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Dental manpower

Sir, dental manpower is indisputably in short supply and promises by government of increases are welcome.

But one hears predominantly of more dentists being promised – another 1000 dentists in the short-term from a variety of sources and, when they graduate in five years time, another 170 trained in the UK.

I, like I Waite (*BDJ* 2004, **197**:170), worry about the suitability of foreign dentists. Foreign dentists are often not permanent and patients tell us they are not happy with frequent changes of dentist.

But do we need all that many more dentists? There are so many activities which can be delegated to ancillary personnel who are properly trained. We know that dental disease is decreasing and statistics indicate that the decay experience of children is likely to stay static over the next 20 years.

It is also known that the majority of caries in children is confined to a relatively small section of the population and that large cohorts of children experience no caries throughout their childhood.

Is it really necessary for a five year qualified highly paid dentist to 'check' every child's dental health every six months? Could this be delegated to therapists? I am not disputing that children should be seen every six months since, children in particular, if caries is present, need to be treated promptly. Their dental development also needs regular assessment.

But I am sure that a closely led team of a dentist and therapist(s) could develop an understanding wherein the therapist consults a dentist in order to provide a prescription/second opinion when a problem is detected. In treating adults, a similar approach could be adopted.

The key is in the 'closely led team' headed by a dentist with mutual respect being developed between the parties for each other's roles. Hygienists form another branch of this team: their value is well documented and widely appreciated.

Again, the key is a close working relationship between dentist, hygienist and patient.

Why then do we not hear of promises by government of more training places for such valuable personnel?

As treatment planning becomes more complex and patients become more demanding, there will be plenty of work for the current generations of dentists at least until the dentally fit youth of today reach middle age! And they will all need treatment for erosion!

By way of increasing PCDs, I was pleased to see the advanced stage of development of some universities in increasing places for PCDs.

It would be nice to hear more openly of these developments so that all parties delivering dental care might be more accurately informed as to future manpower developments and begin to develop the mutual respect referred to above.

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Cause for concern?

Sir, the comments of Longman *et al*¹ were certainly of some concern to us and deserve a response.

As cardiologists and cardiac surgeons working in a large dedicated Cardiothoracic Centre, we are acutely aware of the devastating consequences of infective endocarditis (IE) that occur in patients with predisposing cardiac abnormalities who have undergone dental, interventional or surgical procedures known to cause bacteraemia.

Patients with previous IE, complex cyanotic congenital heart disease, prosthetic heart valves and patients with mitral valve prolapse with significant mitral regurgitation are at highest risk.

The morbidity and mortality in patients with IE remain high despite prolonged in-patient treatment with intravenous antibiotics and cardiac surgical intervention. The cardiac manifestations include heart failure from severe aortic and/or mitral valve regurgitation,

fistulous communications and false aneurysm formation.

Cardiac and paravalvar abscesses may be so extensive as to cause heart block requiring pacemaker implantation and local tissue destruction may make surgery impossible.

They are often lethal complications. The extracardiac embolic and vasculitic complications may affect every organ system.

They include retinal and peripheral limb emboli but the cerebral, renal and gastrointestinal complications are most serious. Cerebral infarction, cerebritis, cerebral abscess and cerebral haemorrhage may occur causing stroke, seizures and death.

Ruptured mycotic aneurysms may result in intracerebral or subarachnoid haemorrhage. Renal infarction and glomerulonephritis cause renal failure.

Splenic infarction, abscess and rupture may be lethal and demand urgent abdominal surgery in an already compromised patient. Bowel infarction and peritonitis is frequently fatal. Prosthetic valve endocarditis is particularly serious and usually requires cardiac surgical intervention with high operative morbidity and mortality.

It is because of these life-threatening and severe disabling complications that every effort should be made to prevent IE. The Guidance on the Prophylaxis and Treatment of Infective Endocarditis in Adults from the Advisory Group of the British Cardiac Society Clinical Practice Committee and the Royal College of Physicians Clinical Effectiveness and Evaluation Unit will soon be published on the British Cardiac Society's website along with the levels of evidence and grades of recommendations.²

Not only will this include recommendations on diagnosis and investigation but advice on antibiotic prophylaxis, medical treatment, indications for surgery and other topics. Wherever possible (and the document has some 800+ references) the evidence linking procedures with IE is presented.

Although it is fair to say that the

strength of evidence associating procedures and subsequent endocarditis is not high, it is based on evidence of associated bacteraemia, case reports, experimental, animal and case-controlled studies and the expertise of the Advisory Group as well as the opinions of expert committees that have reported in the literature rather than randomized controlled clinical trial data.

The Guidance document is consistent with that published recently by the European Society of Cardiology³ and previously by the American Heart Association/American College of Cardiology.⁴ We believe that the recommendations are based on the best evidence available, are clear and capable of realistic implementation.

It is untrue to say that the intravenous regimens are complicated. High-risk patients including those with prosthetic valves are recommended to receive oral amoxicillin and this will be updated soon on www.rcseng.ac.uk.

However, we feel that those patients with previous IE warrant special attention to prevent further episodes because the consequences are so serious.

This should include intravenous prophylaxis – if necessary as an in-patient. We disagree with the suggestion that this is a frequent occurrence that presents a barrier to patient care in dentistry.

The risks of intravenous antibiotic administration are small and the advantages outweigh by far the disadvantages of leaving such patients inadequately protected. It is certainly not mainstream opinion among cardiologists and cardiac surgeons (and hopefully dentists) that current regimens for antibiotic prophylaxis are unnecessarily stringent.

It would appear that it is not the view of Longman and colleagues either, since they advocate continuing to adhere to the BSAC recommendations issued in 1992/3!^{5,6} With regard to the type of

dental procedures that warrant antibiotic prophylaxis, the recommendations are based on the association with significant bacteraemia and hence the risk of producing IE in patients deemed to be at increased risk.

The BCS document refers to the relevant papers. Since IE occurs when bacteria seed the endothelium damaged by high velocity jets (and this is supported by experimental and pathological observation), patients at risk of developing endocarditis should be offered protection by antibiotic prophylaxis when undergoing bacteraemia-inducing procedures, even though specific case reports linking the procedure to endocarditis do not exist.

We cannot support the view that antibiotic prophylaxis should be withheld from such patients until several supporting case reports appear in the literature or data from a randomized clinical trial is available. This we would consider to be suboptimal if not unethical treatment.

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Boosting numbers

Sir, recently, there has been concern raised in the media about the lack of NHS dentists available in the UK especially outside London.

One of the solutions to this urgent problem would be to make it easier for foreign-trained dentists to achieve their practice license without compromising clinical excellence.

A major drawback in this process is the IELTS Exam which is set at a standard higher than our medical colleagues sitting the Plab exams. Considering that

most of the dentists sitting this exam have been trained in English from a very elementary age, they should not have to keep re-writing the IELTS exam because they have scored the same as their medical colleagues.

While we are not advocating a lowering of the standards, we would be grateful if the GDC would look into this in order to help boost the number of dentists in the UK.

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