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

A view from overseas

Sir, the articles and correspondence regarding restorative care for the primary dentition are disappointing. The guidelines of the British Society of Paediatric Dentists (BSPD) were not followed, resulting in 48% of British pre-school children suffering pain with the non-intervention approach. Your readers may be interested in a view from overseas.

The reason why the restored primary teeth were painful is explained by Drs Tickle, Milson and Blinkhorn's comment that all of these pre-school children had interproximal decay[1]. Once interproximal decay is clinically observable, there is a strong likelihood of advanced decay with breakdown of the marginal ridge and pulpal involvement[2].

Restoration of such lesions with conventional Class II restorations are likely to fail due to the lack of proximal support[3]. As recommended both in texts[3] and by the BSPD, only minimal interproximal lesions should be restored with conventional Class II preparations. Larger lesions should be restored with stainless steel crowns especially in the younger child where this restoration needs to last a longer time, which it does[3,4,5]. It is therefore no surprise to me that such restorations failed, resulting in pain. Simply put, when the wrong restorative choice is made, one can expect failure.

The authors state that they do not have the evidence to show that stainless steel crowns are more effective in reducing the risk of pain and minimising the possibility of developing anxiety[1]. This is true.

However, I would suggest this implied criticism of stainless steel crowns is wordsmithing at best. After all, if the stainless steel crown is placed once, and it lasts a lifetime of the tooth which the majority do[4,5] how much future anxiety does the patient suffer when they are not subjected to having failed restorations redone or the tooth extracted?

This careful attention to the restoration brings the child's overall interest to the fore, by saving the child unnecessary retreatment. Two criteria of successful restorations are absence of pain and longevity of the restoration. The work being done falls short of the mark on both counts. In North America, such a high failure rate would result in medico legal and/or licensing problems. It is interesting that there appears to be no action in Britain regarding this, especially given the apparent waste of Government funding.

Based upon these results, one can only hope that parents of pre-school children who are subject to a non-intervention approach will be informed that nearly half of them will suffer pain. British children deserve better and should be treated according to the guidelines of the BSPD, consistent with proven techniques.[4,5]

D. B. Kennedy
Canada
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1. Milson K M, Tickle M, King D. Response to letters to the editor. *Br Dent J* 2004; **196:** 64-65.
2. Stoner J E. Dental caries in deciduous molars. *Br Dent J* 1967; **123:**130.
3. Curzon M E T, Roberts J F, Kennedy D B. *Paediatric Operative Dentistry* 4th ed. Butterworth-Heineman 1996.
4. Roberts J F, Sherriff M. The fate and survival of amalgam and preformed crown molar restorations placed in specialist paediatric dental practice. *Br Dent J* 1990; **169:** 237-244
5. Braff M M. A comparison between stainless steel crowns and multisurface amalgams in primary molars. *J Dent Child* 1976; **42:** 474-478.

The authors of the paper respond: *Dr Kennedy's letter opens with the claim that because the BSPD guidelines were not followed, 48% of the children involved in the study experienced at least one episode of pain. Unfortunately, the study data does not support this position.*

In defence of the stainless steel crown as the treatment of choice for primary molars with large two surface lesions, Dr Kennedy quotes a number of scientific papers. None of the studies he relies upon report on randomised controlled trials undertaken in NHS primary dental care. Thus it is not possible to conclude that, in the hands of NHS dentists, the stainless steel crown is better than any other material for the treatment of two surface caries in primary molars. We do know that stainless steel crowns are not a popular method of restoration with GDPs in England and Wales. Figures from the Dental Practice Board[1] show that in 2003 only 2,793 preformed crowns were fitted in NHS practice, a reduction of 35% over the previous two years. At the same time, the number of intracoronal restorations provided has remained reasonably constant. Dr Kennedy's assumption that the wrong restorative choice inevitably leads to failure may, in principle, be sound. Since the authors of the study are not clear what constitutes the optimal restorative option for primary teeth with large two surface lesions, they are unable to comment further on this point.

The authors feel that successful restorative care is that which addresses the needs of children first and the tooth second. In the UK, NHS GDPs are responsible for the care of over 90% of those children who visit a dentist. The UK public have faith in the service that is offered to children and the GDPs earn the confidence of the public by delivering what they feel is a high quality service. There is no robust evidence to suggest that the stainless steel crown is a better treatment option than other restorative approaches and therefore to suggest that money spent on alternative restorations is a 'waste of government funding' is clearly untenable.
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1. DPB Digest of statistics 2002-2003.

