carry out a crown preparation of an LL7. The first block did not take fully so therefore I placed a second block which was placed higher.

As half the anaesthetic went in the patient complained of double vision and flashing lights which turned from being dark purple to a light purple haze.

I immediately stopped the injection and tried to reassure the patient. On examining her right eye, the eye was looking mesially, possibly compensating for blocking one of the nerves to the left eye muscles.

I was wondering if anybody else has had this phenomenon with colour and flashing lights. I was under the impression that the optic nerve was involved in vision and I was not aware from doing anatomy many years ago that a dental anaesthetic could block this nerve! In fact I feel there must be another reason why this occurrence happened. We carried on with the crown prep after reassuring the patient and after 15 minutes things settled back to normal.

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DOI: 10.1038/sj.bdj.2010.633

TOOLKIT PROCEDURES

Sir, I would like to comment on the recent paper *Caries control in health service practice* by Page *et al.* (BDJ 2010; 208: 449-450), concerning the guidelines in the DH Oral Health toolkit.

My NHS practice is predominantly concerned with the treatment of children. I have been following the toolkit guidelines, including the application of fluoride varnish twice a year to most 3-18-year-old patients, including those at low risk of caries and more frequently to those patients at high risk. At the same time I have been attempting to follow the NICE guidelines on oral health assessments for low risk young patients, increasing the time intervals to nine months or a year, as recommended.

1. I have found that parents seem to appreciate the additional preventative measures provided for their children
2. The authors of the paper are correct, it takes longer to carry out the examination, oral hygiene instruction, cleaning and the

varnish application for these patients. The treatment schedule is slowed, so that for the first time since 2006 I have missed my UDA target by about 10%. Unless I have a sympathetic PCT, it is likely that my NHS income will be similarly reduced. In addition, additional costs have been incurred for materials

3. Fewer band 2 treatments are being carried out, either because the varnish is preventing decay, or because of the slow down in treatment times. Again, it becomes harder to reach the UDA target
4. For low risk patients, the NICE recall and the DH toolkit guidelines cannot be reconciled. For example, say a nine month recall is appropriate, then:

Month 1	Assessment and varnish
Month 6	Varnish
Month 9	Assessment
Month 12	Varnish
Month 18	Assessment and varnish
Month 24	Varnish
Month 27	Assessment
Month 30	Varnish.

The NICE recall assessment guidelines were issued in 2004, long before the oral health toolkit recommendations. NICE therefore needs to review its guidance, to ensure there is no conflict

5. Further to the above, the NHS claim form has recently been amended to include a box which has to be completed stating that the dentist has complied with the NICE guidelines and provided all necessary preventative treatment. If the guidelines cannot always be reconciled, how can the box be completed?
6. In view of the doubts expressed in the recent paper concerning the cost effectiveness of applying fluoride varnish to low risk patients, perhaps NICE should review this new procedure, before it is widely implemented.

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DOI: 10.1038/sj.bdj.2010.634

BRIDGING THE GAP

Sir, We would like to share our experience as an oral and maxillofacial surgery

(OMFS) Senior House Officer (SHO) and a Specialty Trainee Doctor in Paediatrics.

As stated by Harris *et al.*,¹ dental professionals as well as those committed to paediatric dentistry find child protection to be a difficult and challenging area of work with a need for improved child protection training for dental professionals.

OMFS SHOs around the UK are regularly exposed to a considerable number of cases of facial and dental trauma in paediatric patients during on-call duties, often covering several hospital sites. Emergency departments can experience extremely busy times and although in most cases children are initially assessed by experienced nurses and doctors, on occasion OMFS SHOs are the first health contact. For example, expected admissions from peripheral hospitals and out-of-hours dental referrals bypass initial triage. In these cases the responsibility for assessing child protection lies with the on-call OMFS SHO. But are we well prepared for that?

Within these circumstances, we write to remark how crucial child protection awareness is, the need of establishing good rapport with the child in order to extract first hand information and a comprehensive history taking including a detailed family and social history. A systematic facial and dental examination and high standard of record keeping are also valuable in identifying or alleviating concerns.

