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

Opportunistic and reprehensible

Sir, the article by Macluskey, Slevin, Curran and Nesbitt (*BDJ* 2005; **199**: 671-675) raised more questions than it answered. Having stated within the introductory paragraphs that the usual referral centre currently is the nearest 'District General Hospital', the paper then went on to review the differences between a teaching hospital in Scotland and a specialist surgical dental practice in Northern Ireland!

The first identified flaw is that there is no evidence whatsoever that the pattern of referral of patients with third molar disease was in any way comparable between the two centres. By definition, dental teaching hospitals with oral and maxillofacial surgery units tend to attract a referral of more complex cases whereas, by their own admission, the surgical dental practice surveyed attracted over 30% of patients for third molar surgery who required only 'simple extractions'. Even if it is accepted that the case mix was not too disparate, the second question is the degree of discrimination being exercised in submitting patients to surgery. The dental hospital consultation process resulted in more than a quarter of the 50 patients examined being advised that they did not require a surgical procedure. In contrast the practice submitted every one of their 250 patients to a surgical episode.

It also seems remarkable that a dental hospital should choose to put 42% of their patients through local anaesthetic treatments compared to only 30% in the surgical dental practice, whereas 70% of the surgical dental practice patients are subject to local anaesthetic with IV sedation – for which, in that setting, an additional fee is payable.

Finally, the surgical dental practice is to be commended upon the 0% complication rate which was achieved. However it is interesting that within the hospital setting where all surgical practitioners are subject to peer review and continuous peer scrutiny, the comparable morbidity was 13%.

As a group of practitioners of oral and maxillofacial surgery, involved both in individual practice, National Health Service district general and teaching hospital practice, as well as in the teaching of undergraduates and postgraduates, we find the balance of this paper suspect and are concerned that it has been independently reviewed and accepted as a scientific analysis. The suggestion that a practice such as this could be a more proper place to train students is patently opportunistic and professionally reprehensible.

N. Ali, J. Carter, L. Cheng, K. Coghlan, P. Hardee, S. Holmes, I. Hutchinson
London
doi: 10.1038/sj.bdj.4813433

Academic plight

Sir, recruitment and retention has been an issue in clinical academia for many years and while this has never been fully addressed, any article which highlights the plight of clinical academics within dentistry has to be applauded (*BDJ* 2006; **200**: 73-74). Despite the rosy picture painted by O'Brien and Kay, the shortages remain and we need to ask ourselves: why is it suitable people are not queuing up to join us?

To fly high in academia, which is what I believe O'Brien and Kay are advocating, you need to be able to get airborne and you cannot do this if you are laden down, tied or restricted. Unfortunately this is the stark reality of academia. There are several issues not least of which are the competing agendas of research, teaching, training and service provision.

Research governance becomes ever more burdensome and as GDPs are required to undertake CPD we are increasingly called upon to provide Section 63 courses. Add to that chronic understaffing, increases in student numbers and lack of administrative support and the reasons behind a lack of manpower become clear. Opportunities to partake in the so called more attractive pursuits are in reality accepted less and less as to do so often places an unbearable burden on colleagues left behind to hold the fort. The academic masters, like Oliver Twist, want more. Additionally, it is a stark reality that no matter how hard we try in our jobs, our activity and indeed our plights are always on show to the people we want to attract: our students and our junior colleagues.

They witness the challenges we face and it is difficult to paint a rosy picture in today's environment. The resolution of manpower issues, resource funding, realistic expectations and autonomy are desperately needed in academia. I believe if these are sorted then perhaps we can save the plight of the academic in dentistry.

R. McAndrew
By email
doi: 10.1038/sj.bdj.4813434

Propolis: a background

Sir, Dr T. A. Parr reported a patient who developed oral ulceration as a consequence of exposure to a fungicide, who was then treated with propolis (*BDJ* 2006; **200**: 64). However, before clinicians consider using propolis, a little background might be worth considering.

Propolis (bee glue, or royal jelly) is a natural substance based on the resin of pines, collected by bees. The term 'propolis' derives from 'pro' (Greek = before), and 'polis' (city) based on the fact that honeybees use propolis to narrow the opening to their hives.

