Send your letters to the editor, British Dental Journal, 64 Wimpole Street, London W1G 8YS
E-mail 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.

Forward thinking females

Sir, I would like to applaud the courage and forward thinking of women in dentistry to respond to the changes in our profession and identify when the job is done. I qualified in 1985 and have clearly benefited from the achievements of women in dentistry. I have been able to pursue my chosen career, establish my own practice, and involve myself in teaching and some committee work without having to sacrifice my involvement with my children. Not many careers can offer that degree of flexibility to women even in these enlightened days. The work of women in dentistry and others to remove the inequalities for those of my generation have been so effective that my perception became a concern for the future damaging effect of positive discrimination and special arrangements for women which in time would undermine all the achievements. I am profoundly grateful for my equal footing with all of my colleagues and impressed by the forward thinking of Penny Joseph and her colleagues to wind up an organisation before it becomes stale and counterproductive.

Recent publicity for dentistry seems to have generated a considerable increase in interest in dentistry as a career at all levels. Our practice currently sees a very steady stream of students requesting work experience and school leavers looking for training as dental nurses. The quality and enthusiasm of these young people is a joy to see. I will continue to promote dentistry as an excellent career that offers variety, flexibility and challenge for anyone with a zest for life. I am very grateful to those who have contributed to my career satisfaction and I hope that I can give just a little to make it equally good for all dentists of the future. Well done to women in dentistry.

H. Harrison
Cambridge
doi: 10.1038/sj.bdj.4813834

Cultivating interest

Sir, regarding the letter written by E. J. Kay and K. D. O'Brien (*BDJ* 2006; **200:** 73-74) it is interesting to find that fewer graduates are choosing careers as academicians. I think the main problem does not lie with poor interest but with the cultivation of interest in research. Comparing the dental students' magazine *Launchpad* with the equivalent medical students' magazine *StudentBMJ*, it is easy to see why. *Launchpad* is written with students in mind but is it really written by students? Looking back at an issue I can safely say that three-quarters of the pages are mainly written by lecturers for students. I am not saying this is bad but it needs to have a balance. *StudentBMJ* is headed by a student editor and the magazine is divided into many sections from education (written by lecturers and students), interviews with famous clinicians to viewpoints (mostly written by students). There is even a section where important research articles that are published in the *BMJ* are summarised in the *StudentBMJ*. Students are encouraged to submit articles and articles are peer reviewed by other students. The magazine provides a transition period where students are nurtured to read more important articles in established journals. This may help students understand more about the importance of research.

Research projects are mostly conducted in a dental student's final year. There is not much that can be done given this amount of time which coincides with the hectic schedule of applying for jobs. Most students are just geared up to finishing it and putting it out of the way.

Once interest is there, then it is down to a student's own effort. From my experience, I think most lecturers are more than happy for students to contribute ideas or participate in any ongoing research projects that they are conducting.

C. K. Wee
Cardiff
doi: 10.1038/sj.bdj.4813835

Professional arbitration

Sir, I find myself nodding in agreement at the common sense expressed by Drs Carleson and Ludford in letters to the editor in *BDJ* 2006; **200:** 473.

For over 20 years I have provided expert witness reports on valuations, management disagreements and clinical complaints. In recent years the most minor of complaints have sought compensation including three days' pain post extraction and misdiagnosis of a haematoma as an allergy. Such cases are invariably settled out of court with the patient receiving £200-£300 plus legal costs £600-£800. Clearly a Professional Arbitration Process (PAP) could be quicker and cut down the legal costs. However, Dental Arbitrators would have to be trained and paid and I don't consider that CPD points are an appropriate reward for such activity. Also, the income lost to lawyers does not necessarily drift into any dental budget, therefore funding is an issue especially if a patient loses their case.

As to Dr Ludford's letter on comparison of the GMC and GDC, it is worthwhile noting that the former register doctors whereas the latter has increasing income from other registrations such as hygienists. Unfortunately the bureaucratic ethos of this country often means that the common sense approach doesn't prevail. If allowed the space to tell a quick illustrative story, I recently cleared out a couple of years' back issues of the *BDJ* and other magazines to a recycling container. Short of resources and in order to meet its recycling target the council has shipped the lot to Indonesia. This hardly seems to balance out the environmental equation but should you receive any letters to the editor from Indonesia you now know why.

J. Brown
Leeds
doi: 10.1038/sj.bdj.4813836

Metal in the mouth

Sir, my wife and I have volunteered to take part in research on the study of how language and knowledge are processed in the brain. This may involve having an MRI (magnetic resonance imaging) scan of the brain. However, we were closely questioned regarding the materials used in the dental work in our mouths as certain materials can adversely affect the quality of the scan.

