COMMENT

Letters to the editor

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.

Intravenous cannulation

Sharing techniques

Sir, in the United Kingdom, peripheral intravenous cannulation using open cannulae is a technique routinely undertaken by dental staff within certain settings, for example hospital wards or dental practices where intravenous sedation is carried out.

Successful cannulation takes practice, which can be daunting for inexperienced operators and can result in blood spillage. This is particularly the case when some newer designs of safety cannula (designed to prevent sharps injury) are used, as there can be a need to counteract increased resistance when removing the needle compared to when using older types.

This adds further complexity to the procedure and thus increases the risk of blood spillage, which can not only cause a mess, but also a potential contamination risk to those cleaning up afterwards.

Disposable dental patient bibs with plastic backs and adhesive tabs for attaching to the wearer's clothing are widely available.

Within our sedation clinic, a technique has been devised whereby the adhesive tabs are used to secure the bib to the clothing surrounding the arm proximal to the selected vein prior to cannulation.

This means that the bib is held securely in position below the arm, and provides a convenient and reassuring means of protection in case of blood leakage during the cannulation procedure (as shown in Fig. 1). Following the procedure, disposal in the clinical waste is straightforward.

We wish to share this practical alternative use of the dental patient bib with your readers, and particularly those who are new to intravenous cannulation.

J. Smyth and J. Toole, Belfast, UK, by email

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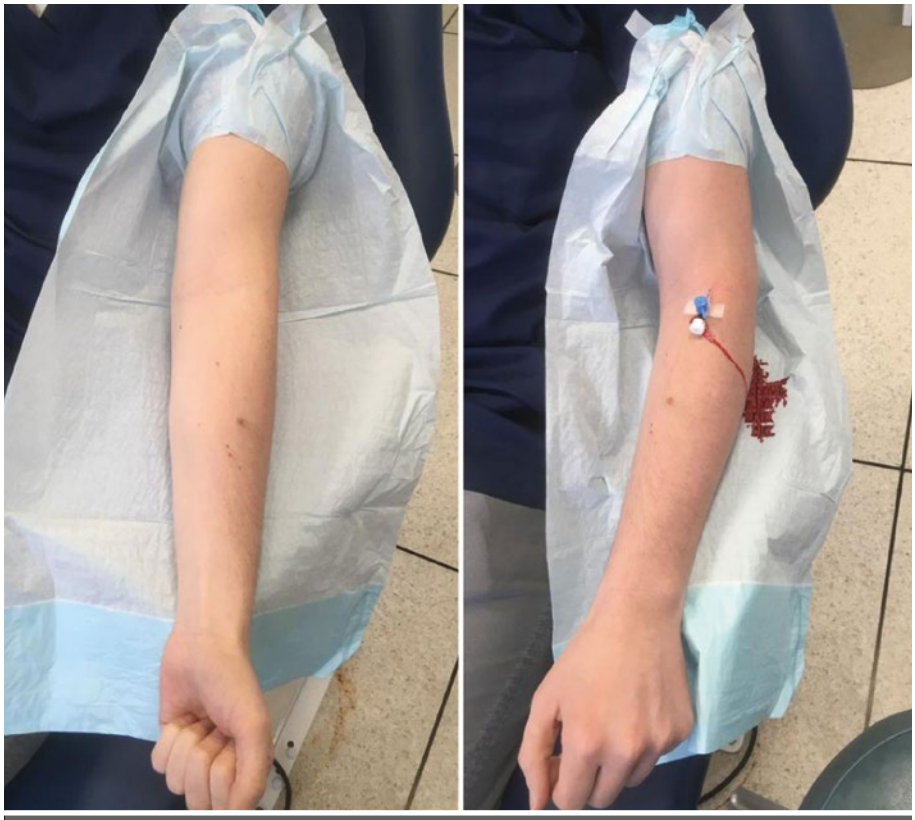

Fig. 1 Bib applied prior to cannulation, and subsequent demonstration of protection following blood spillage during the procedure

Cancer referral

Appropriateness of referrals on the suspected cancer referral pathway - a secondary care perspective

Sir, the recent article on *Mouth cancer: presentation, detection and referral in primary dental care*[1] highlighted the importance of the general practitioner in aiding early diagnosis of oral cancer and appropriate urgent referral to secondary care, as per NICE guidelines.[2]

As a dental core trainee working in a busy maxillofacial unit, we see many cases of non-malignant and pre-malignant oral conditions.

A high amount of patients are also seen on the suspected cancer (SCA) two-week referral pathway. Dentists are required to assess for oro-mucosal lesions and refer for specialist review as deemed appropriate.

