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.

DOI: 10.1038/sj.bdj.2010.455

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.

Hugh V. Capstick
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DOI: 10.1038/sj.bdj.2010.456

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 under-

line 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

DOI: 10.1038/sj.bdj.2010.457

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 disinfectant 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