As a general dental practitioner, I was utterly unaware of this requirement and there appears to be little in the dental literature regarding metals used in dentistry and MRI scans. The Experimental

Psychology department involved would also advise dentists to be more aware of this problem as they frequently have to contact them to ascertain the metallic content of various dental work eg bridges, posts and implants carried out on patients who are about to undergo an MRI scan.

B. Arends
Hertfordshire

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Getting the message across

Sir, at last, common sense has prevailed.[1] I work in the hospital sector and I first became aware of this paper[2] three weeks ago and implemented the guidelines within our unit. However, we are having some problems convincing our patients of the change, and some are still insisting on taking the antibiotics against our advice. We have to remember that we have been very good at educating our patients over the last 30 years of the importance of antibiotic prophylaxis, and now we have to tell them something completely different. It may be a while before we get the message through to all our patients with regards to this change.

A. R. J. Curtis

1. Martin M. A victory for science and common sense. *Br Dent J* 2006; **200:** 471.
2. Elliott T S J, Foweraker J, Fulford MR *et al.* British Society for Antimicrobial Chemotherapy. Guidelines for the prevention of endocarditis. *J Antimicrobial Chemotherapy* 2006.

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Canines: crowding and consent

Sir, although I agree with Dr Hassan and Dr Nute (*BDJ* 2006; **200:** 493-496) that hospital advice is needed for patients with impacted canines, I am concerned that practitioners reading the introduction to their paper might decide to extract the deciduous canines without asking for such advice. I feel some of the papers need explanation. The authors quote Eriksson and Kurol who showed that 78% of permanent canines erupted following the extraction of deciduous canines. It is important to understand that there was no control group in this investigation so that it is possible that the same number of teeth would have erupted without the extractions. Indeed in a randomised controlled trial published in a refereed journal in 2004 by Leonardi *et al.*[1] there was no significant difference between the extraction group and the non extraction control group. However, there was a difference between these two groups and a third group where the deciduous canines were extracted and headgear was used. The significantly improved success rate in this group throws into doubt the suggestion by Hassan and Nute that crowding is not a factor. For this the authors quote a paper by Power *et al.*; again this paper has no control group so that it compares extractions of deciduous canines in cases with and without crowding and finds no difference between the groups. Of course, if the findings of Leonardi *et al.* are true and there is no benefit from the extraction of deciduous canines then there would be no difference between the two groups.

A problem here may be the definition of crowding. From the erupting canine's point of view this would be a space between the lateral incisor and the first premolar that is too small for the canine. In a typical 11-year-old this could occur in a patient with no overall crowding because the deciduous second molar is much bigger than the second premolar tooth.

Practitioners should remember that even if some patients do benefit from the extraction of deciduous canine teeth, some are worse off, because the option of retaining the deciduous tooth into adult life is lost. It is important that when a deciduous canine with a good crown and no root resorption is extracted that a proper consent is obtained, explaining to the patient that they will require complex orthodontics if the permanent canine fails to erupt.

D. J. Spary
Burton on Trent

1. Leonardi M, Armi P, Franchi L, Baccetti T. *Angle Orthodont* 2004; **74:** 581-586.

doi: 10.1038/sj.bdj.4813839

Far too late

Sir, I feel I must reply to the paper on *An audit of referral practice for patients with impacted palatal canines and the impact of referral guidelines* (*BDJ* 2006; **200:** 493-496) by Drs Hassan and Nute.

The article states that a prospective two extra audits undertaken at Basildon and Southend hospitals between September 2001 and September 2003 suggested that patients who are regular attendees with unerupted palatal canine teeth should be referred by the age of 12 years. Surely this is far too late for any simple interventive treatment to be initiated other than as was mentioned in the paper, normally surgical removal or surgical exposure.

When I was at dental school in the mid-1970s at Leeds, the late John Wigglesworth always insisted that radiographs should be taken by the age of nine years to determine the likelihood of possible impaction and perhaps commence such interventive measures as described in the paper.

R. H. Firth
Thirsk

doi: 10.1038/sj.bdj.4813840

Better management

Sir, I read with interest the article entitled *An audit of referral practice for patients with impacted palatal canines and the impact of referral guidelines*, by my regional consultant colleague Spencer Nute and his co-author T. Hassan (*BDJ* 2006; **200:** 493-496).