Propolis is a complex entity, containing about 55% resinous compounds and balsam, 30% beeswax, 10% ethereal and aromatic oils, and 5% bee pollen. Contained chemicals include amino acids; flavanoids including flavones, flavonols and flavanones; terpenes; vanillin; tetochrysin; isalpinin pinocembrin chrysin galangin; ferulic acid; caffeic acid; caffeic acid phenethyl ester; cinnamic acid and cinnamyl alcohol.

Propolis has a degree of antimicrobial action against fungi such as *C. albicans*, and some bacteria[1] including a range of oral microorganisms[2] and viruses, and may be as effective as aciclovir against herpes simplex virus.[3] It also has immunomodulatory activity with augmentation of non-specific antitumour resistance.[4]

Not surprisingly therefore, many claims, not always substantiated, have been made for the general beneficial effects of propolis. In dentistry, propolis has been used in dentifrices,[5] as a storage medium for teeth after evulsion,[6] in periodontal therapy[7] and in endodontics.[8] Propolis ethanolic solutions are the most used propolis products on the market for assisting the

treatment of ulcers in the mouth, thrush or skin infections: there is little evidence base.

While I am a great supporter of holistic dentistry and complementary medicine, the fact is that as well as the fact that there is little evidence base for efficacy, phytomedicines such as propolis, though natural, cannot necessarily always be regarded as safe.[9] Propolis is, for example, well recognised as causing hypersensitivity and anaphylaxis,[10] and as occasionally causing untoward reactions such as allergic cheilitis,[11] and oral ulceration.[12,13]

C. Scully CBE
By email

1. Kosalec I, Pepeljnjak S *et al.* Flavonoid analysis and antimicrobial activity of commercially available propolis products. *Acta Pharm* 2005; **55:** 423-430.
2. Park Y K, Koo M H *et al.* Antimicrobial activity of propolis on oral microorganisms. *Curr Microbiol* 1998; **36:** 24-28.
3. Vynograd N, Vynograd I *et al.* A comparative multi-centre study of the efficacy of propolis, acyclovir and placebo in the treatment of genital herpes (HSV). *Phytomedicine* 2000; **7:** 1-6.
4. Orsolic N, Saranovic A B, Basic I. Direct and indirect mechanism(s) of antitumour activity of propolis and its polyphenolic compounds. *Planta Med* 2006; **72:** 20-27.
5. Botushanov P I, Grigorov G I, Aleksandrov G A. A clinical study of a silicate toothpaste with extract from propolis. *Folia Med (Plovdiv)* 2001; **43:** 28-30.
6. Martin M P, Pileggi R. A quantitative analysis of propolis: a promising new storage media following avulsion. *Dent Traumatol* 2004; **20:** 85-89.
7. Gebaraa E C, Pustiglioni A N, de Lima L A *et al.* Propolis extract as an adjuvant to periodontal treatment. *Oral Health Prev Dent* 2003; **1:** 29-35.
8. Sabir A, Tabbu C R, Agustiono P *et al.* Histological analysis of rat dental pulp tissue capped with propolis. *J Oral Sci* 2005; **47:** 135-138.
9. Cuzzolin L, Zaffani S, Benoni G. Safety implications regarding use of phytomedicines. *Eur J Clin Pharmacol* 2006; **62:** 37-42.
10. Thien F C, Leung R, Baldo B A *et al.* Asthma and anaphylaxis induced by royal jelly. Clinical and *Experimental Allergy* 1996; **26:** 216-222.
11. Lombardi C, Bottello M, Caruso A *et al.* Allergy and skin diseases in musicians. *Allerg Immunol* 2003; **35:** 52-55.
12. Hay K D, Greig D E. Propolis allergy: a cause of oral mucositis with ulceration. *Oral Surg Oral Med Oral Pathol* 1990; **70:** 584-586.
13. Kiderman A, Torten R, Furst A L *et al.* Bi-lateral eosinophilic ulcers in an infant treated with propolis. *J Dermatolog Treat* 2001; **12:** 29-31.

doi: 10.1038/sj.bdj.4813435

Ozone or hot air?

Sir, I write to you concerning my alarm that, in the twenty-first century, it would appear that some of your correspondents can provide controversial lines of therapy for their patients without obtaining informed consent from their patients. If the practitioner, whom some may think has a monopoly of information, cannot provide an evidence base for such proposed procedures, it would therefore follow that the patient cannot make an informed decision therefrom. The burden for informing the patient lies with the practitioner; the patient has no burden to enquire.

