Letters to the Editor

Send your letters to the Editor,
British Dental Journal,
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Email bdj@bda.org

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

SURPRISING FERVOUR

Sir, the letter *No to BDA* (*BDJ* 2010; **208:** 379) raises some very important points and I am grateful to the authors for so candidly expressing the views of their collective memberships.

I have listened to much debate in the BDA's Executive Board and Representative Body on the subject of broadening the membership of the Association. These discussions generate strong feelings on both sides, but the one feature that is common is the total respect and recognition of all the members of the dental team. The BDA is very supportive of the DCP organisations and is on record as encouraging all professionals to join their own professional body. Whether or not the BDA opened its doors to other groups, I think this would remain our position as we recognise the important individual needs of particular groups. So, given that broader membership would merely give DCPs the freedom of choice to join, in addition to their own body, I am rather surprised by the fervour of this broad rejection of such a move even before it has been offered.

Still it is very helpful to have this information. From the mandated leaders and spokespeople of 50,000 dental care professionals, the message to the BDA is received and understood. I hope the individual dental care professionals who have expressed slightly different views will understand why this issue has been so complex.

On a point of clarification, the BDA does not offer professional indemnity cover and has no intention to do so. We believe that it is an important and complex field of activity that is better delivered by specialists in that area with a proven track record.

P. Ward, BDA Chief Executive
DOI: 10.1038/sj.bdj.2010.452

NOT THE ARGUMENT

Sir, Professor Paul Wright (*Long term short cuts; BDJ* 2010; **208:** 241) sets out very clearly the difficulties facing academic dentistry which are easy to understand and which present a real danger to the standards of education of dental students.

It is clear that in many respects the position of dental academe is unique. However, Professor Wright's claim that 'Higher Education in dentistry is one of the few university disciplines that can truly be said to provide public and economic benefits to the nation' is decidedly not the argument to use in order to convey these difficulties to those who might help to address them. Indeed, I imagine such a statement will hardly commend itself to Professor Wright's Vice-Chancellor; it doesn't to me even as a sympathiser!

R. Bettles
By email
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ORTHODONTIC STIMULUS

Sir, the aetiology of malocclusion in modern human populations remains an intriguing, complex and important facet of both academic and clinical areas of interest. It is not the only subject in orthodontics that presents conflicting data, conclusions, and the need for continual updating in response to new knowledge in the applied and basic scientific community within and beyond the dental profession. And certainly not the only compelling subject in orthodontics that deserves serious revisiting in view of the relatively recent paradigm of inculcating evidence-based information in the orthodontic specialty and dental profession at large. Dental editors have a profound and often unappreciated role in identifying such areas that might have far reaching and consequential effects upon individual patient care. Even more difficult is their task of finding capable and willing contributors to any appropriate journalistic or congress formats that might draw enthusiastic interest from our dental colleagues. The demand for no less than a 'debate' on this subject assumes that such a format is currently the most desirable and feasible vehicle of communication for exploration of the role of epigenetic and genetic contributions to malocclusion in modern civilisation. The initial challenge (after appropriate vetting of potential areas of dental interest), therefore, is to avoid unnecessary adversarial and often circus like presentations that discourage participation from interested communities and distracts us from our real purpose as clinicians, educators, researchers, editors, and dental congress programme designers. It is hoped that Dr Mew's letter will serve as a stimulus to the global community of dentistry and orthodontics to more seriously and robustly explore the importance of the aetiology of malocclusion in the formats of dental and orthodontic postgraduate curriculum, research, dental publications, and lecture presentations at our many dental meetings.

E. M. Moskowitz
New York
DOI: 10.1038/sj.bdj.2010.454

A CAUTIOUS APPROACH

Sir, I am currently working in an oral and maxillofacial surgery department of a district hospital where we are receiving progressively larger numbers of referrals of patients on bisphosphonates for extractions.

In light of current guidelines and research,[1,2] we explain to patients the variable risk of bisphosphonate osteonecrosis of the jaws associated with extraction. We advise the benefits of attempting the non-surgical approach first such as RCT, decoronation or review and monitor the tooth.

I write to point out to dental colleagues the importance of initially undertaking the non-surgical treatment options, particularly with patients who were or are given intravenous bisphosphonates.

I also write to raise awareness among our medical colleagues of this risk when initially prescribing bisphosphonates. The patient should be advised to visit the GDP for an assessment prior to commencing treatment to consider possible extraction of teeth of poor prognosis. It should be pointed out to patients that it would be desirable to inform the dentist of the details of their treatment.