They quite rightly pointed out 'Prevention of an impaction is always preferable to its treatment', but that despite local educational lectures and the dissemination of guidelines in the form of algorithms, the number of patients with impacted maxillary canines who had been subsequently referred to Southend Hospital for assessment and management, both at a more appropriate age as well as having had the deciduous canine previously removed, had only slightly increased, albeit without statistical significance.

Although not directly stated in their report, the implication was that the referring GDPs had been encouraged to perform interceptive extractions of the deciduous canines for their patients before referral, on the basis that previous publications had shown that when undertaken before a mean age of just over 11, between 62%[1] and 78%[2] of impacted canines would spontaneously recover. They commented that 'Both studies showed that the outcome was dependent on a number of variables including the patient's age,' but didn't mention that the most reliable predictor of success was in relation to the unerupted canine's position relative to the lateral incisor root which it was adjacent to.

Indeed, the prospect of success has been found to rise as high as between 73%[1] to 91%[2] if the crown of the canine has not overlapped the lateral incisor beyond half its root width. However, when it has, the percentages fall to between 29%[1] and 64%.[2]

In that regard, if general dental practitioners are to be encouraged to undertake pre-referral extraction of deciduous canines in appropriate cases, it might be prudent for them to do so with sufficient knowledge as to be potentially more discerning. Otherwise, in those cases where the canine impaction is severe, and therefore less likely to respond favourably to the intervention, the indiscriminate loss of the deciduous predecessor could disadvantage the patient.

For example, in a situation where an impacted canine would be better managed through its surgical exposure, retaining the deciduous canine would not only provide a natural form of space maintenance in the interim before the successional tooth was close enough to be approximated into

the line of the arch, but equally should the procedure fail, it would still remain, either to act as a substitute for the permanent tooth, assuming it was in good enough condition, or if not, to retain sufficient alveolar bone for longer, so as to facilitate all future alternative restorative options, such as the use of a single osseo-integrated implant.

R. A. C. Chate
Colchester

1. Ericson S, Kurol K. Early treatment of palatally erupting maxillary canines by extraction of the primary canines. *Eur J Orthod* 1988; **10:** 283-295.
2. Power S M, Short M B E. An investigation into the response of palatally displaced canines to the removal of deciduous canines and an assessment of factors contributing to favourable eruption. *Br J Orthod* 1993; **20:** 215-223.

Drs Hassan and Nute respond to the above three letters: We thank Drs Spary, Firth and Chate for their interest in our article.

Dr Firth feels that our advice conflicts with advice he received as a student. We would suggest that the evidence base has developed in the intervening 30 years. Recent Royal College of Surgeons evidence-based guidelines[1] state that the maxillary canines should be palpable in the labial sulcus 'by the age of 10-11' years, and that 'radiographs prior to the age of 10-11 years are usually of little benefit'. We therefore stand by our assertion that patients should be referred by 12 years of age, as it should almost always be possible to diagnose the problem before then.

We agree with Dr Spary that the study by Leonardi et al. *is a valuable contribution to the literature, as it was randomised, included a control group and considered the extra variable of headgear for space maintenance. When undertaking interceptive extractions, it would be advisable to consider using space maintainers, such as headgear, in the future. However, as he will be aware, it can take a considerable time from an article's submission to its publication. This was the case with our article as it was overlooked due to a clerical error at the* BDJ. *The article by Leonardi* et al. *was published after we submitted ours.*

We disagree with Dr Spary that we suggested 'crowding is not a factor'. We made it clear that Ericson and Kurol[2] only treated uncrowded patients. Their high success rate may have been due to adequate space, and so their findings may not be in such contrast to Leonardi et al. *who tried to obtain adequate space with headgear.*

Dr Spary feels that 'practitioners reading the introduction ... might decide to extract the deciduous canines without asking for ... advice'. If one takes a small section of any article out of context, one may draw incorrect conclusions. We believe Dr Spary's concerns are unjustified if our article is taken as a whole. Our title clearly states that this was an audit of **referral practice** *and the impact of our guidelines. The gold standard clearly states the importance of* **timely referral.** *The algorithm sent to the general dentists and reproduced as Figure 2 clearly encourages the* **referral** *of patients. Neither the gold standard nor the algorithm advises dentists to perform interceptive extractions. The discussion consists of eight paragraphs covering referral patterns and their modification, and one discussing interceptive extractions. The conclusion reiterated that referral practice was poor and that our guidelines had a limited impact, not that dentists should extract without specialist advice.*

We briefly discussed the literature on interceptive extractions to highlight why orthodontists want referrals at the correct age. As we were not auditing the efficacy of interceptive extractions, a detailed discussion of the procedure would not have been directly relevant. Indeed, had we done this, readers may have gained the impression that we were educating them to perform interceptive treatment without specialist advice: exactly the opposite of what we, Dr Chate and Dr Spary would wish to do.

