0.24 per 40 practice years in Scotland. This would equate to approximately once every 307 years in England and Wales and once in every 167 years in Scotland. Interestingly, several of the reported cardiac arrests were reported to have occurred in passersby rather than in patients or visitors to the practice, thereby indicating that the public expect a dentist to have the medical knowledge and equipment and be able to be called upon to help in such events when they occur in the vicinity of the practice. It is unclear from the original paper if these calculations of risk assume that the dentist works in a singlehanded practice. If so, then where a practice has multiple dentists, an AED shared between them has a higher risk of being used.

J. Taylor, M. N. Pemberton
Manchester

1. Atherton G J, McCaul J A, Williams S A. Medical emergencies in general dental practice in Great Britain. Part 1: their prevalence over a 10-year period. *Br Dent J* 1999; **186**: 72-79.

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CAREFUL FOLLOW UP

Sir, in this letter we highlight the need for a follow-up to ensure complete resolution of an intra-oral swelling following treatment of presumed dentoalveolar pathology. A 35-year-old lady presented to the maxillofacial department recently with a 15-year history of a swelling growing slowly in the hard palate on the left side.

The upper left first premolar tooth had been root filled 15 years ago as the cause of the swelling was thought to be dental in origin. At the time she was reassured that the swelling would go away some months following her root canal therapy. Recently she changed GDP and was re-referred to our maxillofacial department for the same palatal swelling.

An OPT (Fig. 1) was taken which showed a root filled and crowned upper left first premolar tooth. Biopsy of the lesion confirmed the swelling to be a plexiform neurofibroma. Because of the link to neurofibromatosis¹ she was further investigated with a magnetic resonance scan (Fig. 2) that revealed a similar mass in the cranial cavity. This

was extra-axial with a connection to the inner table of the skull. MRI was used to confirm this.

Fig. 1 An OPT taken at presentation indicating the root filled upper left first premolar

Fig. 2 An MRI indicating the cranial lesion

The patient is undergoing a joint approach with our neurosurgical colleagues with regards to her cranial and oral lesions.

We would like to take this opportunity to remind readers of the importance of careful follow up of any unresolved swelling thought to be related to dental pathology.

N. Shah, C. Mannion, D. S. Holt, York
A. N. Kanatas, Leeds

1. Moosajee S, Boyle C. Neurofibromatosis-1 and the provision of dental care. *Dent Update* 2010; **37**: 405-411.
2. European Society of Endodontology. Quality guidelines for endodontic treatment: consensus report of the European Society of Endodontology. *Int Endod J* 2006; **39**: 921-930.

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GUIDELINES RELEASED

Sir, the long awaited guidelines for the oral health management of patients prescribed bisphosphonates has been released by the Scottish Dental Clinical Effectiveness Programme. The PDF version of the document can be downloaded from the site address <http://www.sdcep.org.uk/index.aspx?o=3120>.

The guidelines address the majority of the concerns that dental practitioners have regarding the patients who are on these drugs and the guidance is also relevant to the prescribers and dispensers of these drugs. A patient advice leaflet has also been provided which would be very useful for patient information.

Z. Imran

By email

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FOR A REASON

Sir, we wanted to share with you the results of a recent clinical audit carried out at our practice.

We investigated the dry socket rate at our practice, which resulted in a higher than expected figure of 18%. Following this we implemented a protocol requiring a pre-extraction chlorhexidine mouthwash, which mirrored what we had been taught as undergraduates however hadn't been doing in practice.

A re-audit cycle was undertaken showing a reduction of cases by almost half (to 10%) after following this simple measure. Not all associates in the practice were routinely following the protocol so a further reduction could be possible with total compliance.

The benefits are evident from improving patient post-operative experience to a reduced burden on already highly sought-after pain appointments, which in turn increases general appointment availability.

Overall this proved an important point: you are taught things for a reason!

J. Flexen

Merseyside

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SEASIDE DENTURE HAZARD

Sir, I feel obliged to warn you about a new unforeseen hazard to denture wearers. I first became aware of this when a long standing patient presented in my surgery feeling rather sorry for himself. He gave a history of recently losing a lower denture which was only a few years old. On further questioning he revealed he had been visiting his brother who lives on the coast. While at the seaside, he took out his lower denture to remove some trapped food.

On placing it on a table a seagull (*Larus argentatus*) promptly swooped down, stole it and flew off!

