Letters to the Editor

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

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LETTERS

RVG GLOVE

Sir, obtaining an intra-oral periapical radiograph (IOPA) is a routine procedure in general dentistry. Today most dental practitioners use radiovisiography (RVG) sensors for this. During use, radiographic equipment can become contaminated with patient blood and/or saliva if aseptic techniques are not practised well. RVG sensors are covered by plastic sleeves for the purpose of cross infection control (Fig. 1a). It has been observed that the corner of the plastic sleeve covering the RVG sensors generally hurts patients, especially while taking mandibular posterior region radiographs. These plastic

sleeves are loose and difficult to hold in place, especially in geriatric and paediatric patients. To overcome this problem we have tried an innovative method of using the finger of a glove to cover the RVG sensor, which fits snugly on the RVG sensor and is not painful since the glove doesn't have sharp corners (Fig. 2). In our practice we have found use of the glove covering the RVG sensor very satisfactory. Also use of the glove is economical when compared to plastic sleeves.

R. S. Desai, S. Shetty, H. Shetty, Mumbai
T. V. Narayan, Bangalore
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NHS ASTONISHMENT

Sir, thank you for publishing the paper by R. Patel *et al.* (BDJ 2011; 211: 133-137) regarding the numbers of EEA dentists working in the UK. I qualified in the UK and worked in the NHS for eight years before entering wholly private practice prior to the introduction of NHS performer numbers. Despite my many years of experience I am unable to return to the NHS as vocational training did not exist when I qualified and I am therefore unable to obtain a performer number.

It is astonishing that an EEA dentist can obtain a performer number and work in the NHS without any vocational training and yet I am unable to do so.

As to the standard of training of dentists in the EEA which is outside the remit of the GDC, we know there is no equivalence as the paper states. The European Union permitted free workforce movement before the harmonising of undergraduate dental education and the results are much like the crisis facing the Euro common currency pulled

apart by the differing economies of the EEA states.

An EEA dentist new to these shores requested information from my dental laboratory on how to make dentures for a patient as it was not part of their training. So we have the situation where a UK qualified dentist with many years' experience is not permitted to work for the NHS, but an EEA dentist who may/may not communicate in good English and may/may not have any experience is welcomed. Can anyone tell me who is protecting the patients?

But then common sense was never a strong part of the EU, and even less in the NHS.

V. Chan

By email

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CALLING DISABLED DENTISTS

Sir, I qualified at Leeds University in December 1983 making me ... ancient! I've worked in various parts of the country and southern Spain for three and a half years. At one time I worked six days a week, although I found working on a Saturday not too successful if it clashed with an important rugby or football match. I left dentistry for a few years to go to drama school and fulfil my passion of becoming a musical theatre actress but the lure of a comfortable income was strong and I returned to 'drilling and filling' (the contract was very different in those days). My stage-work continued in an amateur capacity.

My self-centred life changed dramatically from 1996 when I was diagnosed with Hereditary Spastic Paraparesis (HSP) which is a slowly progressive neurological disorder affecting my

Fig. 1 a) RVG sensor covered with plastic sleeve; b) RVG sensor covered with the finger of a glove

Fig. 2 RVG sensor covered with the glove placed inside the patient's mouth

lower limbs. I now work just outside York in a busy group practice and have had to reduce my hours to four mornings and one afternoon each week and, luckily, no adaptations are needed in the surgery. The practice owner has 'choreographed' the use of the surgeries meaning that I can work mostly in a downstairs surgery. This really helps because I find stairs difficult to climb now and I'm unable to walk without walking aids. I receive 'disability living allowance' which helps with daily activities and a tax reduction for alternative therapies/complementary medicines.

I would really like contact from other members in a similar situation with a view to receiving some advice and support – largely financial advice and that of moving away from general practice to a more suitable branch of dentistry. If you can offer any help please email me at laubran11@hotmail.com.

Laura Branigan, York

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DOES IT WORK?

Sir, in his letter Mr Imran (*BDJ* 2011; 211: 245) states that I am 'out of touch' and unaware of the NICE guidelines which state that evidence by experience is the least valid of all evidence levels.

I invite Mr Imran to consider that my experience has taught me that the commonest cause of post-operative sensitivity subsequent to an amalgam filling is the failure to use a non-irritant lining of adequate thickness to protect the pulp from thermal changes. Does Mr Imran dispute this? Can my experience be the least valid of all evidence levels?

There is so much verbiage these days. For me 'evidence-based' means 'does it work?' I am reminded of the statement 'the operation was successful but the patient died!'

I accept that where the removal of all the carious dentine would probably produce an exposure, then a wash of calcium hydroxide underneath a non-irritant lining can be very effective. This is because calcium hydroxide has a very alkaline pH of 13.8 which is inhibitive for the cariogenic bacteria. A note is then recorded that the filling should be replaced in two years' time.

Secondary dentine thus stimulated to form will permit further excavation of any residual caries without exposure of the pulp. Invariably the tooth will remain vital.

Regarding the application of Duraphat varnish to the perimeter of the cavity, the rationale behind this is that amalgam is the only filling material that advantageously expands when it sets. As it does so, the varnish is squeezed out and replaced by the amalgam, making a more effective seal with the tooth.

A. E. Castle

By email

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WELL EQUIPPED PATIENTS

Sir, I welcome the findings of the *British Dental Journal's* recent report *Oral health awareness in adult patients with diabetes: a questionnaire study* (*BDJ* 2011; 211: E12), which makes the clear and unequivocal link between gum disease and a number of systemic diseases, specifically diabetes and cardiovascular disease. I have long been working to raise awareness amongst our patients and students that good gum health equates to good general health, and this study is a significant step in the right direction towards spreading this message.

As the BDA rightly notes, the development of a new, outcomes-focused contract in England should enable dentists to adopt a more preventative approach to care. Successful outcomes should be measured by the number of clinical interventions we have prevented, rather than undertaken. However, in the spirit of the new NHS, and indeed the mantra of the new government, it is vital that our patients take responsibility for, and ownership of, their gum health. As the survey accurately notes, awareness of the association between gum health and diabetes amongst those with the long-term condition is shockingly poor.

Our own research shows that periodontal specialists and general dental practitioners are equally concerned about the wider health implications of periodontal disease for their own local health economy. The majority (80%) of respondents in a recent survey reported