1. Werner C W, Seymour R A. Are alcohol containing mouthwashes safe? *Br Dent J* 2009; **207**: E19.
2. Speight P. Summary of: Are alcohol containing mouthwashes safe? *Br Dent J* 2009; **207**: 488-489.
3. Warnakulasuriya S. Causes of oral cancer – an appraisal of controversies. *Br Dent J* 2009; **207**: 471-475.
4. Hyatt A T. Diminished, sidelined. *Br Dent J* 2009; **207**: 463.
5. McCullough M J, Farah C S. The role of alcohol in oral carcinogenesis with particular reference to alcohol-containing mouthwashes. *Aust Dent J* 2008; **53**: 302-305.
6. La Vecchia C. Mouthwash and oral cancer risk: an update. *Oral Oncol* 2009; **45**: 198-200.
7. Cole P, Rodu B, Mathisen A. Alcohol-containing mouthwash and oropharyngeal cancer: a review of the epidemiology. *J Am Dent Assoc* 2003; **134**: 1079-1087.
8. Winn D M, Blot W J, McLaughlin J K *et al.* Mouthwash use and oral conditions in the risk of oral and pharyngeal cancer. *Cancer Res* 1991; **51**: 3044-3047.
9. Lachenmeier D W. Safety evaluation of topical applications of ethanol on the skin and inside the oral cavity. *J Occup Med Toxicol* 2008; **3**: 26.
10. Lachenmeier D W, Gumbel-Mako S, Sohnius E M, Keck-Wilhelm A *et al.* Salivary acetaldehyde increase due to alcohol-containing mouthwash use: a risk factor for oral cancer. *Int J Cancer* 2009; **125**: 730-735.
11. Secretan B, Straif K, Baan R *et al.* A review of human carcinogens – Part E: tobacco, areca nut, alcohol, coal smoke, and salted fish. *Lancet Oncol* 2009; **10**: 1033-1034.

DOI: 10.1038/sj.bdj.2010.110

AN UNVIABLE APPROACH

Sir, I have followed the recent series of papers on the role of the dental therapist with interest. They describe attempts to follow a path trodden by the hygienists some years ago, when it was proposed to allow hygienists to set up independent practices. The laws allowing them to work without dentist supervision – and more importantly handle payments directly – were never passed. I do not remember any public debate as to why this never happened, but I suspect that when it was discovered that independent hygienists would charge the same to the patients as those working within a dental practice there was little incentive to allow full independence. The discussion of cost-effectiveness of therapists by the authors¹ goes over much the same ground. When the costs of the legally required nurse/chaperone are added to the low earning potential of a therapist working under NHS contract the whole concept of independent therapists becomes uneconomic. There is no way in which dentistry can be provided on the cheap in the UK by the equivalent of a third world 'barefoot doctor'; the regulations over how we deliver dentistry make this approach unviable. If

cost control to government and patient is a priority why not ask the profession how it can be done? I am sure that many dentists would welcome a full and frank discussion and help to create a system of dental care appropriate to current conditions.

S. W. White
Shanklin

1. Williams S A, Bradley S, Godson J H, Csikar J I, Rowbotham J S. Dental therapy in the United Kingdom: part 3. Financial aspects of current working practices. *Br Dent J* 2009; **207**: 477-483.

DOI: 10.1038/sj.bdj.2010.111

FAMILIAR FORCEPS

Sir, I have been interested in the advert you published recently regarding a new line of dental forceps – 'Physics Forceps from General Medical'. What fascinated me the most was the claim that these forceps were a revolutionary design using a beak and buffer principle. But are they?

Now it is a fact that I have been involved with the dental world for several decades, and casting my mind back I cannot help but notice the similarity of this revolutionary design to the robust and reliable pelican noted for its use in Cromwell's day, and also in Hampton Court some years before that to deprive Good Queen Bess of yet another troublesome tooth. All more than 400 years ago.

The Physics Forceps also bear a very close resemblance to the well known and equally robust dental extractor – the 'Tooth Key' both of which instruments also use the by now familiar beak and bumper design. If you ask the curator of the BDA Museum nicely she will no doubt show you examples of both types.

Perhaps it is well that copyright only extends for 50 years after the designer's death. Or is it possible that somewhere in an English field there lays the body of a well known tooth-puller to Lord Protector Cromwell? Maybe the marketplace tooth-puller feeling spiteful at being deprived of his 5% for the last four centuries, will arise from his grave at midnight, vampire-like, and pursue all those colleagues of mine who forgot to pay the 5% to original designer of these useful but rather outdated dental tools.

But, to those of my colleagues who have purchased these interesting Physics Forceps, and have been foolish enough not to pay the dental phantom, be warned, do not whistle at midnight under a full moon, or even cross the Grimpen Mire at night.

P. Jeavons
Sheffield

DOI: 10.1038/sj.bdj.2010.112

SPIRALLING COSTS

Sir, we know that payment of a retention fee to the General Dental Council is mandatory. I did, however, enclose with it a note asking where the money was being used.

They have at least responded with a letter from a 'Process improvement Co-ordinator'. Thirty-eight percent of their 2008 expenditure was utilised on fitness to practise activity. I do therefore wonder whether the other 62% was merely used to maintain an expensive office!

To make matters worse, I now have an annual retention fee notice from the General Medical Council for £410.00. When first registering with the GMC, this was agreed to be a 'one-off payment'.

I do wonder where this is all spiralling. Perhaps you will publish my concerns, in order that colleagues may have the opportunity of joining with me in a response to these now non-professional bureaucracies.

