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.

Hugh V. Capstick
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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 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

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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 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

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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

of references shows. To the best of our knowledge, no UK dentist has ever been successfully sued for utilising night guard dental bleaching when informed consent has been obtained. Dental bleaching itself has never been illegal as the Chief Dental Officer for England has stated. Rather the UK government wants to regulate dental bleaching products under their particular interpretation of a European Directive.

While for the government this rather embarrassing regulatory farce continues, dentists are wise to remember that irreversible and destructive alternatives such as veneers, crowns or post crowns are not nearly as safe as dental bleaching. The irony is that the ledgers of the defence organisations are peppered with dentists being sued for the adverse outcomes of these destructive procedures used to manage discoloured teeth, especially when informed consent has failed to cover the safer option of dental bleaching.¹

V. Patel, M. Kelleher, M. McGurk
London

1. Kelleher M G D. The 'Daughter Test' in aesthetic ('esthetic') or cosmetic dentistry. *Dent Update* 2010; **37**: 5-11.

DOI: 10.1038/sj.bdj.2010.459

NO RESPONSE

Sir, I welcome your editorial devoted to the problem of the future treatment of the edentulous and its reference to my recent paper in your Journal.¹ That paper not only showed the reduction in teaching and experience available to current undergraduates, but also reported the view held by respondents to the questionnaire that official checks and balances, which should be provided by officialdom, such as GDC visitations, were failing to ensure that GDC guidelines are being met.

Subsequent to publication of the paper, I sent electronic copies to a number of organisations that should be concerned by the reported findings, such as the Minister of Health, the Conservative shadow health spokesman, and two different GDC email addresses with a request that copies be sent to all members of GDC. Initially no response was received from any of them. Then a chance contact with my local parliamentary candidate

prompted an acknowledgement from the Conservative shadow for dentistry, but offered no further consideration until after the general election. Subsequently, I sent a hard copy by recorded delivery to the Chairperson of GDC. I have not had an acknowledgement from her either.

This does not bode well for the future treatment of this unfortunate group of patients.

R. Clark

1. Clark R K F, Radford D R, Juszczak A S. Current trends in complete denture teaching in British dental schools. *Br Dent J* 2010; **208**: E10.

DOI: 10.1038/sj.bdj.2010.460

NONSENSICAL SUGGESTION

Sir, I refer to your editorial *Beware the irony of the humble full-full* (BDJ 2010; **208**: 327) and in this context wish to point out the foolishness of the GDC policy of refusing the reduced fee registration for retired practitioners. In 45 years of making dentures I have probably done more than any of today's recruits would find to do in several centuries. This wealth of practical experience is just thrown away because of the excessive cost of full registration and insurance required merely to teach voluntarily or for a modest honorarium. In making full prostheses there is no substitute for practical experience and passing that on should be a priority. Instead it is ridiculed and cast aside. The nonsensical and unsafe modern suggestion that impressions for full dentures should be taken with the patient supine demonstrates the point very well.

A. Carmichael

By email

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