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## Dental sedation

Sir, the paper by Shearer *et al* (*BDJ* 2004, **196**: 93-98) was very enlightening and demonstrated some very entrenched views held by many anaesthetists in Scotland. These suggest to me that some of the opinions expressed may be informed more by professional self-interest than simply patient safety since no evidence was offered why the anaesthetists felt that, on the whole, dentists should not carry out conscious sedation.

The shared airway was mentioned but, by definition, conscious sedation should be no more of a problem than where routine dentistry is carried out using local anaesthesia alone. The opinions of anaesthetists, however highly skilled, are still just that and, like those given in the Poswillo Report<sup>1</sup>, were not strictly evidence-based.

If the consensus opinion of the Scottish anaesthetists were to be taken to its logical conclusion then all dental sedation cases should be transferred to hospital. This clearly, given the present situation in the NHS, would be impossible, greatly increase the cost per case and would probably not bring any tangible health gain. The ability of anaesthetists to carry out effective sedation should be closely examined.

There is anecdotal evidence that some anaesthetists do not titrate the dose of the sedative agent according to the patient response, but would give what is in their opinion a safe standard bolus dose weight; when using midazolam, for example, this could vary from a 2mg to 10mg which clearly might either give insufficient sedation to enable satisfactory operative dentistry to be carried out or, in frail patients, elicit an excessive response with a real risk of loss of consciousness.

There can be no universal standard dose because the levels of anxiety in patients can vary hugely as do their responses to the sedating agent. Indeed dentists have recounted to me instances where the sedation has been routinely administered by an anaesthetist who required that patients fast before treatment and where

the depth of sedation exceeded the level where loss of consciousness was unlikely.

This type of sedation is not the sort practised by dentists and certainly would not be approved of by Poswillo<sup>1</sup> or by the Department of Health<sup>2</sup>. The transfer of all dental general anaesthesia (DGA) into hospital settings following the recommendation of the Department of Health Report in 2000<sup>2</sup> has led to long waiting lists in many areas.

The possible transfer of dental sedation to an acute setting would have devastating effects on waiting times for treatment and create huge problems in patient management. If dental sedation were to be transferred to anaesthetic hospital departments it follows that all sedation (including relative analgesia) would fall within the domain of the anaesthetist.

This would necessitate that the midwives' use of nitrous oxide in the delivery suite could then only be sanctioned if anaesthetic staff were present at all times. This muddled thinking needs to be tempered with some hard evidence that looks carefully at risk.

All clinical interventions carry risk; the task is to look at probabilities and consequences in order to manage risk rationally. The resource implications of anaesthetists having a monopoly of sedation for dentistry is enormous and would effectively outweigh any putative benefit.

The use of sedation in dentistry needs to be positively encouraged to reduce the need for a DGA, particularly in children, and to avoid exacerbating the problem of large swathes of the population being prevented from seeking timely dental care due to extreme anxiety.

Indeed, a study in Scotland in 1990<sup>3</sup> concluded that the 'Poswillo Report' had not increased the use of inhalation sedation at all while a similar survey in the North West of England reported a similar under-utilisation of inhalation sedation<sup>4</sup>.

The use of inhalation sedation can reduce the need for a DGA<sup>5</sup>. This should help reduce the need for repeat DGAs which has been reported at levels ranging

from 9.5% in London<sup>6</sup>, 23% in Leicester<sup>7</sup> an estimated at 25% in Glasgow<sup>6</sup> and 31.8% in North Wales<sup>8</sup>.

I would also like to put the record straight regarding postgraduate courses for conscious sedation. There have been several excellent courses held in North Wales over the last few years providing a mix of didactic teaching and 'hands on' experience and using the expertise of the sedation teachers from dental schools across the UK.

In addition there have been several courses for dental nurses working towards their post-basic qualification in conscious sedation in which the pass rate has been exemplary. North Wales is not a rural backwater but is often ahead of the game!

Those of us who practice sedation need to firmly maintain our right to administer sedation safely and to demonstrate our commitment to high standards of practice, training, clinical audit and continuing professional development. If we do not, who knows when a special interest group might decide that regional block anaesthesia should be the next target?