Clinical waste companies

Sir, I have experienced several problems when dealing with companies who dispose of clinical and hazardous waste. Our practice has been approached for business in the past by one company which I discovered on making checks was not registered as required by law. I found that it was not easy to verify registration as the information was only kept for companies disposing of waste locally and there was no central record of these companies. This situation may have changed by now, but at the time it meant that it took a lot of effort to find out whether a company was acting legally. At the time I was interested in changing companies because of the

problems we were having with our existing company. We reported to our Health Authority, (who organise the collection of clinical waste for us) that the company being used was not collecting the waste regularly, so that we ended up with a mountain of waste for incineration which could have posed a fire risk.

Eventually, the company turned up with apologies about a company take over. However, the staff employed were not wearing gloves and proper protective clothing and did not have the necessary receipt books to issue receipts for the waste which we keep to prove that the waste has been properly disposed of and for billing purposes. Furthermore the vans being used did not have the rigid containers for waste now required by health and safety law. On this occasion we were forced to refuse to release the waste to the collector, and a number of doctors had taken the same action and complained.

Our latest problem has been with the disposal of our waste amalgam containers, containers for used fixer and developer, and amalgam capsule containers which we purchased from a company from their catalogue. The service was advertised as including disposal of the waste and so we were surprised when we received a bill from the company who came and collected the waste, which turned out to be the very same company who dispose of our clinical waste.

Again, I was forced, regretfully, to complain and again, the excuse was something about a take over. Apparently the original company who produced the waste amalgam containers initially included a free postal disposal service which is now of course illegal as hazardous substances cannot be sent through the post. Later models included a telephone number to contact, which is now of course unobtainable as the company no longer exists but was purchased by a much larger waste disposal company.

Since I considered the contract to be with the company who had sold us the containers, our practice decided to ignore the threat of County Court Proceedings to retrieve the cost of the collection which was sent to us by the waste company and arrived after only one account having been sent. Then, after discussing the matter with our dental suppliers who were very helpful, it was agreed that we should not have been charged.

In my opinion the charges for disposing of clinical and hazardous waste are excessive. The NHS ultimately has to absorb this high cost. What is more, we are responsible for ensuring the safe disposal of waste and do not have a certain guarantee of what happens to it, as has been highlighted by other waste scandals.

J. Fieldhouse
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The Professional Services Directorate, BDA, responds: Waste carriers and brokers have to be registered by the Environment Agency in England and Wales and by SEPA in Scotland. Although there is no centrally held register, a list of those licensed to collect and dispose of clinical waste are held by the regional offices of the Agency.

The Environment Agency General Enquiry line will be able to locate your regional office if you have a complaint to make regarding a waste collection company or would like to verify a company's registration on 0845 9333111.

The law on the carriage of dangerous goods by road did change in 2002 to require bulk riding containers to be used, however the Health and Safety Executive did issue an exemption to this in relation to clinical waste, meaning its bulk transportation does not have to be in rigid containers. When waste is transferred, a written description of the waste must be transferred with it. In addition, a transfer note must be completed and copies kept by both parties. No form of waste should be sent through the post.

Waste collectors usually provide a standard term service contract for you to sign. You should always thoroughly check the wording, including the small print, before you sign. Everything on the contract including the commitments in the small print are legally binding. They are also enforceable even if a member of staff has signed on your behalf and you have accepted the goods or the service.

You should always check the length of the contract and the exclusivity clause. If the contract is for a fixed term you could be committed to using that firm for that period and an exclusivity clause prevents you from using another firm. You need to consider whether you are happy to commit to one business in this way.

Check the quality of service they provide and clear definitions of their commitments to you. When companies are taken over, the new company may send you their new standard contract. Check that this matches the terms and conditions that you had before, as some companies will introduce new fixed terms or exclusivity clauses. You should then consider how you would be affected if the standard of service declines. Further guidance on waste disposal can be found in BDA Advice Sheet A3 'Health and Safety Law for Dental Practice' and coming editions of BDA News.

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