plastic restorations, perhaps reinforcing the need to undertake a holistic approach to patient care, and that the final restoration is an integral and very important element of endodontic treatment.

Two of the correspondents cite the recent systematic review by Ng et al. which is a welcome contribution to the literature. However, the majority of studies included in systematic reviews are likely to have been undertaken by specialists in specialist centres and therefore the relevance to the outcomes of care provided by GDPs needs to be questioned. Our paper reports the first study of the outcomes of NHS-funded care provided by GDPs. It is critically important to understand what works in the hands of GDPs, as they provide the majority of endodontic treatment in the UK. The study was preliminary in nature and raises many more questions than it answers, but it will hopefully start to inform a series of primary care based studies to improve the evidence base for endodontic care provided in the UK.

In the discussion section of the paper, in addition to the need for a stronger evidence base, we also called for a clearer understanding of what we mean by quality: how we define quality and how we measure quality. In the past quality in dentistry has largely been normatively judged and process-based; in the future we think quality needs to be more patient-centred and focused on outcomes. Only when we have a strong evidence base and an agreed understanding of quality can we be confident of what we are trying to achieve in setting 'standards of patient care'.

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NOT KISSING

Sir, I read the case presented as *Kissing molars* (BDJ 2008; 204: 281-282) with great interest, but it raises a number of serious points regarding the nomenclature of the unusually impacted teeth. How can we call the two closely apposed teeth with the dentigerous cyst seen in one of them 'kissing molars'? The term 'kissing molars' as first described by Van Hoof in 1973¹ refers to teeth which have occlusal surfaces contacting each other in a single follicular space and roots pointing in opposite directions. The radiograph shown in the article does not show contacting occlusal surfaces.

Moreover, the presence of a dentigerous cyst in association with the second molar which was proven histopathologically clearly suggests that there was no contact between the two impacted molars thus discounting them from being 'kissing' molars. Also, the legend of the figure stating *impacted mandibular second and third molars with a single follicular space* cannot be true considering the presence of a dentigerous cyst. I would prefer to call them an unusual impaction.

M. Juneja
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1. Van Hoof R F. Four kissing molars. *Oral Surg Oral Med Oral Pathol* 1973; 35: 284.

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MODIFY OUR PRACTICE

Sir, in the letter by J. Cooper (*Mysterious conditions*, BDJ 2008; 204: 283) the author raised some interesting and important points. These included questions over why guidance relating to vCJD¹ was only based on 'plausibility', 'prudence' and 'possibility' and not using 'the scientific approach' as employed by the National Institute for Health and Clinical Excellence (NICE). Moreover, there was some discussion of the NICE draft proposal (now an implemented guideline as of March 2008) for antibiotic prophylaxis against infective endocarditis.²

The correspondent clearly aired dissatisfaction over the manner in which the guidance on vCJD was implemented. Certainly, few can argue that the impact of this guidance in general dental practice was not problematic, with the main problem apparently being of a financial nature, compounded by the constraints of the new GDS contract. The author goes on to suggest that evidence-based dentistry 'only applies when a mysterious set of circumstances compel its application – politics, time etc.' Although I can empathise on certain points raised, I feel the letter failed to address several key issues.

Bodies such as NICE and the Department of Health make guidance based on the best available evidence whether that is optimal in quality or otherwise. It is not always practical, nor ethical to conduct double-masked, randomised, placebo controlled clinical trials in every situation. Hence decisions must be made using the best available evidence. The

alternative would be for such organisations to provide no guidelines at all.

Moreover, the letter did not contain any reference to the pragmatic logic behind the publication of the aforementioned guidance. The provision of antibiotic prophylaxis was not without its own side effects. Included were possible problems with diarrhoea, thrush, allergic response, potential anaphylaxis and the issue of potentiating antimicrobial resistance. Ultimately, the guideline development group at NICE were 'convinced by the evidence suggesting that current antibiotic prophylaxis regimens might result in a net loss of life'.² Conversely, with regards to the vCJD recommendations, what are the potential side effects on patients when their dentist treats endodontic files as single use only?

I believe that as a profession we should treat all potential risks to patients as serious and should use clinical governance in order to, where plausible, modify our practice accordingly. This could involve actions to counter the theoretical but potentially devastating threat posed by vCJD, or indeed the relative risk of iatrogenic harm associated with infective endocarditis prophylaxis.

R. McMillan
Birmingham

1. Department of Health. *Precautionary advice given to dentists on re use of instruments*. 19 April 2007. <http://www.gnn.gov.uk>. Reference 146384P.
2. National Institute for Health and Clinical Excellence. NICE guideline 64. *Prophylaxis against infective endocarditis in adults and children undergoing interventional procedures*. March 2008. <http://www.nice.org.uk/nicemedia/pdf/CG64NICEguidance.pdf>

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ADDITIONAL QUALIFICATIONS

Sir, the majority of the dental profession will have had an opportunity to read the GDC recommendations regarding additional qualifications (AQs). They have arisen from the clearly identifiable anomalies that exist in the registration procedures and more importantly in how the general public interprets the possession of an AQ. 'The more the better' is the majority experience thereby leaving scope for misleading and potential safety breaches.