It can often be difficult to distinguish which referral pathway is appropriate, due to the constraints of assessing patients in general practice[3] and the rise in so-called 'defensive referring' with the increase in GDC fitness to practise cases linked to delayed diagnosis of oral cancer.[4]

However, it remains the case that although oral cancer diagnosis rates are improving, only a small proportion of patients referred to the urgent pathway are in fact diagnosed with malignant conditions.

We decided to undertake a retrospective audit of SCA referrals, over 12 months, sent to the Oral and Maxillofacial Unit by GMPs and GDPs.

Of 155 head and neck referrals sent in 2018, 12 patients were diagnosed with oral cancer. Of the remaining 143 referrals, the majority of patients were diagnosed with potentially malignant and pre-malignant conditions, predominantly lichen planus, and the rest had no abnormal findings at all.

The relatively low proportions of oral cancer diagnosis reported across maxillofacial units nationally[5] suggest that the urgent cancer pathway is being overused.

This poses the question of how the appropriateness of referrals can be assured to improve effectiveness and reduce significant strain on secondary care services.

Whilst it is clearly in patients' best interests that primary care practitioners are sending all cases for a specialist second opinion, or in fear of missing serious conditions, it could be suggested that further training and guidance may be needed for practitioners to direct patients to the correct referral pathway.

This would decrease the impact on service provision in secondary care and ultimately improve patient outcomes.

N. Tajmehr, Wilmslow, UK, by email

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Brexit

Brexit

Sir, it is unpardonable that two of your members are calling for a people's vote.[1]

For their information, we have already had a people's vote in 2016 and the British public voted to leave the EU. Their comments disrespect the British people and the democratic process in this country. We didn't vote for a deal, we voted to leave the EU.

The authors should be reminded that there are about 1.3 million unemployed in this country. They should train and recruit staff from the indigenous population rather than looking to finding cheaper employees from Eastern Europe. If the market is flooded with unskilled labour, this reduces wages and increases rents for those already living here.

EU citizens came to live here of their own free will and therefore must take responsibility for any uncertainty in their future. Our concerns should be with the unemployed and homeless of this country. What about their uncertainty and their prospects of finding work?

We pay into the EU far more than we get out of it. We have a moral duty to leave, whatever the outcome.

S. Aldridge, London, UK, by email

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Research

Promoting research in primary care

Sir, I was pleasantly surprised to see the National Institute of Health Research (NIHR) Top 10 Research Priorities.[1]

They are useful not only to research groups but also to clinicians providing care. It is impossible to address the issues within NHS dentistry without addressing the existing inequalities to accessing and receiving dental care.

Having worked in both England and Scotland, I have noticed a stark difference in each country's approach to dental public health.

For example, the Scottish dental community is unified through a stronger network than in England. General dental practitioners (GDPs) signed up to NHS Education for Scotland (NES) all recently received notification of NIHR's priorities.

Most Scottish dentists are well acquainted with NES, which is also responsible for coordinating and funding dental training at undergraduate, vocational, core and specialty levels.

NES is the education and training organisation administering professional development and supporting programmes including Childsmile and the Scottish Dental Clinical Effectiveness Programme.

The Scottish Dental Practice Based Research Network (SDPBRN) is also part of NES and has used this communication platform to circulate a NIHR survey to GDPs.[2]

This survey, aimed at primary dental care practitioners, looked to identify and integrate professionals interested in research with the ultimate aim of strengthening the workforce. By working with NIHR Clinical Research Network Oral and Dental Specialty Group, GDPs can make the leap from accrued wisdom to applicable evidence that may result in meaningful change.

The survey is also supported by British Society for Oral and Dental Research and is available to all UK practitioners.[3]

However, I suspect this survey is not widely known among English GDPs.

One barrier is the lack of a communication platform to distribute such information to practitioners in England. The structure of NHS England, as a complex and fragmentary organisation, means that achieving universal communication is problematic. The importance of communication is often overlooked not least because dentists in primary care may find themselves isolated.

I urge the dental profession in England to prioritise communication and make use of our existing resources and networks, despite not having an equivalent organisation to Scotland's NES.

Following the issuing of the NHS Long Term Plan,[4] the fact that oral health was 'largely ignored' should not come as a surprise.

Oral health has often been excluded from previous NHS strategy plans. This can change by working together to produce the research base to answer NIHR's key questions and form a compelling argument for oral health measures in the future NHS strategy plans.

As the dental services have always done, we need to take our own steps to support NHS dentistry. The survey's deadline has recently passed but expressing interest of participation to NIHR may possibly be accepted.

K. T. Lau, Maidstone, UK, by email

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