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

concern, particularly around diabetes and heart disease.[1]

In light of this renewed drive towards preventative healthcare in the UK, combined with the burden of periodontal disease on our ageing population, treatments that allow for proactive patient self-management of this condition should be welcomed by patients and dentists alike. It is imperative that I continue to strive to educate patients on the signs and symptoms of periodontal disease and ensure that they are well equipped with the necessary self-management techniques for effective preventative homecare.

H. Mostafa
By email

1. Mostafa H. Survey of 66 periodontal specialists and general dental practitioners conducted in September 2011.

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AN ADVISED CHOICE

Sir, many GDPs look at some point in their career to the possibility of studying for a postgraduate qualification. This journal is full of adverts trying to catch the eye of the dentist looking to enhance their skills, develop their practice or reinvigorate their career. This was a path I took when I committed to a part time MSc at the University of Edinburgh. I looked to this opportunity to learn new skills and provide a stimulating challenge. Unfortunately the course failed to live up to my understandably high expectations. I left after two years, comfortably passing the diploma, but deciding against taking the qualification further due to my dissatisfaction. The course floundered under a weight of poor planning and organisation, with fundamentals, such as the need to provide feedback, being ignored.

I write this letter not to discourage my colleagues from this path, but to encourage them to enter into postgraduate education with their eyes open. The University of Edinburgh is a very highly regarded institution with an international reputation; however, the nature of the rewarding body is clearly no guarantee of course quality. I would advise my fellow dentists to do a substantial amount of research before committing to a course, questioning levels of support that they should expect and analysing the timetabling of any coursework they will be required to complete. In my experience it is easy to describe a course as, 'PT and modular, being ideally suited to the busy GDP', while failing to recognise even the most obvious commitment, such as being sympathetic to a parent's need to take holidays at fixed times.

I would like to think that my problems were very much the minority; however, I hope my words will allow anybody interested in this career opportunity to make a more advised choice. Further details can be found in my course review on the Hotcourses.com website.

S. Steven, Edinburgh

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DISEASE RISK

Sir, recently there has been a paradigm shift in our understanding of periodontal disease. The current consensus is on a risk based approach in evaluating patients for periodontal disease and subsequently for its treatment.

The American Academy of Periodontology has devised a simple tool for the general public to self assess their periodontal risk. It can be accessed by the general public on their website at http://www.perio.org/consumer/4a.html

It contains a set of 12 questions and once answers are submitted, a proprietary calculation determines the individual's risk for periodontal disease. It categorises the risk into low, medium or high and generates a report. This Periodontal Disease Risk Score and the information contained in the report is intended to help educate patients about common risk factors related to periodontal diseases and to assist in the decision of when referral to a periodontist would be advisable.

It is surprising that the British Society of Periodontology does not have a periodontal risk assessment tool for the general population and their website refers patients to the American Academy of Periodontology website (http://www.bsperio.org.uk/patients/) for extensive information.

Z. Imran, Dundee

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