

Letters to the editor

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NHS dentistry

Nuffield Report – the silenced majority

Sir, the Nuffield Report¹ comes at a time when NHS dentistry is never far away from the news headlines, accompanied by constant headlines of the public being unable to access NHS dental services. Identifying the problems leading to the current crisis is key to finding solutions.

Whilst the report portrays NHS dentistry in England through a particular lens and highlights several important and recurring challenges in the provision of dental care, the Dental Professional Alliance is keen to understand why the largest registrable group of dental professionals was not involved in the discussions that resulted in the publication of the report.

The wider members of the dental team are key to the ongoing delivery of dental care and dental treatments. Dental hygienists and dental therapists have recently been identified as being part of the solutions to some of the so-called ‘wicked’ problems. In England, dental hygienists and dental therapists can now open courses of NHS treatment, mirroring their way of working in the private sector.

Dental nurses have been identified as vital in the delivery of preventative practice. Of course, the demand for dental nurses is undoubtedly likely to rise, as we contemplate their role in further supporting dental hygienists and dental therapists.

Orthodontic therapists play a pivotal role in providing NHS orthodontic care, with NHS contracts financially reliant on this group to enable the number of patients being treated. Clinical dental technologists have also been identified as a group of clinicians who can be used to help with the provision of removable dental appliances (predominantly dentures). Dental technicians are not generally patient-facing; however, they play a vital role in both NHS and private settings. It is worth noting

that there are currently more technicians leaving the register than registering each year, highlighting a growing problem.

The Dental Professional Alliance is at a loss to understand the rationale for not including the full representation of all professional bodies, as without this a balanced opinion is impossible. It is also a wasted opportunity for the NHS to fully utilise the skills and knowledge of these valuable professionals.

F. Ellwood on behalf of Dental Professional Alliance, London, UK

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<https://doi.org/10.1038/s41415-024-7300-4>

Anaesthesia and sedation

New sedation guidance in primary care

Sir, we are collectively concerned regarding the new Clinical Standards for Dental Anxiety Management¹ published by NHS England on 17 January 2023. The biggest change being the ban of multi-drug sedation techniques in community and primary care settings within the NHS. Although these standards do not apply to secondary or private care, there is apprehension that this shift reflects a broader trend.

Despite being published a year ago, there has been no announcement regarding implementation, causing unrest among sedation practitioners nationwide. The Association of Dental Anaesthetists and Sedationists (ADAS) surveyed its members working in NHS primary care sedation practices, with results indicating widespread concern: 73% believed that sedation duration and recovery time would increase, 64% believed there would be an increase in

sedation failure and 73% believed it would negatively impact on patient satisfaction.

Advanced sedation technique (AST) using a combination of midazolam and opioids have been long established in anaesthesia and conscious sedation with evidence of safety when used in suitably qualified and experienced hands.^{2,3} The use of opioids provides systemic analgesia for complex and often painful dental procedures and has a synergistic effect, reducing the dose of midazolam required. The IACSD standards suggest its use in patients for whom midazolam alone does not produce adequate anxiolysis.⁴ The combined use of nitrous oxide and midazolam has its place in managing patients with a severe gag reflex and those who would benefit from the mild analgesic and anxiolytic effects of nitrous oxide. Multi-drug sedation doesn't necessarily induce deeper sedation.

An AST ban would impact on already stretched secondary care with increased referral volume and a concomitant burden of oral diseases worsening dental anxiety and poorer outcomes. More patients on GA waiting lists would further increase NHS burden and disadvantaging those who cannot be seen elsewhere. NHS treatment options under GA are limited to simple restorations and extractions, thus leaving many without viable alternatives. The rationale behind these proposed changes remains unclear. Is it driven by patient safety concerns, or is it a short-sighted cost-saving measure? Without published data on the mortality and morbidity of multi-drug sedation in primary care, the decision lacks transparency.

We fear that patient care would be negatively and irreversibly impacted if this guideline is implemented without due consideration to the available evidence and having alternative resources put in place. We call for a multi-agency stakeholder engagement and discussion to ensure

informed decision-making that prioritises patient care and NHS interests.

