the use of dental amalgam is 'likely to be time limited'. Her comment that policymakers in England need to focus on preventive interventions is well made, but misses the fact that administrators of dental schemes, worldwide, have so far failed to devise a reliable way of paying for prevention of disease, be this in medicine or in dentistry.

It is the third article in the series that caused me concern. Susie Sanderson[3] has linked a reference from my work with Dr Steve Lucarotti[4] with a statement that 'alternative restorative materials suitable for large posterior cavities [...] are prone to failure sooner than dental amalgam'. Unfortunately, while the numbers included in the study are large (3,504,225 composite restorations), this reference relates to resin composite restorations in anterior teeth and Class V restorations in posterior teeth, not to resin composite restorations in loadbearing surfaces in posterior teeth, hence it is not valid to the present discussion on the 'Great Amalgam Debate'. There are many other references detailing well-designed cohort studies which indicate positive results for posterior composite restorations which Dr Sanderson could have used, but space does not permit me to include the lengthy list of these.

Instead, I will draw readers' attention to a practice-based study by Laske and colleagues[5] giving details of a massive (358,548 restorations in 75,556 regularly-attending patients) dataset established in the Netherlands using data from electronic patient files from 67 general dentists collected between 1996 and 2011. Their results indicated an overall Annual Failure Rate (AFR) varying between 2.3% and 7.9% (mean 4.6% at ten years), with restorations in molars having higher AFR, and the AFR of composites being 4.4%, and amalgam 5.1%, with the authors stating that 'by far the most common restorative material used by the participating GDPs was composite' (240,701 composites vs 34,510 amalgams) and a majority of restorations being placed in molars rather than premolars (177,015 vs 108,359, respectively), a more severe test for a restorative material. May I therefore suggest that, in light of robust data such as these, the statement in Dr Sanderson's article that 'resin composite restorations are prone to failure sooner than those in dental amalgam'[3] is misleading and should be revisited?

F. J. T. Burke, Birmingham, UK

References

1. Wilson N H F, Lunch C D. The great amalgam debate or debacle: a perspective. *Br Dent J* 2022; **233:** 870–871.
2. Hurley S. Dental amalgam: a material choice. *Br Dent J* 2022; **233:** 872–873.
3. Sanderson S. The great amalgam debate. *Br Dent J* 2022; **233:** 874.
4. Burke F J T, Lucarotti P S K. The ultimate guide to restoration longevity in England and Wales. Part 4: resin composite restorations: time to next re-intervention and to extraction of the restored tooth. *Br Dent J* 2018; **224**: 945–956.
5. Laske M, Opdam N J M, Bronkhorst E M, Braspenning J C C, Huysmans M C D N J M. Longevity of Class II restorations placed in Dutch general dental practices. Descriptive study out of a practice based research network. *J Dent* 2016; **46:** 12–17.

https://doi.org/10.1038/s41415-023-5473-x

Dental trauma

Facial trauma due to e-scooters

Sir, since the double cohort study published in the *BDJ*,[1] we report a further increase in the number of outpatient trauma cases presenting to the Oral and Maxillofacial Department (OMFS) following collisions involving e-scooters. The majority of e-scooter rentals in our patient cohort were for leisure and social use, with a significant proportion of patients disclosing that they were not wearing a helmet with some also allegedly intoxicated at the time of the incident.

As reported in the Department of Transport National Statistics (DTNS) factsheet, in 2021 there were 1,352 collisions involving e-scooters compared to 460 in 2020, with 1,434 compared to 484 casualties, respectively.[2] The Parliamentary Advisory Council for Transport Safety (PACTS) published a report proposing that if the government legalises private use of e-scooters, helmet wearing should be mandatory and drink driving, dangerous or careless riding should be prohibited.[3] Computational modelling of e-scooters compared to pedal cyclists found a similarity in the speed of impact between the riders' heads and ground with 40% of impacts with e-scooters to the face. However, the number or severity of facial fractures caused by e-scooter collisions has not been recorded by DTNS.

While the previous study highlighted 12 ED referrals to OMFS during a 16-week period in 2020, a brief overview has identified ten patients similarly involved within only an eight-week period during 2022, 40% of which required surgical management. Fractures identified included Le Fort I, Le Fort II, nasal bone fractures, orbital fractures and zygoma fractures. This data assessment did not include facial lacerations and inpatient trauma data.

A study showed the average cost per patient admitted to King's College Hospital following e-scooter collisions is over £1,000. Although this is not limited to facial injuries, it highlights the cost burden of e-scooter injuries on the NHS.[4] We understand the benefits that e-scooters contribute to the joint effort against climate change and reducing pollution within cities. However, it is imperative that public safety is further considered in the government's decisions regarding their legalisation which may include enforcement of mandatory helmet use and prohibition of drink driving, dangerous or careless riding as per PACTS' recommendations.

I. Turner, M. Shah, London, UK

References

1. Pepper T, Barker M, Smyth D, Kingham M, Dua R, Fan K. Electric scooters: a quick way to get to the emergency department? *Br Dent J* 2022; **232:** 535–537.
2. Department for Transport. National statistics. Reported road casualties Great Britain: E-scooter factsheet 2021. Updated 29 September 2021. Available at: https://www.gov.uk/government/statistics/reported-road-casualties-great-britain-e-scooter-factsheet-2021/reported-road-casualties-great-britain-e-scooter-factsheet-2021#:~:text=severity%20adjustments%20section.-,Main%20points,compared%20to%2083%20in%202020 (accessed December 2022).
3. PACTS. The safety of private e-scooters in the UK. Interim report. October 2021. Available at: https://www.pacts.org.uk/wp-content/uploads/PACTS-The-safety-of-private-e-scooters-in-the-UK-Report-5.0.pdf (accessed December 2022).
4. Ahluwalia R, Grainger C, Coffey D *et al.* The e-scooter pandemic at a UK Major Trauma Centre: A cost-based cohort analysis of injury presentation and treatment. *Surgeon* 2022; doi: 10.1016/j.surge.2022.07.001.

https://doi.org/10.1038/s41415-023-5472-y

Correction to: Challenges and obstacles

The original article can be found online at https://doi.org/10.1038/s41415-022-5319-y.

Author's correction note:

Letter *Br Dent J* 2022; **233:** 905.

When this letter was originally published, an author's name (S. Patil) was spelled incorrectly. The authors of this letter are M. A. Rais, A. K. Awad, E. Veseli, S. Patil and M. R. Tovani-Palone.

https://doi.org/10.1038/s41415-023-5452-2