Letters to the Editor

Send your letters to the Editor,
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Priority will be given to letters less than 500 words long.
Authors must sign the letter, which may be edited for reasons of space.

GREEN DENTISTRY

Sir, a recent item in a national newspaper once again accused dentistry of being a serious polluter by the use of mercury. These writers fail to acknowledge that relative to volcanic emissions the manufacture, use and disposal of dental mercury has traditionally been a minor source of world pollution. Over the past two decades the use of dental amalgam has further declined. Reading this provoked the thought 'how environmentally friendly is dentistry?' Have environmental audits of dentistry been carried out?

Such an examination would show progress and areas for improvement and should be wide ranging, for example from dental manufacturing to the clinic waste containers, from the clinic front door to the extracted air. Should treatment plans be guided by environmental concerns? Is environmental awareness included in dental training programmes? Is being 'green' cost effective?

Moving away from the clinical scenario what about the *BDJ* being printed on recycled paper or only available online? Can the hot air at dental committee meetings be harnessed?

Through this journal there is an opportunity to share concerns and demonstrate progress made. Most important would be to learn of tips on how to make the practice of dentistry greener.

P. Erridge
East Grinstead

Ed's note: The BDJ *is printed on paper that comes from well managed sustainable sources which conform to internationally recognised certification bodies.*

The cover story of the summer issue of Vital *featured the first carbon neutral dental practice in the UK. See www.nature.com/vital.*

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FINITE RESOURCES

Sir, the current woes at the petrol pumps should serve to remind us that fossil fuels are a finite resource, and their preservation should be a priority for all of us. It was pleasing to read that measures were taken at the recent BDA Conference to use recycled materials and enable recycling of drinks containers. However, it is important to put these 'green' measures into context. The environmental impact of a large-scale event such as a conference is considerable, and the overwhelming majority of CO_2 emissions resulting from the event will be generated from delegates and speakers travelling to and from the conference centre. By way of example, a recent environmental impact audit carried out on behalf of the rock group Radiohead showed that 86-97% of the total 'carbon footprint' of their concerts was related to attendees' travel to and from the venues (Best Foot Forward Ltd, Oxford, 2007).

The FDI, recognising the importance of these issues, webcasts presentations from the World Health Professions Alliance and the Annual World Dental Congress, thus obviating the need for many people to travel hundreds of miles to attend in person. The BDA has not as yet made such arrangements for their conferences, but are currently considering the possibility.

The use of technology to reduce unnecessary travel is to be applauded. The BDA, and all other dental organisations that organise events such as these, should make every effort to utilise this technology so that significant reductions in CO_2 emissions may be made. Let us not forget that climate change is, in the words of the British Government, 'the greatest long-term challenge facing the world today. There is strong and indisputable evidence that climate change is happening and that man-made emissions are its main cause' (DEFRA, 2006).

D. Knibb
Exeter

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THE HALL TECHNIQUE

Sir, we note J. P. Murphy's letter regarding the Hall Technique (*BDJ* 2008; **204:** 476). We are uncertain whether this letter is meant to be a serious contribution to the scientific debate on how to manage caries in children, as it seems to mainly consist of recycled arguments from Roberts *et al.* (*BDJ* 2006; **200:** 600-601), to which we have already responded (*BDJ* 2006; **201:** 249-250). We were pleased to note, however, that environments considered suitable for the Hall Technique have been increased from 'in the field, in developing countries' (sic) to include 'war zones'.

Regarding J. P. Murphy's other comments, most are dealt with in a paper we published last year.[1] Nevertheless, we answer them here:

1. 'This technique could precipitate a maxillary or mandibular cellulitis if the decayed tooth undergoes necrosis'. This is indeed a possible consequence of failing to treat a carious primary tooth. However, sealing in decay **as a treatment option** in our study gave results which, at two years, were comparable to conventional restorative techniques carried

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out by specialist paediatric dentists. As detailed in the paper, 19/124 traditionally managed teeth, compared to only 3/124 treated with the Hall Technique, went on to show clinical or radiographic signs of necrosis. These teeth (where almost half of the teeth had caries radiographically over halfway through dentine) were matched clinically and radiographically; the study was split mouth in design and the randomisation was controlled centrally