X. Yeo, Barking; M. Jawad, London, UK

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<https://doi.org/10.1038/s41415-024-7305-3>

Dental careers

Highly recommended programme

Sir, we were pleased to read the letter regarding the DCT 2 equivalency published in your journal.¹ We would like to share our experience as new dental graduates. We are part of the Joint Dental Foundation Core Training programme (JDFCT) initiated by Health Education England which combines the primary (DFT) and secondary care placements (DCT Year 1), starting immediately after graduation.²

As final year students, we aspired to achieve experience in both primary and secondary care in our careers. We were fortunate to select this two-year programme which involves alternate week placements in hospital and dental practice. Although this was initially a steep learning curve, the past few months have vastly and rapidly increased our scope of knowledge and practical skills. We have been provided with ample opportunities to proceed with dental procedures under supervision, including biopsies, surgical extractions and assisting in more complex head and neck surgeries such as free flap cases. Additionally, we've been fortunate to actively contribute to and engage in daily ward rounds, allowing us to assess patients both before and after surgical procedures. Furthermore, we have been able to assist with consultant-led clinics, giving us an appreciation of how referrals are handled in secondary care; this has provided us with a better understanding of the different stages of hospital-based patient management. The primary setting involves working in a

dental practice as a GDP, performing most procedures such as RCTs, crowns, restorations, periodontal treatment and more.

In spite of the interruption in the continuity of our experience due to alternation of general and hospital practice, we still have the same targets as general yearly cohorts over our two years of training. These include supervised learning events (direct observation of procedural skills, case-based discussions and more), reflections and a logbook of our clinical experience, which makes the training optimal and adequate.

Despite the challenges, we highly recommend this to anyone looking to do a joint training programme as we believe this comprehensive approach ensures skill development takes precedence without any compromise on our existing clinical abilities within general dentistry.

Y. Mohajer, Luton and Hitchin; S. Patel, Luton and Hitchin; R. Sangam, Hitchin; V. Sharma, Luton, UK

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<https://doi.org/10.1038/s41415-024-7302-2>

Dental implants

CGF-induced implant osteogenesis

Sir, I read the article by Kandhari *et al.*¹ with interest: bone quality, volume, height and width all play a pivotal role in dental implant stability, success and survival. Most young dentists are unable to determine whether the implant area has sufficient bone mass during the implantation process. Meanwhile, selecting the right type of bone grafting material is also extremely challenging. A lack of adequate bone can be overcome with various bone grafting procedures. Long-term and stable implants depend on many factors including the amount of bone required, the site of implant placement, patient preferences and clinician factors. The authors provided an overview of bone grafting indications, materials and types of bone grafting techniques, while discussing the properties needed to ensure optimal success of guided bone regeneration techniques.

Recently, one clinical study evaluated the combined use of concentrated growth factors

(CGFs) and adipose-derived stem cells (ADSCs) as cytokines and seed cells for bone regeneration in patients with immediate dental implants. Shubham *et al.*² showed that although there was no significant difference in results between groups at all time points, the application of concentrated platelets unexpectedly improved the stability of implants after surgery. When comparing the quantity and quality of bone regeneration for data statistics and measurements, the difference between the three groups was not statistically significant. Another clinical study by Andrea *et al.*³ found that data obtained from surgical interventions with CGF-permeated dental implants presented better results in terms of optimal osseointegration and reduced post-surgical complications. These data, taken together, highlight new and interesting perspectives in the use of CGF in the dental implantology field to improve osseointegration and promote the healing process.

CGF, as a healing biomaterial, has been routinely applied in dental implant surgery to accelerate healing and reduce post-operative discomfort, which has a positive impact on the success of dental implantation. In order to increase the long-term stability of implants, we need to explore more effective methods, and the use of growth factors is one of them.

M. N. Huang, S. J. Tang, Guiyang, China

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<https://doi.org/10.1038/s41415-024-7303-1>

Paediatric dentistry

Sodium hypochlorite and paediatric patients

Sir, sodium hypochlorite (NaClO) is an effective intracanal irrigant used widely in restorative and paediatric dentistry which although generally considered safe, has cytotoxic effects that can result in soft tissue necrosis if extruded beyond the root canal system.¹ Whilst the consequence of extrusion is well recognised, there is limited literature