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

Evidence based dentistry

Sir, what a breath of fresh air the 'opinion' piece was from Dr A Toy (*BDJ* 2005, 198:67) concerning the general practice shortcomings of evidence based dentistry.

No sensible GDP ever discounts 'evidence base' although he/she may well choose to disregard large amounts of it for very valid reasons. It is the elevation and mantra of 'evidence base' to the point where the proactive double blind study becomes the only research considered of value.

The swampy and messy lowlands of general practice must be trusted and visited by academia much, much more.

C. Debenham
London
doi: 10.1038/sj.bdj.4812224

A mouthful of trouble

Sir, in spite of being an avid supporter of *The Independent* newspaper, I have never regarded it highly for its reporting on scientific subjects and I thought that Jane Feinmann's article *A mouthful of trouble* (14 December 2004) a particularly bad example.

The piece began with an old wife's tale about calcium deficiency after pregnancy requiring nineteen fillings. Whatever the patient in question may think, there is no causal relationship between dental caries and pregnancy but sadly this weak argument sets the tone for the rest of the article.

Indeed it contained only one significant factual statement, "No reliable multi-centre research data exists to support fears that mercury in fillings has a toxic effect on the brain or central nervous system". The evidence for the safety of amalgam is particularly strong.

The levels of mercury toxicity have been firmly established by studies of massive environmental pollution by the material in Japan.

The best research indicates that for mercury in fillings to reach a toxic level it would require over 3,000 fillings in one mouth.

Recent research has shown that dentists have increased levels of mercury in their blood, about four times as much as the general population. This is still well below a level that is dangerous.

Minimum intervention, also mentioned in the article, is fine for very small cavities in teeth; there is nothing new about this idea. Yes, there is a list of risk factors, but it is well established that the major one is the frequency of exposure to sugar-containing foods. This is a fact worth airing in your pages.

Patients need reassuring that silver amalgam remains the most reliable, safe and cost-effective material for the majority of fillings. Tooth-coloured plastics materials (composites) are twice the price and less reliable. Amalgam-free dental surgeries might be thriving, but their success depends on exploiting people's fears, which may well be whipped up by journalism of this sort.

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doi: 10.1038/sj.bdj.4812222

Managing change

Sir, it was interesting to read 'Style over Substance' (*BDJ* 2004, 197:11). It stated the point that people do not listen to what they do not want to hear, often shooting the messenger. This was made in the context of postgraduate education in dentistry but is a philosophical point common to human beings in all contexts.

Knowledge about your market place is fundamental in successful business. There have been significant changes in oral health over the last few decades which will have an impact on oral health care delivery for the future.

Firstly, caries levels in young individuals are low, over 60% of 12 year olds are caries free. Most of these are likely to enter into adult life with low caries levels having experienced no/few consequences of disease.

Will this impact on the decision-making of young adults in the disposal of their finite incomes? Secondly, the sub-section of the community with relatively high levels of caries requiring traditional dentistry is mainly, but not exclusively, from deprived populations.

Thirdly, six monthly asymptomatic attendances for dental health checking are no longer recommended for low risk individuals.

Fourthly, technical advances in treatment modalities have made the delivery of treatment easier and faster. Finally the effectiveness of routine scaling for improved periodontal health is questionable.

This translates into reduced per capita need for dental care. Supply induced demand for care may sustain niche markets. Is this a message we want to hear?

Clearly, individual practitioners will be able to develop their practices towards niche markets. Collectively, can dentists survive on niche markets? What implications would that have on oral health inequalities? What future is being created for young dentists?

With April 2006 on the doorstep should we not accept the above and think collectively in order to develop a secure future not only for us as dentists but also the communities we serve?

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Application packs

Sir, I was amused and intrigued to read the postscript to the advertisement for a dentist with Bradford Personal Dental Service (*BDJ* 2005, 198:2 2005) stating that application packs were available in large print and Braille.

Is this political correctness gone mad or is it a sad reflection on the desperate manpower shortage in NHS dentistry?

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