From a height of 100 feet a lower denture may very well resemble a large prawn or crayfish, an irresistible treat to the avian eye, especially for a hungry seagull. These birds have featured many times in the media, having earned a reputation for increasingly aggressive behaviour to people. (*Postal deliveries in Devon disrupted by seagull attacks*; BBC News 23 June 2010; *When seagulls attack*; Daily Echo 1 February 2009; *The birds* by Hitchcock et al. 1963). I have encountered patients who have had dentures eaten by dogs on several occasions over the years but this has been a new experience for both of us.

I strongly suggest that on fitting a new denture after giving our patients the usual advice on denture maintenance and hygiene we must warn them never to remove them at the seaside.

R. A. Raeburn

By email

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PEACE OF MIND

Sir, I write in response to the letter of P. Manek (*AED value*; *BDJ* 2011; 210: 501) on the value of AEDs in the practice setting. In the five-yearly CPD cycle, the GDC¹ recommend at least ten hours of medical emergency training which serves to highlight the importance of managing medical emergencies within the dental setting.

Although this letter suggests only a very small chance of a cardiac arrest occurring in the dental surgery, the benefit of having an AED readily available leads to a certain 'peace of mind' for the dentist, the staff and patients alike should the unlikely occur. Indeed many patients feel reassured if an AED is on display as this indicates a practice that is well equipped and prepared. In addition it is an expectation of the public that AEDs are available in all healthcare environments.²

Whilst the quality and complexity of AEDs vary with price, machines are available from as little as £599 plus VAT with a seven-year warranty.

Consideration should also be given to the fact that most practices contain

more than one dentist; it may be the relative, parent, a member of staff or a passerby who may arrest, which when taken into the equation alter the statistics significantly.

Add in the fear and anxiety exhibited by many patients combined with an element of pain and the odds of a cardiac arrest occurring increase further.

It is indeed correct that the majority of out of hospital cardiac arrests (OHCAs) are shockable but due to the lack of immediate ECG evidence the figures are not accurate. The Resuscitation Council³ suggests that the proportion of OHCAs is around 60% and each minute's delay before shock delivery results in a decreased successful outcome of 10–12%. The overall survival to hospital discharge from a VF/VT (ventricular fibrillation/pulseless ventricular tachycardia) arrest is 21.2%.³ With these statistics in mind and with consideration to ambulance arrival times varying, it would seem prudent to re-evaluate 'cost' implications of these life-saving machines.

S. J. Ellison

Bristol

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2. The Resuscitation Council (UK). *Medical emergencies and resuscitation. Standards for clinical practice and training for dental practitioners and dental care professionals in general dental practice*. pp 12–13. London: The Resuscitation Council, 2006.
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MISSSES THE POINT

Sir, P. Manek's letter (*AED value*; *BDJ* 2011; 210: 501) makes interesting reading and his points concerning good quality CPR training and prevention programmes are well made. I would, however, question his reasoning with reference to dentists having AEDs in their practices. While his estimation of the likelihood of use of an AED in his practice is interesting and apparently sound it rather misses the point. We should not consider each individual dental practice in isolation. If defibrillators are widely available in medical and dental surgeries, health centres, chemists etc and in non-health based locations such as stations, car parks,

shopping centres and the like, should any one of us suffer sudden cardiac arrest the likelihood that a defibrillator is readily available allowing rapid defibrillation is greatly increased. Statistically there is something like a 10% reduction in the chances of successful defibrillation for every minute of delay following the arrest.

As healthcare providers and responsible members of the community we should see the deployment of an AED in our dental practice as a measure not just for our patients but as a resource for our local community. Members of the public (not just our own patients) should be able to rely upon any healthcare premises having an AED available in the event that it is needed. It will still be true that most AEDs will never be used other than in training. Looking at it from a different point of view, however, the more AEDs that are deployed the greater will be the chances of early defibrillation being implemented in a cardiac arrest.

I would draw your readers' attention to the Automatic External Defibrillators for Dentist Practices in Walsall – see <http://www.walsall.nhs.uk/communications/news/dentistsdefib.asp>.

R. S. Moore

By email

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INCREASINGLY DIVERGENT

Sir, Tabiat-Pour and colleagues' recent article provides a very useful overview of *Education, regulation, representation and remuneration in dentistry* (*BDJ* 2011; 210: 431–438). However, they've missed several important differences between Wales and England. To highlight a few, the Care Quality Commission's remit stops at Offa's Dyke – as does Monitor's. In Wales the healthcare regulator is Healthcare Inspectorate Wales (HIW), and we have retained Community Health Councils. The system in Wales is increasingly divergent from that in England and the other home countries – we keep a warm 'welcome in the hillside' to readers who'd like to visit us!

Diolch yn fawr.

L. Howells

By email

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