Our observation is that oro-dental examination is often poorly documented and not comprehensively referred by emergency department staff. As a paediatric doctor working in a children's emergency department, I have seen first hand that basic dental knowledge is lacking from both adult and paediatric doctors.

In these clinical settings, how many times are children seen by professionals who are not appropriately trained to assess child protection? How often do people ask for help in this matter or know the appropriate referral pathway? Who should have the responsibility in ensuring a child is in a place of safety and has not been subject to abuse?

Although child protection training in secondary care is regularly offered to all staff in contact with children, the regulation of this is well overseen in paediatric

ric medicine but may be lacking in other departments. Perhaps specific courses should be included in OMFS SHOs' induction programmes, thus becoming a uniformly mandatory requirement. We think that an appraisal system for dentists should be implemented to help identify gaps in knowledge and training as occurs in paediatric specialist training on an annual basis. Some basic dental training would also be beneficial for at least emergency doctors. In terms of management, we believe that in cases of facial and dental trauma each child should be jointly shared with the paediatric medical team.

Finally, as per GDC principles,² dental professionals are expected to find out about local procedures for child protection and to follow those if child abuse is suspected. We suggest the 'Child protection and the dental team' website (www.cpdt.org.uk) by the Department of Health as a great educational source.

Aitor de Gea Rico
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1. Harris J C, Elcock C, Sidebotham P D, Welbury R R. Safeguarding children in dentistry: 1. Child protection training, experience and practice of dental professionals with an interest in paediatric dentistry. *Br Dent J* 2009; **206**: 409–414.
2. General Dental Council. *Standards for dental professionals*. Principle 1.8. London: GDC, 2005.

DOI: 10.1038/sj.bdj.2010.635

DENTAL PENSIONERS

Sir, I note Hugh Capstick's letter *1948 club* (*BDJ* 2010; **208**: 440) suggesting the formation of a club for those who entered the NHS on founder's day, July 5 1948.

As a potential candidate may I ask what he has in mind? A sort of dental Chelsea Pensioners with all conventional benefits?

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DOI: 10.1038/sj.bdj.2010.636

POLARITY OF ATTITUDE

Sir, I read your recent editorial 'Research and the axe factor' (*BDJ* 2010; **208**: 547) with interest and particularly found pleasing your acknowledgement that a past editorial 'Asking the right questions' could have been phrased differently.

However, your current editorial uses the phrase 'ivory-towered academics'

which suggests some kind of deliberate strategy and which incidentally involves a slight on perhaps one arm of the profession. Alternatively you may be reflecting a real polarity of attitude which exists between those directly in contact with the general public, namely the general practitioner, and those whose main interests lie in research of any kind and teaching.

My own experiences as a general practitioner and a long-term elected past member to two national committees while engaged in my own research programme gives some evidence to support the conclusion of the latter alternative.

Your current editorial, quite properly, makes a strong case for research to relate to the everyday events of dentistry and particularly with the behaviour of a subset of the population. The behavioural sciences have over a long period attracted the studied attention of some dentists, psychologists and sociologists who in their day have attracted unkind remarks from those who have seen dentistry as only being concerned with the dental and medical tissues. It is comforting to see the general acceptance of the fact that teeth are attached to people and that what people think of their teeth is of crucial importance. Many of these belief systems can now generally be understood and acted upon, bringing acceptance to forms of treatment which were not available to these patients in the past.

However, attitudes and belief systems are subject to change over the life cycle of the individual and throughout the generations. The scientific approach when determining these factors must of necessity be different to those which investigate the fundamental nature of the dental tissues, their structure, composition, biochemistry, genetic constitution, etc. There must surely be a respectable place in our profession for those whose work this is and who have the ability to communicate their findings and basic knowledge easily to others, and through necessity to each other, and, just as crucially, with those working in other disciplines.

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DOI: 10.1038/sj.bdj.2010.637