared the value of one session of dental health education with 'four-monthly' sessions, over a period of two years?

E. Kidd

London

The authors of the letter respond: It must be appreciated that this study was carried out in a high caries location during the normal, everyday conduct of general dental practice. The availability of patients and premises rested in the hands of the practitioners not the research team, which was as it would be in any substantive scheme. Research in general dental

practice cannot be as tightly controlled as a traditional caries clinical trial.

The reason why caries prevalence was eventually chosen rather than increment was explained in the methodology section of the paper. The oral health educator recorded caries at baseline because this was carried out at the first visit for dental health education at the appropriate practice. However, it was appreciated that she would know the allocation to groups of the children at the end, so this information was used only to assist in allocating the children to groups on a randomised, cluster technique. In fact, the dental health educator did examine the children for caries at the end of the study and the results demonstrate the importance of the examiner being blinded to group allocation. The mean dmft (SD) of the control group was 3.09 (2.90) and that of the test group 1.82 (2.07), a difference of 41% ($p<0.001$). These compare with those of the independent dental epidemiologist of 3.22 (2.85) and 2.65 (2.56), a difference of 18% ($p>0.05$).

The initial protocol required that the children should have some caries experience at baseline to add a dimension to their caries risk status. Again, the practitioners disagreed with this, largely because they had insufficient young children of regularly attending families who met this criterion and they believed that, based on the family history, of which they were aware, they could select those caries free infants who would demonstrate caries in the next two years.

The fact that several of these children in the control group were caries free at the end demonstrates the difficulty that exists in predicting which young children will get caries. It was decided to leave these children in the final analysis because this represented what would be the case in the real world¹. Because of the young age of these children and the fact that the final examinations were conducted in schools or the children's homes, no radiographs were taken. The individual components of caries prevalence in all posterior teeth, including first permanent molars but omitting early caries, as determined by the dental epidemiologist were: decayed teeth - Control group - 1.69, Test group - 1.49; missing teeth - Control group- 0.69, Test group - 0.34; filled teeth - Control group - 0.93, Test group - 0.69. None of these differences were statistically significant.

It should be appreciated that this was a test of a specific model for delivering dental health education in general practice by an outside funding agency seconding a dental health educator to practices on a sessional basis. This created problems of its own some of which were described in

the discussion. We thought it only ethical to provide some minimal preventive advice to all the mothers who attended for the baseline exam. This was done before allocation to groups so all received advice on the importance of brushing with a fluoride toothpaste. This might be the least these regularly attending mothers might receive from their practitioners without the assistance of a dental health educator.

A. S. Blinkhorn
P. J. Holloway
Manchester
doi: 10.1038/sj.bdj.4811211

1. Fergusson, D et al. *Br Med J* 2002; **325**: 652

Hot dentures

Sir,- In response to V. Egemonye's letter in *BDJ* 2004, **196**:312 that gave details of self-administered dentistry, I too can report an unusual case involving a patient with a full upper denture.

He presented to me complaining of soreness with 'peeling skin' in the roof of his mouth, which on examination was indeed very red and angry-looking across the full denture bearing area.

Checking the denture I found a reline had been applied, although the quality of the fit and extension was poor. On further questioning the patient admitted that he had done the reline himself by melting a plastic plant pot in a saucepan, pouring the molten plastic onto the denture, and then seating it under biting pressure whilst it was still hot. That explained a lot!

G. Scott
By email
doi: 10.1038/sj.bdj.4811209

Age	% caries free	Mean DMF (def for 5 year olds)
5 years	32%	4.29 (def)
12 years	66%	0.7
14 years	44%	1.74

Figure 1. Percentage of children with no evidence of caries, and mean numbers of decayed, missing (or extracted), or filled teeth (1989).

Age	% caries free	Mean DMF
12 years	40% (n=70)	5.1
14 years	47% (n=69)	5.4

Figure 2. Percentage of children with no evidence of caries, and mean numbers of decayed, missing, or filled permanent teeth (1998).

The above tables were printed in *BDJ* 2003, **196**: 125 with the omission of the word 'free'. The correct tables are printed above.
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