B. Karet

doi: 10.1038/sj.bdj.4813436

Courage for debate

Sir, I was sad to see that the letters criticising my opinion article, *Science versus empiricism* (*BDJ* 2005 **199**: 495-497) tended to be personal rather that scientific.

Empiricism essentially means experiment, and if one thing does not work, try something else (trial and error) but it is valueless without scientific logic. It is empiricism which has led the specialty around the houses on the extraction issue. Angle tried without and it did not work so Tweed tried with it and that failed too. Now no one knows. My critics would do better if they analysed people with naturally straight teeth and used scientific logic to work out why, but they do not do this.

Dr Horobin agrees with me that our modern lifestyle is the obvious cause of malocclusion, but Dr Di Biase believes that 'the aetiology of malocclusion is poorly understood'. Is it ethical to treat a disease that you do not understand? Twenty-five years ago I first put forward an explanation for the aetiology of malocclusion[1] and again in 2004;[2] no one has ever challenged it scientifically and I know of no rational alternative. It is just ignored as it does not slot in with mechanical/surgical thinking.

Dr McIntyre quotes 1,915 articles which failed to show that functional appliances had a significant effect on mandibular growth, a finding that may be true, but negative evidence is dangerous. I have not seen one article that shows that growth guidance appliances do not produce a change, or for that matter that orthodontic treatment has any long-term benefit at all.

Too few orthodontists pay attention to the direction of facial growth or are aware of the overwhelming influence of oral posture. How can one correct a mandible when the maxilla has dropped half an inch? No one who rests their tongue against the palate with their lips sealed will have a malocclusion, despite what Mr Pearson says.

My own research on identical twins has convinced me that a substantial ratio of patients receiving conventional treatment suffer some facial damage and that the teeth of most patients need to be held straight for ever, hardly an optimal result. Orthodontists are poorly placed to refute this as they prefer the flat faces they create,[3-5] while the general public prefer a forward (horizontally) growing face. I do not say this to annoy people but to encourage reasoned debate.

We have to balance the merits of fixed appliances that we know are 'clinically effective' (in the short-term anyway) against other methods that may be more 'clinically efficacious'. Postural changes are very hard to achieve and inevitably there is a high rate of failure but if we do not try, then extractions and/or orthognathic surgery become inevitable. Some children improve their oral posture spontaneously and this, as Dr McIntyre reminds us, may be the group that grow favourably regardless of treatment. Mr Pearson recommends a double blind clinical trial but how does one assess the changes in oral posture? No one has yet developed a means of measuring tongue posture, so it would prove nothing.

I know of only one way. Select a number of good responses to each treatment and compare them. The most 'effective' method will have a higher ratio of satisfactory results but if one method is more 'efficacious' it is likely to have a higher ratio of excellent results. I would be happy to present 10 of my good cases so that they could be matched against those of any other orthodontist in the UK. Because I have been in practice longer than most, it might be fair to increase this to three other orthodontists. My only condition would be that they are assessed by lay judges. Sadly, many will see this as provocative but I can see no other way to settle this debate.

I have made similar offers in the past, even to pay the cost (substantial) of an independent scientific enquiry to assess the science supporting orthotropics versus orthodontics. I also offered to pay the individual orthodontists for attending to give evidence. It seems that no orthodontist has the courage to show their cases or debate this issue on a purely scientific basis.

J. Mew
By email

1. Mew J R C. The aetiology of malocclusion: can the Tropic Premise assist our understanding. *Br Dent J* 1981; **151:** 296-302.
2. Mew J R C. The Postural Basis of Malocclusion: A philosophical overview. *Am J Orthod Dentofacial Orthop* 2004; **126:** 729-738.
3. Peck H, Peck S. A concept of facial aesthetics. *Angle Orthodontist* 1970; **40:** 119-127.
4. Soh J, Chew M T, Wong H B. Professional assessment of facial profile attractiveness. *Am J Orthod Dentofacial Orthop* 2005; **128:** 201-205.
5. Tedesco L A, Albino J E, Cunat J J *et al.* A dental-facial attractiveness scale. *Amer J Orthodont* 1983; **83:** 38-43.

doi: 10.1038/sj.bdj.4813437

Political motives

Sir, I would like to reply to L. Westcott's letter (*BDJ* 2006; **200**: 125) *No honours for dentists*. I sympathise entirely with L. Westcott. I suppose the idea of not grading a BDS is not really to show any differentiation; you either pass or fail or get honours and sometimes distinctions. However it does seem rather senseless that you cannot get a place in medical school with a BDS, considering how closely related the subjects are, and the length of

the courses for medicine and dentistry are the same. In my view the BDS degree should be 'honours' anyway, because of the five year period to do a bachelor's degree. In addition dental students have to pass each and every professional exam 1-5 in order to proceed; they cannot just scrape through with a pass or 3rd of 40%: the pass mark is 50 and above. There are a lot of courses such as Hygiene and Therapy converting to degree, BSc etc (three years); perhaps it is time the BDS degree is promoted to honours, masters or DDS like in the States and Canada. I get the feeling there could be smatterings of underlying political motives going on perhaps.