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## Inclusive association

Sir, I was interested to read Mr Bradley's letter (*BDJ* 2004, **196**: 513) describing the British Association of Oral and Maxillofacial Surgeons (BAOMS) as an 'inclusive association'. Having been accepted onto the specialist list in surgical dentistry in 2001, I wished to join an association that would represent this speciality. Unlike other specialists in BAOMS, surgical dentists are welcome to join, pay the appropriate subscription, but are the only ones denied voting rights! Clearly there is a role for a more inclusive, 'inclusive association'.

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## Surgical skills

Sir, the paper in *BDJ* 2004, **196**:167-71 prompted us to analyse retrospectively the influence of operator seniority on morbidity of secondary alveolar bone grafting procedures in our unit.

We analysed 77 cases randomly over a 10 year period, 55 of whom were treated by SHOs and 22 by registrars. Overall donor site morbidity was low with no major complications reported. Twenty two minor complications occurred including immediate post-operative pain (9), bleeding (8), wound infection (3) and delayed mobilisation (1).

There was no statistically significant difference in outcomes between those treated by SHOs and registrars. In conclusion, we propose that alveolar bone grafting from the ilium under supervision may be an appropriate procedure for trainee maxillofacial surgeons, particularly senior house officers, to enhance their surgical skills.

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## Definition clarification

Sir, leukoplakia is a common lesion observed in clinical practice and the term is familiar to the majority of dentists. But a review of the literature reveals that there is considerable ambiguity in the interpretation and use of the term leukoplakia.

In 1978, a World Health Organization (WHO) group defined oral leukoplakia as: 'A white patch or plaque that cannot be characterised, clinically or pathologically as any other disease.' The accompanying text emphasised that the term leukoplakia should carry no histological connotation

and should be used only in a descriptive clinical sense. In addition, it was also mentioned that this proposed definition is rather a negative definition and the need for revision and refinement of this definition should be done in the future with increasing knowledge<sup>1</sup>.

At the international seminar held in 1983, the outcome of which was published in 1984<sup>2</sup> a new definition was proposed as 'Leukoplakia is a whitish patch or plaque that cannot be characterised clinically or pathologically as any other disease and it is not associated with any physical or chemical causative agent except the use of tobacco.'

Another new definition of leukoplakia was proposed at the International Symposium in Sweden 1994<sup>3</sup> as 'A predominantly white lesion of the oral mucosa that cannot be characterised as any other definable lesion, some oral leukoplakias will transform into cancer'. The rationale for proposing this new definition was made on the basis of following difficulties in interpretation of previous definitions by WHO in 1978 and Axell in 1984.

The word 'pathologically' in the description of leukoplakia is sometimes interpreted to imply that the diagnosis cannot be made without a biopsy.

Even after careful clinical and histopathological examination, there are some white lesions for which doubt remains as to whether they fall into the category of leukoplakia or any other. Also, the extent to which it is possible to apply adjunctive tests to biopsy material to exclude other diseases varies from laboratory to laboratory. An association with physical or chemical causative agents is difficult to assess and the possibility of a coincidental association cannot readily be eliminated.

Several tobacco-induced lesions, such as leukokeratosis nicotina palatinae, palatal keratosis in reverse smokers and 'snuff dipper's lesion,' are not traditionally described as leukoplakias even though they are partly white and associated with the use of tobacco.

Difficulty was experienced because of the subjective nature of the degree of whiteness of the mucosa required before a diagnosis of leukoplakia should be made. Some authors attempted to overcome this by defining certain lesions as 'pre-leukoplakia.' The condition described as 'leukoedema' may also present problems in this respect. The lesion described as having leukoplakia and associated with immunocompromised patient, particularly those who are HIV positive, has introduced a complication in terminology. It could now be classified as a diagnosable

disease and as such, the use of the word 'leukoplakia' in its title is confusing.

Many reports in the literature do not specify whether a diagnosis of leukoplakia has been reached on the basis of a clinical examination alone or after the histopathological report on a biopsy.

Earlier definitions of leukoplakia included the criteria in relation to size (> 5 mm) which does not have any significance. In spite of identification of these difficulties recent text books<sup>4,5</sup> still advocate the use of the WHO definition of 1978 while journals advocate use of new definitions. This ambiguity poses a risk of misinterpretation of the patient's record and publications. Therefore, I believe there is a need for standardisation of the definition for better clarity and understanding to avoid confusion.

