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.

COMPARATIVE CARIOGENICITY

Sir, I was saddened to find that the red herring of intrinsic and extrinsic sugars and their comparative cariogenicity appeared once again in the paper *A comparison of the nutritional knowledge...* (*BDJ* 2011; **210:** 33-38).

The report of the Committee on Medical Aspects of Food Policy, 'Dietary sugars and human disease', has been responsible for much confusion in the delivery of diet advice since it was published in 1989. The myth that intrinsic sugars are somehow less potentially damaging to the dentition than extrinsic sugars was debunked by I. Hussein, M. A. Pollard and M. E. J. Curzon in *A comparison of the effects of some extrinsic and intrinsic sugars on dental plaque pH* (*Int J Paediatr Dent* 1996; **6:** 81-86). The most sensible advice to give patients is to avoid eating between meals as all snacking has the potential to cause either caries or obesity.

I. Kirk
Wirral

The lead author of the article, Dr Maria Morgan, responds: I would like to thank the correspondent for their interest in the article. But I and my colleagues would like to emphasise that we referred to the COMA report 'Dietary sugars and human disease' as part of the guidelines that are in current use. It was not our intention to focus in on non-milk extrinsic sugars and intrinsic sugars per se. *We would agree with what the correspondent says about snacking, that for the general population snacking should be kept to a minimum, but there will be some instances where smaller frequent meals are indicated for specific nutritional concerns. I hope this clarifies things.*

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COMPLAINANTS WANT CASH

Sir, I would strongly encourage *BDJ* readers not to be misled by your dental news headline 'Most complainants just want an apology' generated by the Parliamentary and Health Service Ombudsman (PHSO). Sixteen years of instructions in preparing liability and causation reports leads me to believe – as far as clinical matters are concerned – that complainants want money.

Aggrieved dental patients are quick to find out that complaining to a PCT, GDC and PHSO will, if upheld, not involve compensation for general and special damages. As a result they immediately consult a personal injury solicitor through the internet. The solicitor or their instructed expert will then take a view. The result is that approximately 75% of the matters complained about are completely without merit and another 10% marginal. None of this appears in any statistical data not least the PHSO. Even the defence societies are unaware of the number of complainants unless they receive a Letter before Action. Many of these lie dormant in files for three years before being shredded. It is the classical iceberg phenomenon.

My expertise is only with high street dentistry. However, contrary to the findings of consumer orientated government quangos attempting to redress the balance of power between patients and dentists, the compensation culture is alive and kicking and complainants want more than just an apology.

E. Gordon
By email

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CYCLIC NEUTROPENIA

Sir, I am writing this letter in regards to a 5-year-old patient who presented in our Oral Maxillofacial Department, with a history of recurrent oral ulcerations. The patient was referred in by their general medical practitioner due to ulcers that had occurred in the mouth every six weeks. The ulcers lasted for a few days and had been an ongoing problem for three years. The patient's mother mentioned that the oral ulcers seemed to coincide with malaise, fatigue and with the patient generally feeling ill and run down whilst the oral ulcers were present. Other than this, the patient's medical history was unremarkable. Extraoral examination was also unremarkable but intraorally, the patient had slightly inflamed gingivae, with sites of recovering ulcers.

In order to help diagnose the cause of the ulceration, it was decided that it was necessary to arrange for a blood test to be taken. However, it was not just the one blood test that would be performed, but a series of blood tests every week for six weeks. The patient returned for a review appointment along with the blood test results after this period. Five of the six weeks showed normal blood test results; however, on one of the weeks there was a marked decrease in the neutrophil count, and this coincided with the patient presenting with oral ulcers and feeling fatigued.

Based on the history and the blood results, a diagnosis of cyclic neutropenia was made.

This rare condition was explained to the patient's parent and the patient was referred back to the general medical practitioner in order to have appropriate treatment in order to combat the deficiency in neutrophils that occur in a regular occurrence. The patient was advised to use Orabase, which helped

alleviate the symptoms caused by the ulcers, as and when they occurred.

Cyclic neutropenia is a rare variant of neutropenia, and is a condition characterised by a marked decrease in circulating neutrophils in the peripheral blood, occurring in a cyclic fashion every three to six weeks. Some of the oral symptoms that have been reported in this condition include ulcers,[1] gingivitis, periodontitis[2] and even tooth loss.[3] The best way to diagnose the condition is to have a series of routine blood tests which would show the decrease in neutrophils.

Although cyclic neutropenia is rare, it is fairly simple to diagnose and this case highlights the importance of how a history can help point the general dental practitioner in the right direction and the importance of the weekly blood tests in order to confirm the diagnosis. It is vital the GDP helps the patient understand the importance of good oral hygiene in this condition and although the condition requires the GMP to treat this condition, it signifies the importance of working with other health professionals in order to provide a high standard of care for the patients.