M. Parsons
Sheffield
doi: 10.1038/sj.bdj.4813438

Stamping our feet

Sir, is it just me or do others feel the need for a Mission Statement for our profession?

Fashions change all the time. For a while we all wanted to be called Doctor, so we changed the name of tartar to calculus and stamped our feet. Finally the GDC agreed not to prosecute us for using the coveted title (although I believe anyone else could) and now we have reached a satisfactory muddle. Some of us are Doctor, some of us are not. Some organisations insist on the title; others deny that we are anything other than Mr/Mrs/Ms. So that is settled and clearly it is time to move on.

Now we want to be like Richard Branson and we spend our time fussing about management, marketing and salesmanship. Ethical selling, of course. Although what I really mean is Treatment Acceptance. A mission statement is a basic requirement for any self-respecting business and we really cannot go on much longer without one. It could be something like: 'We aim to improve the quality of people's lives by using our special knowledge and skills.' Could it please NOT be, 'We try to fix it as cheaply as possible'?

N. Cole
Isles of Scilly
doi: 10.1038/sj.bdj.4813439

OMFS training revisited

Sir, as a group of London based trainees in Oral and Maxillofacial Surgery (OMFS), we would like to register our deep concern regarding the comments by L. W. McArdle (*BDJ* 2006; **200**: 2) who is not an OMFS trainer.

We unreservedly reject the assertion that OMFS trainees lack the 'appropriate training and clinical experience' because OMFS units are 'failing to deliver' training opportunities. This is factually incorrect as demonstrated by the RITA process which is rigorously executed by the London Deanery. For further factual accuracy RITA stands for Record of In-Training Assessment,[1] not 'Registrar In Training Assessment' as quoted by L. W. McArdle.

Specialist Registrars (SpR) accepted on to OMFS training programmes typically have had significant experience of dentoalveolar surgery even prior to entry on to a second degree course and often continue such work during their studies as a necessity of being self financing students (most, if not all, have held Surgical Royal College approved OMFS SHO training posts prior to reading for said second degree). Add to this the validated exposure during SpR training and it becomes readily apparent that senior OMFS trainees are well beyond 'acquiring the necessary skills in surgical dentistry required for inclusion on the GDC's specialist lists'.

Furthermore, as far as we are aware, within the London Deanery no OMFS trainee has failed to pass through the final RITA interview as a consequence of not being exposed to adequate training in surgical dentistry. Successfully completing annual RITA interviews is just one element of the requirements necessary to obtain a CCT in Oral and Maxillofacial Surgery which is recognised by the GDC for inclusion on its Oral Surgery and Surgical Dentistry Specialist lists.

The suggestion that we will become 'consultants lacking proficiency in this clinical field' is clearly incorrect and damaging to our professional reputation both within the dental community and the public at large and we therefore request the author retract his comments.

M. Cameron, B. Visavadia, M. Heliotis, M. Shelley, L. Cascarini, M. Kumar, K. Fan, C. Mills, B. Swinson, S. Hodges, C. Bridle, S. Walsh, C. Leiw, D. Coombes, N. Shah, P. Norris, J. McKenzie, J. Collyer, J. Antscherl, B. Bisase, D. Chin-Shong

Mr McArdle replies: *As a trainer in surgical dentistry, I consider that it is reasonable for me to comment on training in this specialty for all who should be undertaking it.*

I believe that the OMFS SpRs have missed my point as my comments are not directed at any specific group of individuals. A significant number of the signatories and other OMFS trainees are already on the GDC's specialist list for surgical dentistry. I have always been fully aware of this and my concerns have never been directed at those who have demonstrated competencies in this way.