**A. Auluck**

By email

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## An academic home

Sir, I read with interest the comments from Mr Bradley (*BDJ* 2004, **196**:13) concerning the reformation of the British Association of Oral Surgeons (BAOS).

As Mr Bradley will know, the British Association of Surgical Dentistry was established in 1999 following the creation of the speciality of surgical dentistry. It had been hoped that the British Association of Oral and Maxillofacial Surgeons (BAOMS) would provide an academic home for specialists in surgical dentistry but sadly, at that time, the majority of BAOMS fellows did not see it that way! Consequently, a significant number of surgical dentists considered that the interests of surgical dentistry could only be benefited by the creation of a new professional association. In the last four years this has proven to be the case and we continue to grow with the support of all within the dental profession.

Upon reflection of the recent views of the SDAC and the GDC it is the opinion that oral surgery best describes the clinical

activity of all our membership. The decision was therefore taken, after considerable thought and debate, to amend the name of the association to The British Association of Oral Surgeons. Mr Bradley can rest assured that the BAOS espouses the highest of ideals and standards for oral surgery and will maintain friendly links and dialogue with all allied associations within the dental profession. Anyone wishing further information regarding joining BAOS should contact our secretary: Yvonne Gilbert, at the Association's office at the Royal College of Surgeons of Edinburgh, Nicolson St, Edinburgh.

**L. McArdle**

**By email**

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## Cause for concern?

Sir, The recent Recommendations on Dental Aspects of Endocarditis Prophylaxis from the British Cardiac Society (BCS) and the Royal College of Physicians (RCP)<sup>1</sup> give us great cause for concern. They differ significantly from previous international and national guidance in that they increase the necessity to prescribe antibiotic prophylaxis.

The document<sup>1</sup> advises the use of prophylaxis for a variety of routine restorative dental procedures. In addition the cohort of 'high risk' patients has been greatly increased. Intravenous (IV) antibiotics are deemed necessary for patients who have a prosthetic heart valve or have mitral valve prolapse with regurgitation or thickened valve leaflets. This potential increase in the number of administrations of antibiotics is surprising when scientific opinion<sup>2</sup> suggests that current regimes for antibiotic prophylaxis are considered to be unnecessarily stringent.

Recommendations have to be based on the best documentary evidence available and should be capable of realistic implementation. With time the recommendations will inevitably be tested in a court of law and upheld as best practice. Many of the recommendations made by the BCS/RCP are unsupported by clear documentary evidence and are confusing. The IV regimes have an increased complexity that is unjustified. In particular a fundamental assumption is made that the generation of a bacteraemia by a dental procedure is always associated with a risk of infective endocarditis (IE), thankfully this is not a fact. A bacteraemia is implicated as a risk factor if it has been shown that it can be associated with IE. It is generally accepted that dental surgery and scaling can cause IE. Many of the

procedures, however, advocated by the BCS/RCP as requiring prophylaxis have not been reported as causing infective endocarditis. In particular placement of a rubber dam, matrix band and wedge placement and retraction cord placement.

The BCS/RCP document also unnecessarily perpetuates the use of IV prophylaxis for certain risk groups. In the USA the use of oral antibiotic prophylaxis has been shown to be effective, even in high-risk groups<sup>3</sup>. The use of oral antibiotics in high-risk groups has not been associated with an increase in the number of cases of IE following dental procedures. In the USA the administration of IV antibiotic prophylaxis has been reserved for use only in patients who cannot take oral medication. The use of IV antibiotic prophylaxis presents a barrier to patient care in dentistry and also carries inherent risks. Further discussion is therefore, required, about the BCS/RCP recommendations. Liverpool University Dental Hospital will not be adopting these recommendations until the issues raised in this letter have been addressed. We will therefore continue to follow the guidance given in the DPF (2002-4) based on the original BSAC recommendations.

We feel that the BCS/RCP recommendations need urgent revision if they are to stand up to scientific scrutiny and not to lead to an unnecessary increase in the use of antibiotics.

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## Double whammy

Sir, I have worked as a GDP since 1983. I have had my gross income cut by 10% to fund the over 55-year-olds slow down in income. As a consequence have my superannuated benefits been lowered?

As I approach the age that my income was to be boosted I learn that it will not be, due to the new contract. Am I to loose out in an unfortunate double whammy? It is bad enough going grey, we need all the help we can get at this time.

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