2. 'It would be difficult to monitor a tooth after a full coverage SSC was placed with radiographs'. We are at a loss to see how this would be more difficult than for a conventionally placed PMC
3. 'The administration of infiltration local anaesthesia with mesial, distal, and occlusal preparation of the deciduous tooth for a preformed SSC is a very straightforward affair.' This may be so but in 2001, Scottish Dental Practice Board records showed that only less than 0.5% of all restorations placed in children's teeth in Scotland were PMCs.[2] They are simply not used in the general practice setting in the UK
4. 'Removal of decay is very simple.' It is not in dispute that the process of removing caries is simple. What is being contested is whether complete caries removal is necessary. Our study would indicate that in the case of the Hall Technique it is not. This agrees with other work much of which has been ignored by the profession for several decades[3]
5. If Dr Murphy really can provide a 'pulpotomy and a PMC in six minutes', all in, then he is more of a technician than we will ever be. However, there is more to clinicianship than speedy delivery. Good clinical care involves providing effective dental treatment which children can cope with, and their dentists can deliver effectively. Our study shows the Hall Technique fulfils these criteria.

We do take exception to the comment that children in the study were 'human guinea pigs ... experimented on by the least experienced of the dental team'. The study had full Ethics Committee approval, complied to the letter with Good Clinical Practice Guidelines and above all, as with all our clinical research, the interests of the patient were held paramount. In addition, the majority of the practitioners in the study were principal GDPs in their practice and the rest were long standing associate GDPs; hardly the least experienced of the dental team! This type of ill-informed, emotive criticism is unhelpful in progressing discussion within the profession, on the management of dental caries in children.

N. Innes, D. Evans, D. Stirrups
By email

1. Innes N P T, Evans D J P, Stirrups D R. The Hall Technique; a randomized controlled clinical trial of a novel method of managing carious primary molars in general dental practice: acceptability of the technique and outcomes at 23 months. *BMC Oral Health* 2007; **7:** 18.
2. SDPB: Trinity Park House E. Scottish Dental Practice Board Annual Report 2001/2002. http://www.sdpb.scot.nhs.uk
3. Ricketts D N, Kidd E A, Innes N, Clarkson J. Complete or ultraconservative removal of decayed tissue in unfilled teeth. *Cochrane Database Syst Rev* 2006; **3:** CD003808.

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RETIREMENT CONCERN

Sir, I endorse the sentiments of Baroness Gardner, who is pointing out the undesirable fall-out of the GDC's decision to remove the 'retired dentists' registration list.

I have just retired from a career in both general practice and teaching. Whilst no longer doing any clinical dentistry I am involved with King's College London Dental Institute in an honorary capacity. I am also an examiner for Dental Nurses and Honorary Secretary of SAAD. To do these (unpaid) tasks I need to be on the Dentists Register. This means not only paying the full registration fee but I am obliged to achieve targets in CPD, including the core subjects which are irrelevant to me in my situation.

I understand that the Government has no objection to a retired list so would urge the GDC to consider it. The GMC lists retired doctors but they do not have practising certificates.

I would also urge retired dentists and those about to retire to contact the GDC, their MP, me or Baroness Gardner to express their concern in this matter.

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DRY SOCKET SECRETS

Sir, an interesting paper published as an abstract in the *BDJ* (**204:** 559)[1] discusses the relationship of cigarette smoking to post-operative complications from dental extractions among female prison inmates. The authors report that dry socket is increased following third molar extractions and surgical extractions but not specifically in smokers. I can concur with this finding.

My colleagues and I operate a dental service at Styal Women's Prison, where the majority of the women require several extractions and over 95% smoke.

From 1 April 2007 – 31 March 2008 out of 481 routine extractions and minor surgical procedures (364 by the author) there were seven post-operative complications, which could be classified as alveolar osteitis. Since the majority of women smoke post-operatively, diligently ignoring the written and verbal instructions given, we feel that this complication rate of 1.45% is lower than most published reports.

I feel that the major contributing factor to the development of dry socket is a traumatic extraction and any patient factors post-operatively have relatively little bearing on this complication. The extractions, although grossly carious and frequently infected, are relatively 'easy'. Interestingly despite 70% of the women being infected with Hepatitis C, with potential liver damage, no cases of post-extraction haemorrhage occurred during the year. We do, however, routinely place Alvéo-Penga[2] in all sockets, as recommended by the manufacturers; maybe this is the secret!

J. A. Speechley
Warrington

1. Heng C H, Badner V M *et al.* Relationship of cigarette smoking to post operative complications from dental extractions among female inmates. *Oral Surg* 2007; **104:** 757-762.
2. Alvéo-Penga – Pierre Rolland France.

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