My opinion, however, remains the same. It is my observation that competency in surgical dentistry is assumed and my concern therefore is one of complacency. It cannot be presumed that OMFS trainees

will have achieved competency in surgical dentistry skills before entering OMFS training and it cannot be presumed that these skills will be a by-product of OMFS training. It is my opinion and, in my experience, the opinion of other oral surgeons and OMFS surgeons, that surgical dentistry training for OMFS trainees needs to be emphasised if they are to continue to provide these skills when consultants.

*The assessment of OMFS training programmes is under the mandate of the SAC in OMFS and, based upon G. D. Wood's comments (*BDJ *2005;* ***199:*** *249), they too have noted the importance of this issue. As I stated in my original letter: deficiencies in surgical dentistry training will have implications for future consultant led services.*

L. W. McArdle is senior specialist clinical teacher and honorary associate specialist in oral surgery at Guy's Hospital. He is programme director for the MClinDent (Surgical Dentistry) degree at Kings College London and Hon Secretary of the British Association of Oral Surgeons based in Edinburgh.

Editor's note: *The postscript from Mr McArdle makes clear his reason for writing to the Editor from an address in Edinburgh. We quote the name of the correspondent and the city/town as given in the address from which the letter originates as a reference at the foot of each letter we publish (or 'by email' if received electronically). In the instance of Mr McArdle's previous letter (*BDJ *2006* ***200****: 2), we received a complaint about this practice with the accusation that we were negligent in not pointing out the location in which Mr McArdle worked, rather the location and position from which he sent his letter. We are therefore grateful to Mr McArdle for clarifying the matter.*

The correspondence over this subject has clearly touched on important issues affecting the profession and I believe that the BDJ *is the appropriate place for such topics to be debated. However, on this matter and on others which readers have already raised and will wish to raise in the future, I would put forward a reminder that the* BDJ *is a journal which represents us as a profession and that part of the privilege of being a profession involves being respectful of the opinions and standing of others. I would therefore urge future correspondents to be mindful of this and to guard carefully against making remarks that may be, rightly or wrongly, construed as personal or derogatory to individuals, specific fields of practice or the profession in general.*

doi: 10.1038/sj.bdj.4813448

Caries before concrescence?

Sir, the case report involving concrescence of the mandibular molars (*BDJ* 2006; **200**: 141–142) was of some concern. The patient is reported as having several episodes of pain from the lower right third molar region. There is no mention of treatment of the grossly carious second molar in this quadrant prior to being listed for a significant surgical procedure.

M. Forde
St Helens

Dr Kaan Gunduz, the author of the case report, responds: *A clinical diagnosis of pulpitis of the second lower right molar tooth caused by caries was made. The patient was anaesthetised with local anaesthetic, and the teeth were isolated with rubber dam. A pulpotomy was performed. Also, the caries on the first lower right molar was excavated without evidence of pulp exposure and restorated with amalgam.*

doi: 10.1038/sj.bdj.4813440

Worthwhile projects

Sir, Hedger and colleagues (*BDJ* 2006; **199**: 754) are looking for a scientific enquiry to establish the truth about functional appliances. There is extensive literature about functional appliances and perhaps the most significant studies are those of Tulloch[1] and O'Brien.[2]

As a member of the BOS and of the Establishment I should like to refute the suggestion that we do not use functional appliances. I have been using them for 40 years and have recently carried out a prospective trial, of twin blocks and activators. The preliminary results which have been analysed by my colleague are disappointing – of the 60 patients included in the trial only 27 achieved satisfactory resolution of their malocclusion with functional appliances alone. Fifteen achieved partial overjet reduction and required completion of treatment with fixed appliances and in nearly half of the cases (28) functional appliances failed to achieve any satisfactory reduction of overjet. This poor success rate may partially explain why they represent only 3% of NHS treatment.

I am sure that the British Orthodontic Society Foundation would be delighted to receive financial contributions as these funds are used to support worthwhile orthodontic research projects.

K. G. Isaacson
R. Walker
Basingstoke

1. Tulloch J F C, Proffit W R, Phillips C. Outcomes in a 2-phase randomised clinical trial of early Class II treatment. *Am J Orthod Dentofac Orthop* 2004; **125:** 657–667.
2. O'Brien K, Wright J, Conboy F *et al.* Effectiveness of treatment of Class II malocclusion with Herbst and Twin Block appliances. A randomised controlled trial. *AJDO* 2003; **124:** 128–137.

doi: 10.1038/sj.bdj.4813441

Climbing every mountain

Sir, I write in response to the article by Kay and O'Brien (*BDJ* 2006; **200**: 73–74) on academic dentistry. As a young clinician wishing to pursue a career in academic restorative dentistry I was encouraged by their enthusiastic advertisement of an academic career.