To conclude, until further data are present, one should take a cautious approach when considering extractions for patients on bisphosphonates, particularly via the intravenous route if given for other reasons than osteoporosis.

S. Girgis
Sidcup

1. Arrain Y, Masud T. Recent recommendations on bisphosphonate-associated osteonecrosis of the jaw. *Dent Update* 2008; **35:** 238-242.
2. McLeod N, Davies B, Brennan P. Management of patients at risk of bisphosphonate osteonecrosis in maxillofacial surgery unit in the UK. *Surgeon* 2009; **7:** 18-23.

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1948 CLUB

Sir, I entered the NHS on July 5 1948. I am curious to know if there are others still about who did the same, and would they get in touch with me with a view to forming a July 5 1948 club.

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CRASS HOOTS

Sir, the points made by the microbiologist patients J. M. Ewart and A. A. Jack in their letter *Crass advice* (*BDJ* 2010; **208:** 243-244) are well drawn. They rightly underline the vexing point of cost, ultimately to their patient, but then the NHS administrators presumably have to justify their salaries somehow.

Considering further the need for the sterilisation of instruments to be used in a non-sterile setting, I do recall at various points in my career that at least part of the reason for having hydrochloric acid in one's stomach was to kill off pathogens and that intact skin/mucous membranes were also a defence against them. I am sure I am not the only dentist to pick up pieces of food which I have inadvertently dropped onto a microbiologically dubious floor and carried on eating it - and have done so since childhood.

Crass advice made me laugh, my socks eventually falling off when I realised the letter was in an issue of our Journal otherwise largely devoted to *Evidence Based Dentistry*.

R. L. Bartlett
Emsworth

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INCONGRUOUS AT BEST

Sir, I read Dr Benson's article on cleaning cheek photographic retractors with interest (*BDJ* 2010; **208:** E14) and especially the comments about infection risk being akin to 'restaurant cutlery items'.

As a partner in two dental practices (and a taxpayer), it does worry me that washer disinfectors seem to be inevitable which could cost the dental profession (and taxpayer) perhaps £50 million. For example, one dental practice for every 10,000 patients equals 6,000 practices at £4,000 per washer disinfector equals £24 million, then there are the extra equipment costs etc. Let's say £50 million.

As we are disposing of all instruments that enter root canals, I feel that the overall purpose of washer disinfectors must be to remove debris (in a non-manual ie improved health and safety manner) and *I suppose* disinfect prions although as we are disposing of the presumed predominant source of prions (intra-canal instruments) after single use I am unsure if washer disinfectors should be designed with this in mind? An alcohol wipe or even an ultrasonic seems a distinctly lightweight way to remove debris - surely dishwashers do better than this?

I then contacted Dr Benson who informed me that this research had already been done and that research from 1995 indicates that dishwashers are quite effective. He also kindly attached the article while making the valid point that dishwashers do not have print-outs to validate cleaning cycles.

I suppose my main point is that I wonder if the Great British public would be particularly enamoured with the dental profession for spending this amount of money with the potentially vanishingly small health returns relative to perhaps spending £50 million on implants for a lower retained denture. To pick but one example, let alone relative to bullet-proof vests in Afghanistan or the national debt... In addition, the idea of wandering out of the dentist's, post-filling and eating at the local restaurant one hour later with 'relatively' unclean cutlery seems well, incongruous at best.

In short (perhaps in conjunction with further scientific research) a relatively ordinary dishwasher with cycle validation software followed by an autoclave may be an acceptable solution generally for dentistry in conjunction with one-use intra-canal based instruments. Maybe?

S. Cove
By email

DOI: 10.1038/sj.bdj.2010.458

REGULATORY FARCE

Sir, we write in response to the letter of H. Beckett (*BDJ* 2010; **208:** 273-274).

The article by Patel, Kelleher and McGurk (*BDJ* 2010; **208:** 61-64) simply sought to point out that low concentration hydrogen peroxide has a valuable, safe and historically proven role in surgery around the head and neck region.

The continuing UK regulatory controversy about its use for dental bleaching by trained professionals is not based on any known safety issues, but rather on ill-conceived regulatory ones.

The safety of dilute carbamide peroxide, which releases about one third of its volume as hydrogen peroxide, has been examined exhaustively and has been proven to be safe, as our list