We collected data on the absence of primary canines, as some patients are referred by primary care specialists who should be aware of best practice. These patients may have been referred later because appropriate interceptive extractions were tried unsuccessfully. It could have been unfair to the referring practitioners to assume that all 'late' referrals were due to poor management.

We carried out this project and article to encourage timely referral. This allows orthodontists and patients to have an informed discussion and decide upon the best course of action. We do not encourage general dentists to undertake treatment without specialist advice. If, like Dr Chate and Dr Spary, some readers found this aspect of our article ambiguous, *then we thank them for raising the issue so that we could clarify it.*

1. *Husain J, Burden D, McSherry P. The management of the palatally impacted maxillary canine. www.rcseng.ac.uk/fds/docs/ectopic_canine.pdf 2004.*
2. *Ericson S, Kurol J. Early treatment of palatally erupting maxillary canines by extraction of the primary canine.* Eur J Orthod *1988; 10: 283-295.*

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Wholly untested

Sir, it was with great interest and some concern that I read the recent paper authored by Innes, Stirrups and Evans *et al.* (*BDJ* 2006; **200:** 451-454) concerned with the retrospective analysis of what was described in the title of the article as, 'a novel technique' for managing primary molar caries in general practice. The paper explores the use of the so-called 'Hall' technique over the period from 1988 to 2001 in 259 children aged between two and 11 years of age.

It is clear on the facts that the treatment regimen adopted by Dr Hall and provided for the 259 children over the 13 year period was, at the time of treatment provision, wholly untested by scientific analysis and was founded upon Dr Hall's 'impression' that the technique was clinically effective, and indeed remains, at the date of publication, unsupported by the reported outcome of randomised clinical trials.

The use of this untried and untested restorative procedure in children raises significant questions about how Dr Hall ensured the protection of the children's legal and ethical rights to self determination whilst providing dental care for them. Given the age of the children concerned, did Dr Hall tell the children's carers before treating the children that she was proposing treatment that was unsubstantiated by scientific evidence? Were all of the children's carers involved in a full discussion of the risks of the 'Hall' technique, and were they offered the alternative options for treatment of the children in their care, including that of the recognised and evidentially-based approach to the provision of PMCs involving caries removal?

These are matters which are at the heart of whether or not proper consent was obtained by Dr Hall in the treatment of these children. The concerns are self evident – if full information was not provided, and proper valid consent was not obtained, and documented, before treatment was given, then this paper records an egregious failure over an extended period to respect the rights of one of the most vulnerable groups in society.

C. Dean
Elstree

Dr Dafydd Evans responds on behalf of the authors: Our response to C. Dean's letter is tempered by the knowledge that he will have been unaware of the full background to the Hall technique, due to the word limits on articles wisely imposed by editors of scientific journals.

Norna Hall initially provided conventionally fitted preformed metal crowns (PMCs) for her child patients. On moving to a general dental practice in Buckie, Scotland, she found herself faced with very high levels of dental

disease (Scottish children have amongst the poorest oral health of any country in Europe). This was coupled with low levels of dental expectation from the parents. She found that missing out some of the stages associated with the conventional provision of PMCs (enforced by behavioural limitations) made restorative care more acceptable to her patients and their parents, yet did not seem to affect the outcome. To determine if this impression was valid, Norna Hall audited, in 1991, the outcomes for 111 PMCs which had been fitted for at least two years on primary molars with moderate to advanced decay.

These data confirmed the outcome as being acceptable, so she continued to offer the technique to her patients. The data were presented in a paper by the authors on a pilot trial of the technique published in 2000 in the online journal of the Scottish Dental Practice Based Research Network. This paper was referenced in our article, and can be readily accessed.[1] With regard to obtaining valid consent before providing treatment, Norna Hall advised all parents as part of the consent process that her method of using PMCs was not widely used, but seemed to be effective. It is correct that there was no evidence from randomised controlled trials (RCTs) when Norna Hall started to use the technique (as, interestingly, there is still no evidence to date from RCTs supporting the use of the correspondent's favoured technique, that of conventionally fitted PMCs), but there was already some evidence in 1987 regarding the effect of sealing in caries in permanent teeth on its progression.[2] Instead of just wringing her hands about children's rights, Norna Hall, who practised in a remote and rural area with little specialist support, actively did something to help her child patients achieve their fundamental right to oral health and freedom from dental pain. For this she has our commendation, and our respect.

