

overlooked by the general dental practitioner (GDP).

With the rise in third molar surgery being carried out in a primary care setting, it is important for the GDP to be competent in giving the patient all treatment options to allow an informed decision to be made.

M. Shaath, Manchester, UK, by email

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DOI: 10.1038/s41415-019-0218-6

Advice post operation

Postoperative care advice: who cares?

Sir, adequate postoperative care advice (PCA) empowers patients and prevents morbidity. Improved awareness amongst patients and development of new communication methods has vastly increased the need for accurate and helpful PCA. There is a binding need to involve and listen to the patients in the care they receive.

We investigated if the patients have a choice regarding who should be delivering the PCA after a surgical procedure. One hundred patients who underwent minor oral surgical procedures in our local oral and maxillofacial surgery department agreed to participate in a survey between September–November 2018.

Both the surgeon and the nurse were blinded in this survey to prevent bias. The survey forms were given by the receptionist to the participating patients post-operatively.

All participants underwent routinely performed procedures in the department including wisdom tooth removal, complex extractions and oral biopsies.

Males dominated the cohort (62%) with the majority of our patients above the age of 40 (72%). About two-thirds of the patients (66%) were given PCA by both the surgeon as well as the nurse with only 20 patients being advised by the nurse only.

Based on the survey, about 60% of patients preferred involvement of the surgeon in provision of PCA. Further data analysis did not reveal any statistical difference between genders and different age groups regarding preferences for PCA delivery (Table 1 and 2).

Traditionally, the nursing staff deliver the PCA in most oral surgical units using verbal information as well as written leaflets, a practice endorsed by the Cochrane review (2005).¹

Our study shows a lack of rigidity amongst patients as to who should be the deliverer of the PCA. This was also noted in a large study of 636 participants by Bornstein *et al.* (2000).²

Due to small sample size, significant analogies cannot be derived and the authors are fully aware of the drawback of this humble study.

Nevertheless, the involvement of the operating surgeon in all modes of patient

care is reiterated by this survey. We hope that this small study will be a precursor for further research into the subject of patient choice in all modalities of care.

S. Mumtaz, C. Batchford, and L. Shepherd, London, UK, by email

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DOI: 10.1038/s41415-019-0217-7

Infective endocarditis

Infective endocarditis guidance

Sir, as you are aware in 2016, the National Institute for Health and Care Excellence (NICE) released guidance that ‘antibiotic prophylaxis against infective endocarditis (IE) is not recommended routinely for people undergoing dental procedures’.¹

The subjective term ‘routinely’ is open to interpretation and has caused uncertainty amongst healthcare professionals.

Following this, in August 2018, the Scottish Dental Clinical Effectiveness Programme (SDCEP) published guidance 64 to provide clarification for the management of patients at increased risk of IE.²

It has separated high risk patients into two groups:

1. Patients considered to be at high risk of IE
2. Patients considered to be at high risk of IE and of potentially severe and life-threatening complications.

Although this guidance aimed to provide clarity, we felt it was still open to interpretation.

At Mid-Yorkshire Hospitals NHS Trust, a consensus protocol was jointly developed by Oral and Maxillofacial Surgery and Cardiology, providing an easy to use algorithm for management of these patients – <https://www.midyorks.nhs.uk/oral-and-maxillofacial-surgery>.

This protocol has simplified the management of patients at increased risk of IE undergoing invasive oral procedures.

In turn this has streamlined the process and reduced delays to treatment, as communication with cardiology regarding each individual case is not necessary.

Table 1 Gender specific preference

Gender/preference						
	Surgeon	Nurse	Both	Neither	SD	P value
Male	20	12	18	12	2.06	0.094
Female	8	12	14	4	2.22	

Table 2 Comparison of age groups & their preferences (One-way ANOVA and Bonferroni analysis)

Age preference					
	Surgeon	Nurse	Both	Neither	P value
0–17	2	0	2	0	0.790
18–40	4	2	8	0	0.296
41–60	12	12	10	4	0.889
61–80	10	6	8	10	0.691
>80	0	4	4	2	0.494

We also hope it will prevent over-prescription of antibiotic prophylaxis and this is something we will audit in due course.