In response to their title question 'where is everybody?' I believe the answer lies partly in the 'hurdles' mentioned in the article. I would like to highlight these hurdles further.

A young clinician will usually first complete Vocational Training, and then be required to undertake Senior House Office (SHO) posts in order to sit the MFDS exam. The SHO posts (which are themselves very competitive) will be expected to cover a variety of disciplines, usually at least oral and maxillofacial surgery and the clinician's chosen specialty. Upon completing the necessary SHO posts and MFDS the clinician is then required to undertake a PhD and gain a National Training Number (NTN) leading to a Certificate of Completion of Specialist Training (CCST). During this time, the pressure to produce high quality publications and attract research grants, not to mention teaching commitments, is a further strain on the clinician's time. Even after completing all of the above, the clinician may still have to wait a number of years before being eligible for a senior lecturer position.

I am sure you may appreciate that from my perspective the above 'hurdles' sometimes look more like mountains! However, having undertaken the necessary SHO posts, MFDS and with publications underway, I am not deterred. I am currently considering self-funding a PhD in order to make myself eligible for a lecturer position and NTN. This does however mean that I am going to be at least in my mid-thirties before completing all of the above – and I have focussed my career towards this goal since qualifying, which I presume is relatively rare. Senior lectureship is still a distant goal, far away on the horizon. I wonder how many of my colleagues are understandably put off by the above hurdles, especially given that any clinician with the above experience would be able to pursue a career in private practice or as an NHS consultant much sooner and with more immediate financial gain.

Until more dedicated career pathways are created which allow time for completion of a PhD and CCST, and are given to candidates who are dedicated to academia, I fear the problems of recruiting new academics will not only persist, but may even worsen.

M. W. Barber
Sheffield
doi: 10.1038/sj.bdj.4813442

Multi vs. single dose

Sir, I was heartened to read the letter from P. Williams (*BDJ* 2006; **200:** 124) with regard to his success with a single tablet of 200mg metronidazole as a post-operative preventative of infection. This concurs with my own experience, published in the *BDJ* in February 2004, where a single dose 200mg metronidazole has (so far!) stopped all incidences of post-operative infection irrespective of surgical difficulty.

At a recent antibiotics course however, I was surprised to note that a centre of excellence still made no reference to small single dose therapy as being a reportedly good way to treat our patients, and that anything between five and 10 day courses of postoperative antibiotics are still being taught as the norm. This is despite the evidence from Professor Martin[1] and experiential evidence from oral surgeon practitioners such as Mr Williams or others.

As Mr Williams states, it really is time GDPs tried to cut down on the numbers of multi-dose courses of antibiotics in favour of single dose regimes, if only because although controversial, it appears to work. Consequently, I also urge colleagues to try it as part of their own regime.

R. Kitchen
Bristol

1. Longman L P, Martin M V. The use of antibiotics in the prevention of post-operative infection: a reappraisal. *Br Dent J* 1991; **170:** 257-262.

doi: 10.1038/sj.bdj.4813443

Follow the guidelines

Sir, we refer to a recent letter from P. Williams on this subject (*BDJ* 2006; **200:** 124). With the increasing problem of antimicrobial resistance and the potential serious side effects of antibiotics dentists have a moral and ethical duty to prescribe appropriately.[1,2] To prescribe even a single dose of 200mg of metronidazole immediately after the majority of adult extractions, in our opinion, is an inappropriate use of antibiotics.

We would point the author to the scientific evidence which shows that the incidence of postoperative infections following extractions is extremely low (4%) and also to the evidence and guidelines that support our view.[3-8] The clinical experiences of one practitioner undertaking a relatively small number of extractions does not constitute good scientific evidence. We would urge practitioners to follow the existing guidelines and consider using a local application of chlorhexidine rather than systemic antibiotics.[9]