B. Littler
Chelmsford

DOI: 10.1038/sj.bdj.2010.113

CAVALIER ATTITUDE

Sir, over the years I have prescribed Adcortyl in Orabase (triamcinolone acetonide 0.1%) for patients with recurrent oral ulceration. More recently it has been available as an 'over the counter' medicine.

I have been told by a number of patients that it is no longer available as it has been withdrawn. They could obtain no further information.

This prompted me to make enquiries on their behalf. I visited the DPF website where Adcortyl in Orabase is still listed.

I then contacted the manufacturers, Squibb Pharmaceuticals, who informed me that it had been withdrawn for 'commercial reasons'. When I asked how that

left patients who had used this product to their benefit for many years, and myself as a practitioner, no longer able to prescribe or recommend it, I was told that this was a matter of 'clinical judgement'.

I requested the name of their medical director so I could pursue this to be told that Squibb had a 'no names policy'; this also applied to the name of their chief executive, although presumably this has to be in the public domain.

To withdraw a medicine when no comparable alternative is available, not on grounds of safety nor efficacy, but solely for commercial reasons, seems to display a cavalier attitude to patient well-being and this from a company whose mission is 'to extend and enhance human life'. To do so behind a cloak of anonymity adds a further unacceptable dimension.

This example raises fundamental ethical principles relating to drug companies as to what is acceptable when commercial imperatives appear to outweigh the needs of patients.

In view of the implications perhaps the BDA could consider an approach to the Medicines and Healthcare products Regulatory Agency (MHRA) to clarify the issues involved.

G. Feaver
London

DOI: 10.1038/sj.bdj.2010.114

INTERNET CAUTION

Sir, I read with interest the article *Dental patients' use of the Internet*.¹ I would like to reinforce the need for patients to be cautious about information available online by briefly discussing a condition called Neurocutaneous Syndrome, NCS, which I was recently made aware of.

NCS is described as 'a newly discovered toxicity disorder' and is 'characterized by neurological sensations, pain, depleted energy and memory loss as well as itchy cutaneous lesions'. The diagnostic criteria for NCS seem to consist of only two aspects. One, that the patient has NCS symptoms and two, that one or more teeth are restored with a 'toxic' material.

Online² there is a large amount of information including eight published articles (62 pages). There are significant claims, related to NCS, such as:

- 'Oral symptoms especially gum disease, occur nearest the damage area and should not be surprising. They are caused by either toxic dental materials or by secondary bacterial infections.'
- 'This epidemic-in-disguise has been routinely misdiagnosed by medical professionals who often label patients as delusional.'
- Over 400 dental products are listed as '*causative agents*' and '*are now recognised as toxic*'. The list of 'toxic' products reads almost as an inventory for a dental surgery. Examples include Dycal, Life, Sealapex, Prime and Bond, Temp bond, Zinc oxide products, light cured dental composites, gutta percha, prophylactic paste and Aquasil to name but a few.

NCS as a condition is not evidence-based medicine. The evidence so far presented has been of poor quality with several discrepancies. The highest levels of evidence presented are case studies and opinions, which are the weakest levels of evidence,³ level 3 and 4. All the publications are produced by a single author. Furthermore all but one are published in the same non-dental journal, with the only one in a dental journal, triggering a flood of critical letters.⁴

The case studies have numerous discrepancies, for example, the first case study in the most recent publication describes NCS symptoms in a patient. The author diagnoses NCS on the basis that she had dental work completed in 1982, 20 years before any symptoms developed. However 'blood biocompatibility test results are not available to date' and the author lost contact with the patient before dental rehabilitation was started. It seems that all the author has done is to describe a case where a patient with a dermatological complaint had fillings.

From the information available I can understand why a patient would be concerned about this condition, and present to their dentist requesting removal of their fillings.

Biocompatibility issues are a recognised complication and can produce systemic presentations⁵ but I feel the claims

of the existence of this condition and the proposed treatment of dental rehabilitation by removing all fillings is not justified given the current lack of a significant evidence base.

R. Holliday
Edinburgh

1. Ni Riordáin R, McCreary C. Dental patients' use of the Internet. *Br Dent J* 2009; **207**: 583-586.
2. Parasitology Center Inc. <http://www.parasitetesting.com/>
3. Scottish Intercollegiate Guidelines Network (SIGN). *SIGN 50, a guideline developer's handbook*. 2008.
4. Readers sound off (letters). *CDA J* 2004; **32**: 956. http://www.cda.org/page/Library/cda_member/pubs/journal/jour1204/feedback.pdf
5. van Noort R. *Introduction to dental materials*, 2nd ed. Mosby, 2002.

DOI: 10.1038/sj.bdj.2010.115

THE NHS REALITY

Sir, in relation to your editorial *No going back* (*BDJ* 2009; **208**: 45), the NHS was dreamt of as being free at the point of delivery and yet over time patient charges have been steadily increasing. Patients now pay a much bigger share of dental fees and this is not NHS dentistry other than in the imagination of Department of Health (DoH). In reality it is actually a very cheap form of private dentistry forced upon the profession by dictatorial bullying. Perhaps I am unduly harsh but I believe that if the politicians were actually interested in the nation's dental wellbeing, they should have purchased essential treatment at reasonable prices. Good quality examination and treatment planning leads its way to appropriate treatment. Most dental professionals would be solidly behind such an honest service.

I see new graduates coming in for job interviews and their first question usually is to enquire about the potential for private practice. The DoH can bring in as many figures as they wish but the reality is as you write 'no going back'. There is a trend away from NHS dentistry which seems to be developing momentum slowly and quietly. I congratulate you for noting this in the way that you have.

I. A. S. Syed
By email

DOI: 10.1038/sj.bdj.2010.116