We appreciate there may be some difference in opinions amongst cardiologists, however, we would encourage all departments and dental practices to consult with their local cardiology departments to develop a similar protocol.

R. El-Nashar, Wakefield, UK, by email

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DOI: 10.1038/s41415-019-0216-8

Dental radiographs

Dental radiographs in electronic medical records

Sir, one of the consistent problems which secondary care practitioners face is the poor quality of dental radiographs on the new electronic medical records (EMR) system.

These radiographs are sent by the referring general dental practitioners (GDP) via the hospital referrals email system (NHS Mail).

The referral document is printed and then scanned onto the EMR system. The NRPB (2001) instituted standards to monitor quality assurance in dental radiology and proposed that the image quality be regularly audited.¹

When the image quality on EMR is unacceptable, the patients have repeat

radiographs by the hospital team, resulting in further radiological exposure and prolonged assessment times.

In November 2017, we conducted a retrospective clinical audit in the Oral and Maxillofacial Surgery Department to assess the image quality of dental radiographs sent by GDPs.

An initial assessment of 100 radiographs on the EMR system as well as the original referral document in the NHS Mail was undertaken.

The results proved that significant degradation of image quality resulted due to the inefficient process of ‘print and scan’ method (Table 1).

More importantly, 59% of these patients were re-exposed to attain diagnostically acceptable radiographs.

The results of the audit were presented to the EMR team and an alternative pathway was suggested as follows: *referral received from GDP > referral document saved and uploaded directly to the EMR > clinician reviews the document/radiograph on the EMR.*

The EMR team provided trained staff to facilitate this process. In June 2018, we audited a further 100 dental radiographs comparing both the EMR as well as the original referral document in NHS Mail.

The comparative results showed no difference in the image quality but reduced the need for radiographic re-exposure of the patients to 10% (Table 2).

In conclusion, a simple initiative, effective communication and teamworking has improved the quality of dental radiographs, reduced the appointment times, improved diagnostic accuracy and prevented radiographic re-exposure to patients.

We hope that more hospitals will incorporate this safe and simple system to improve the quality assurance of radiographical images.

Y. Hamrang-Yousefi, M. Pannu and J. Siddiqi, Chelmsford and Basildon, UK, by email

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DOI: 10.1038/s41415-019-0215-9

Cancer referral

Scottish referral guidelines for suspected cancer

Sir, guidelines on cancer referrals in Scotland have been updated in a bid to recognise symptoms of the disease earlier.

The updated guidelines also reflect changes within primary care, recognising not only the role played by primary care professionals such as dentists, pharmacists and advanced nurse practitioners in spotting symptoms, but also the importance of putting individuals at the centre of decision-making.¹

All healthcare professionals should be sensitive to the needs of patients, carers and relatives when cancer is suspected.

Realistic Medicine² is the Scottish Government’s initiative to put the person at the centre of decision-making and encourages a personalised approach to their care.

Good communication is the key and five questions to be considered by all involved can help lead to informed decision-making:

- Is this really needed?
- What are the benefits and risks?
- What are the possible side effects?
- Are there alternative options?
- What would happen if we did nothing?

There are some key changes in the referral guideline on head and neck cancer. These include: (a) dysphagia removed – refer to upper gastrointestinal – but pain on swallowing stays [new]; (b) role of dentists emphasised – access to urgent suspicion of cancer referral [new].¹

Good practice points have also been added to the section on head and neck cancer: (i) with the changing pattern of disease (in particular HPV associated cancers), age, non-smoking or non-drinking status should not be a barrier to referral; (ii) dentists

Grading	EMR	NHS Mail
Grade 1	16%	75%
Grade 2	38%	16%
Grade 3	46%	9%

Grading	EMR	NHS Mail
Grade 1	72%	72%
Grade 2	19%	19%
Grade 3	9%	9%