1. *Evans D J P, Southwick C A P, Foley J* I et al. *A pilot trial of a novel use of preformed metal crowns for managing carious primary teeth. http://www.dundee.ac.uk/tuith/Articles/rt03.htm*
2. *Mertz-Fairhurst E J, Call-Smith K M, Shuster G S* et al. *Clinical performance of sealed composite restorations placed over caries compared with sealed and unsealed amalgam restorations.* J Am Dent Assoc *1987; 115: 689-694.*

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Wise withdrawal?

Sir, thank you for Dr Michael Martin's lucid editorial (*BDJ* 2006; **200:** 471) relating to the recent report published by the British Society for Antimicrobial Chemotherapy. Although patients diagnosed with the auto-immune disease Lupus Erythaematosus were not included in the three groups of at-risk patients, I have three such patients for whom I prescribe prophylactic antibiotics since I have been led to believe that they are more at risk of endocarditis following a transient bacteraemia.

I have often wondered at the need for such precautions and since none of my three patients have ever had endocarditis, would it be wise to stop this regime? One of the patients has a particularly active form of the disease and I wonder if withdrawal could be deemed negligent. I understand the arguments regarding the production of antibiotic sensitivity or allergy in such patients, but in 33 years of general practice, I have not had one such case in any patients taking prophylactic antibiotics.

G. J. Marshall
Cheshire
doi: 10.1038/sj.bdj.4813843

Something to contribute

Sir, as a co-author in the paper, Macluskey, Slevin, Curran and Nesbitt (*BDJ* 2005, **199:** 671-675) I was disappointed to see that your journal had published a letter by Ali *et al.* (*BDJ* 2006; **200:** 359) without affording us an opportunity to reply in the same issue.

There are certain issues raised by Ali *et al.* (*BDJ* 2006; **200:** 359) that merit further clarification. Firstly, no assumption of similarities in referral patterns was made between these two disparate sites. In fact, as clearly stated in the beginning of the paper, our aim was to investigate differences in the referral pattern between the two sites. However, our results suggest that very similar referral patterns do exist.

One difference in referrals noted was that the well established specialist practice received the majority of referrals from dental colleagues who would all be familiar with guidelines for the referral of third molars. This may not be the case with the general medical practitioners referring to the dental school. This was one explanation given for the fact that all patients referral to the specialist practice were treated. The inference that patients received intravenous sedation for financial gain, rather than patient benefit or preference, is objectionable.

The teaching of the fundamental principles of oral surgery is the primary responsibility of academic oral surgeons within the environment of an academic institution. We strongly advocate that this essential component of the undergraduate curriculum should not be delegated to individuals out with such a protected teaching environment. However, outreach is a reality with the majority of UK undergraduate institutions exposing their senior students to outreach in its various guises. Many of these programmes are supervised by non-academic staff. Students are afforded an opportunity to undertake treatment in outreach that may include surgical procedures, thus enhancing their experience. Observation of an appropriately qualified, experienced professional, whether it be a surgical dentistry, endodontic or orthodontic specialist practice, would show students the possibilities feasible in practice, inform referral patterns, as well as inspire future generations of specialists. At no point in our manuscript do we suggest that teaching be delegated to a specialist practitioner, but that does not mean that an enthusiastic practitioner with special interests does not have something to contribute to the undergraduate experience.

M. Macluskey
Dundee
doi: 10.1038/sj.bdj.4813844

Practical advice

Sir, having been a serving member of Social Services committees for over eight years I write to offer practical advice as to how to progress cases of possible child abuse, as raised in the *BDJ* 27 May issue by Dr Hussain (2006; **200:** 540).

The first conversation in such cases I would suggest is with the family GP. Likely as not there will be previous history and the doctor will often take over the referral from you. If the buck stays with you there are three avenues that may be preferable to directly contacting Social Services. You can speak to your local police Child Protection Officer or to the relevant school teacher who has responsibility for Children in Care (who are usually 'statemented'), or to a city councillor, one of whom is directly responsible for children's services. As a councillor I referred such cases without divulging my sources, who were usually neighbours.

Anonymity can however never be fully assured. The concerned dentist should make a note in the patient's records and a parent is entitled to view medical and social services records relating to their offspring. However, by following the above route and involving other professionals, the involvement of the GDP is shared and lessens the chance of a parent becoming confrontational. Lastly I would mention that there are hotlines such as NSPCC 0808 800 5000 which anyone can contact to discuss such cases.

J. Brown
Leeds
doi: 10.1038/sj.bdj.4813845