N. Palmer
L. Longman
By email

1. Standing Medical Advisory Committee. The path of least resistance. London: Department of Health, 1998.
2. Houvinen P, Cars O. Control of antimicrobial resistance: time for action. The essentials of control are already well known. *Br Med J* 1998; **317:** 613-614.
3. Hill M. No benefit from prophylactic antibiotics in third molar surgery. *Evid Based Dent* 2005; **6:** 10.
4. Jaafar N, Nor G M. The prevalence of post-extraction complications in an outpatient dental clinic in Kuala Lumpur Malaysis – a retrospective surgery. *Singapore Dent J* 2000; **23:** 24-28.
5. Poeschl P W, Eckel D, Poeschl E. Postoperative prophylactic antibiotic treatment in third molar surgery – a necessity? *J Oral Maxillofac Surg* 2004; **62:** 3-8.
6. Faculty of General Dental Practitioners (UK) Royal College of Surgeons, England. Adult antimicrobial prescribing in primary care for general dental practitioners. 2000.
7. Faculty of Dental Surgery. National Clinical Guidelines. London: Royal College of Surgeons of England, 1997.
8. Oginni F O, Fatusi O A, Alagbe A O. A clinical evaluation of dry socket in a Nigerian teaching hospital. *J Oral Maxillofac Surg* 2003; **61:** 871-876.
9. Larsen P E. The effect of a chlorhexidine rinse on the incidence of alveolar osteitis following the surgical removal of impacted mandibular third molars. *J Oral Maxillofac Surg*1991; **49:** 932-937.

doi: 10.1038/sj.bdj.4813444

Surprising advice

Sir, like L. Westcott (*BDJ* 2006: **200:** 125) I, too, applied to Cambridge University to further the education provided by GKT (although it was still Guy's when I gained my BDS in 1978). Cambridge is well-known for a certain lack of cohesion and uniformity when it comes to decision-making, and I am a little surprised that advice appears to have been taken from one college admissions tutor only.

In 1992 I applied to Cambridge for enrolment on an M.Phil degree course, to be told the same thing by the head of the department I was applying to: that is, that the equivalent of an upper second degree was required, and that dentistry was not a classified degree. I was, however, also told that this was not a problem – I would simply need to get two academic references relating to my time as a BDS student. This I duly did, supported most enthusiastically by the delightful A. H. R. Rowe, and gained entry to my chosen college (Sidney Sussex) with no problem at all. My postgraduate education, which became a Doctorate and a pathway to writing, was admittedly within the History Faculty, not the Faculty of Medicine. But as far as admission to the University goes, I can't see how this would make any difference.

R. King
Cambridge
doi: 10.1038/sj.bdj.4813445

Try Oxford

Sir, L. Westcott (*BDJ* 2006; **200:** 125) should try Oxford. I took a second undergraduate degree (albeit not in medicine) there following a first qualification in dentistry, and my college accepted without question that my dental degree entitled me to a waiver of one out of the three years of the course.

B. Soper
doi: 10.1038/sj.bdj.4813446

Paying to park

Sir, is it reasonable to expect NHS staff to pay to come to work? More and more hospitals are asking hospital staff to pay car parking fees in order to gain extra funds. In some hospitals the amount paid is proportional to the amount one earns, but in others (such as mine) a set fee is payable per day, regardless of income. For those lower down the pay scale, such as domestic and ancillary staff, this may be a considerable chunk of their wages. It might be acceptable if one could actually find a parking space without having to hunt for a spot for half an hour.

In addition, surely there should be some concession for very ill individuals (eg cancer patients) and their immediate families, who, at present, are running up hefty car parking bills. I understand hospitals want to discourage people who are not attending hospital from using their car parks but maybe the Department of Health could set a limit for the maximum car parking charges individual NHS trusts can impose. Perhaps they could also specify that if staff do have to pay parking fees, it should be in line with what they earn, and they should be guaranteed a parking space.

Z. Shrivastva
Liverpool
doi: 10.1038/sj.bdj.4813447

Immediate referral

Sir, I feel I must strongly support Professor Thomson's view (*BDJ* 2006; **200:** 242) on the need for specialist referral and biopsy and find the reply of Professors Scully and Felix alarming if not slightly arrogant. I work in hospital practice as an oral surgeon and occasionally in 'High Street' specialist practice also. If someone presents to me in the latter I organise an immediate referral to my local oral surgery colleagues and I do not mess around with biopsy in this setting. I also feel that charging a patient either on a GDS basis or a private basis for this is inappropriate. Do Professors Scully and Felix have to cope with the surgical problems that such a delay could potentially cause?

A. R. J. Curtis
By email
doi: 10.1038/sj.bdj.4813490