What is the GDC to do? Doubtless, the GDC Education Committee has many difficult meetings ahead and pressure from

the Fitness to Practise Policy Committee will play a major role in the final policy outcome decision. We at the British Association of Oral Implantology (BSOI) recognise the difficulties ahead and applaud the GDC in its attempts to ensure the public does not fall foul of the vagaries of advertising embellished by lists of letters designed to impress and coerce.

It is at this time that representative associations within dentistry need to take the lead in the provision of suggestions and ideas that will alleviate the current impasse and begin to push forward solutions that could maintain the academic hunger of dentists within the postgraduate arena and ensure such awards are recognised for their relevance to the practice of clinical dentistry.

The BSOI has drawn together a group of clinicians with expertise in the postgraduate clinical educational field and is dedicated to providing dentists with guidance required to satisfy the educational and clinical demands in postgraduate implant dentistry, to suit the requirements of all clinicians, particularly those in primary care. BSOI embraces all those involved in postgraduate training and has pledged to try and ensure uniformity in quality by collaboration between various postgraduate institutions, particularly those within the primary care sector. This collaboration could be the key to providing solutions for the GDC.

We feel that the GDC in conjunction with representative educational bodies could identify those standards required for award of an AQ within a particular field, which would be subject to regular review and revalidation. Those in the business of providing education would be made to produce these standards and report their agreed findings to the GDC. This is not a decision one association is capable of making; all representative parties should play a role. It would also be the duty of those representatives to police the education, training and assessment procedures.

Accordingly, the AQ attached to each clinical individual would have a level of recognition currently only attached to the BDS, would satisfy the GDC's desire to ensure that registers and information contained within IS of clear benefit to the public and would satisfy the

requirement that any AQ identified with an individual had been rigorously quality assured. This is an opportunity and we recommend the GDC turns to the clinical arena for a solution to this dilemma.

S-J. Crean & the Board of

The British Society of Oral Implantology

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DON'T BE DOWNHEARTED

Sir, fellow and prospective students taking the excellent and worldwide King's College MClintDent (Prosthodontics) degree by distance learning need not be too downhearted that it will not be recognised in the UK as an additional qualification. (Maclean J. *Additional qualifications*. *BDJ* 2008; 204: 420).

Many UK students do the residential part of the course at the dental school in Dharwad, Karnataka together with Indian and other international students.¹ Therefore, the Dental Council of India has just recognised the MClintDent as India's second postgraduate degree alongside the MDS.

At least should we choose to practise in India our hard work would be acknowledged there!

M. W. Austin
Hove

1. Austin M W. Star of India: the first MClintDent (prosthodontics) residential week in India. *Br Dent J* 2006; 200: 352-353.

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INCISOR TRANSPOSITION

Sir, a 56-year-old male patient reporting for a routine dental check-up revealed right upper central and lateral incisors that had interchanged their positions (Fig. 1). The lateral incisor was slightly malformed (increased mesio-distal and cervico-incisal crown width) and the patient was totally unaware of the condition. An intraoral periapical radiograph revealed transposition of the upper right central and lateral incisors (Fig. 2). An incomplete *dens in dente* was observed in relation to the lateral incisor. Since the patient was not concerned with aesthetics and because of financial constraints no treatment was instituted.

Transposition has been described as an interchange of the position of permanent teeth and is considered to be a relatively rare dental anomaly. It was defined by

Peck *et al.*¹ as the positional interchange of two adjacent teeth, particularly of the roots, or the development or eruption of a tooth in a position occupied normally by a non-adjacent tooth. The maxillary canine is the most commonly involved tooth¹⁻⁴ where in most of the cases it changes its eruptive place with a lateral incisor or a first premolar. The incidence of tooth transposition has been reported to be about 0.4%.² Many articles have been published on the transposition of the maxillary canine with other teeth but to the best of our knowledge, only eight cases of transposition of a maxillary central incisor with a lateral incisor have been reported.

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Karnataka

1. Plunkett D J, Dysart P S, Kardos T B, Herbison G P. A study of transposed canines in a sample of orthodontic patients. *Br J Orthod* 1995; 25: 203-208.
2. Turkkahraman H, Sayin M D, Yilmaz H H. Maxillary canine transposition to incisor site: a rare condition. *Angle Orthod* 2005; 75: 284-287.
3. Peck S, Peck L. Classification of maxillary tooth transpositions. *Am J Orthod Dentofacial Orthop* 1995; 107: 505-517.
4. Shapira Y. Transposition of canines. *J Am Dent Assoc* 1980; 100: 710-712.

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Fig. 1 Interchanged upper central and lateral incisors

Fig. 2 Transposition of the upper right central and lateral incisors