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