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, periodontitis² 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

1. Nakai Y, Ishihara C, Ogata S, Shimono T. Oral manifestations of cyclic neutropenia in a Japanese child: case report with a 5-year follow-up. *Pediatr Dent* 2003; **25**: 383-388.
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 of 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 naïve 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 naïve 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

1. Shaw D. Unethical aspects of homeopathy. *Br Dent J* 2010; **209**: 493-496.
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

these rogue practitioners continue to abuse the public's trust, often for many years, whilst the GDC is singularly ineffective in responding to concerns raised, even when reported from multiple sources. The inability of the GDC to deal with these cases is a disincentive for registrants to raise concerns and promotes an 'it's somebody else's problem' attitude to prevail. Added to this, DCP registration has produced no discernable benefits for dental staff whilst burdening them with additional expense and taking a significant number of nurses out of the profession who were often part-time and back-up staff. New dental nurses who are often very able but have a weakness in examinations are also cast aside.

Launching its revalidation consultation exercise whilst we are all in the thick of CQC and HTM 01-05 compliance amply demonstrates the lack of insight that the GDC has for the profession and the weight of administration that we have to bear which distracts from our primary concern of patient care.

J. P. Taylor

By email

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TUITION FEE RISE

Sir, following on from the recent controversy of the Browne Review¹ and the resultant House of Commons vote to raise the cap on student tuition fees, clinical undergraduate fees will likely rise to £9,000 per year. Dental or medical graduates will almost certainly be leaving university with a minimum tuition debt of £45,000.

Should a dental graduate wish to embark on a career within oral and maxillofacial surgery s/he will need to undertake a further clinical degree in medicine. This usually takes the form of an accelerated three or four year course, however, there are still a number of trainees undertaking a full five year programme.

For those on an accelerated course, the NHS bursary system will pay for all but the first year. However, those on a five year course will carry the full cost of tuition fees themselves.

I feel that the recent changes to higher education funding and student

finance will result in a career within OMFS being at best, less attractive and at worst, financially elitist. This, alongside the recent discussions regarding the future of oral surgery² may result in fewer dental graduates choosing to undertake a degree in medicine in order to specialise in oral and maxillofacial surgery.

R. Cobb

London

1. Brown J. Securing a sustainable future for higher education. An independent review of higher education funding & student finance. 12 October 2010. www.independent.gov.uk/browne-report
2. Medical Education England. Oral Surgery Review Group. Dental Programme Board of Medical Education England: Review of Oral Surgery Services and Training. www.mee.nhs.uk/our_work/work_priorities/review_of_oral_surgery.aspx

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DENOMINATIONS

Sir, it has been (correctly) brought to my attention that there was an error in the author status and specialty name quoted on my previously published article *Oral and maxillofacial surgery - a case of mistaken identity?* (BDJ 2011; 210: 9-11).

I am currently a penultimate year dental student - having previously studied medicine and completed my Member of the Royal College of Surgeons (MRCS) examinations. Working part time in oral and maxillofacial surgical jobs during my dental undergraduate training (as a means of gaining both experience and marginally improved financial sustenance) grants me the lengthy denomination 'Part-time Junior Trainee in Oral and Maxillofacial Surgery and simultaneous Penultimate Year Dental Student'.

As (again, correctly) pointed out by our reader, it is only once I have completed my BDS and been successful in obtaining a National Training number, that I may justifiably use the more economical rank of 'Specialist Trainee in Oral and Maxillofacial Surgery'.

Furthermore, concerns were expressed that the opinion provided by the article was perhaps 'inexperienced' and without sufficient referencing. I disagree. The paper primarily portrays the views of those that responded to the questionnaire - which for the majority of cases are Consultants in Oral and Maxillofacial surgery. The lack of references in

the paper is primarily due to the fact that it is, as mentioned before, an opinion - with no direct reference to previously documented or published word. In fact, the Oxford Dictionary defines *opinion* as 'a view or judgement formed about something, not necessarily based on fact or knowledge'.¹

I apologise for any confusion or annoyance caused by the errors in both specialty name and author status. It is not and certainly was not, my intention to deceive or mislead. 'There is no greater mistake than the hasty conclusion that opinions are worthless because they are badly argued.' (Thomas Huxley)

D. van Gijn MBBS BSc MRCS

Dental student

1. Definition of 'opinion'. Oxford Dictionaries. www.oxforddictionaries.com/definition/opinion?view=uk

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THE OLDEST BRIDGE

Sir, how long should a bridge last? As a student I was told ten to 15 years, but I have heard that the average NHS bridge in the 1960s lasted less than five. What is the oldest bridge in the UK now? The photo (Fig. 1) illustrates a five unit upper and three unit lower that were placed in 1965 following a machine shop accident. They have been well cared for and the supporting teeth all have good percussion resonances. Sadly I can't remember the name of the laboratory to which most of the credit should go.

Fig. 1 Five unit upper and three unit lower placed in 1965

J. Mew

By email

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