K. Keshwara, Y. Zanganah
By email

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2. Zaromb A, Chamberlain D, Schoor R, Almas K, Blei F. Periodontitis as a manifestation of chronic benign neutropenia. *J Periodontol* 2006; **77:** 1921-1926.
3. da Fonseca M A, Fontes F. Early tooth loss due to cyclic neutropenia: long-term follow-up of one patient. *Spec Care Dentist* 2000; **20:** 187-190.

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NEW LEVELS OF SILLINESS

Sir, I read with interest the continuing correspondence with regard to providing molar root canal treatment under the current NHS arrangements. D. Burton (*It is reprehensible; BDJ* 2010; **209:** 592) draws our attention to 'a system which simply dictates a fee', which presumably is his take on the way the NHS dental contract functions. Whilst I must emphasise that I am not a willing advocate of the present system, which does little to encourage dentists to ignore the many perverse incentives put in front them, I feel it is important that we are not misled about the problems. The major difference between the old and new GDS was the abolishment of a fee structure for individual items of treatment, to be replaced by the much more flawed system of 'activity' targets (units of dental activity – UDAs). It took the 'swings and roundabouts' argument of the old way to new levels of silliness and was, to the dentist still wedded to the concept of fee-per-item, frankly unfair. In theory, it should have worked – but as expected, the theory turned out to be very näive and ill-considered.

The theory – and therefore the basis of the contract – was that if we continue to work at the same rate and doing the same sort of things throughout the year, we would earn much the same under the new contract. How näive is that! The point, of course, is that the fee for doing a molar root filling is therefore not the equivalent of 3 UDAs, just as the fee for doing a buccal 'stick-on' composite is not the equivalent of 3 UDAs. As soon as you try and put a figure on the value of individual item of treatment, the whole thing becomes absolutely untenable and therefore absurd. 'Why should one practice be getting 3 x £18 for an extraction, whilst another gets 3 x £32 for the same extraction?' All this is old hat now – but we still read about dentists trying to justify why they cannot do such-and-such treatment under the NHS and the point is still well and truly being missed. So Dr Burton, please get your 'facts' right.

By all means complain about the 'new' contract, but now more importantly, don't let the Government make the same mistake again with its new 'new' contract. I am not hopeful - fee per item seems to be hard-wired into our psyche - and dentists will always be dentists.

J. Scott
Eastbourne

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PRETTY POWERFUL

Sir, I find it disappointing that homeopathy is being slated again in the media.[1] Some people seem to have a real problem with accepting something that, at present, science is unable to explain. I have no doubt that there is some placebo effect with homeopathic treatment in adult patients but that does not explain how it works in animals[2,3] and babies.

I have to declare an interest here because my wife is a homeopath. As an A-level science teacher, she became involved in homeopathy when she saw the effect that homeopathic treatment had on our young son who was covered in eczema. With one series of homeopathic remedies, the eczema, that had failed to respond to any conventional medicine, almost completely disappeared. This is only one case and does not prove anything but when you see it with your own eyes, I can tell you it is pretty powerful.

As an experienced researcher, I know that randomised controlled trials are the best available evidence. When you know a little about homeopathy, as I do, you realise how difficult this is to organise. Four patients with the same 'disease' may each require a different homeopathic remedy and therefore testing the effect of one remedy on one condition, as is normal in conventional medicine, does not fit a homeopathic model.

I have an open mind when it comes to treating my patients. If they feel that something will help them and I am content that it will not do them any harm, I am happy to recommend it. The scientific explanation will come in time – I hope I will see it.

T. Mellor
By email

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2. Werner C, Sobiraj A, Sundrum A. Efficacy of homeopathic and antibiotic treatment strategies in cases of mild and moderate bovine clinical mastitis. *J Dairy Res* 2010; **77:** 460-467.
3. Klocke P, Ivemeyer S, Butler G, Maeschli A, Heil F. A randomized controlled trial to compare the use of homeopathy and internal Teat Sealers for the prevention of mastitis in organically farmed dairy cows during the dry period and 100 days post-calving. *Homeopathy* 2010; **99:** 90-98.

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SINGULARLY INEFFECTIVE

Sir, I am sure that I am not alone in taking little comfort from Alison Lockyer's Opinion piece (*BDJ* 2010; **209:** 551-552) and fully endorse Stephen Hancocks' comments regarding divergence away from any form of cooperative engagement with the profession.

Most GDPs will be aware of 'someone at risk of breaching our standards' amongst their ranks but it seems that