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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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

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

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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.