ALTOGETHER MANAGEABLE

Sir, having just finished an 18-month placement as an oral and maxillofacial senior house officer (OMFS SHO) I was particularly delighted to read the excellent article in July's edition, *An evaluation of senior house officer training in oral and maxillofacial surgery*.¹ As one of the respondents to their survey, it would appear from the results that I had the 'average' experience of an OMFS SHO, on most accounts. However, my personal experience as an SHO included one 'bleep-free' training session (1.5 hours) per week which provided an open forum to discuss cases and the management of many OMFS situations. Although this may not be the norm, it certainly added to the educational value of the post, and where feasible, is an invaluable asset to any SHO/DF2 placement, especially in the initial stages of the steepest learning curve you can possibly imagine.

I understand the difficulty providing a standardised OMFS SHO training programme as it is only in speaking to my fellow senior house officers that one realises how varied rotas, duties and exposures to specialist interests in that particular unit may be. Realistically, being a medical specialty, most 'competencies' as mentioned in the above article could be directly observed by any medically trained senior clinician on the ward, ie not necessarily of the maxillofacial variety. With the advent of electronic logbooks (online portfolios) to record one's completion of procedures then and there, this seems a relevant, reasonable and altogether manageable method of improving learning outcomes for senior house officers.

N. E. O'Murchu, Glasgow

1. Stancliffe H, Little R, Keith D, Durham J. An evaluation of senior house officer training in oral and maxillofacial surgery. *Br Dent J* 2011; **211**: 75-80.

DOI: 10.1038/sj.bdj.2011.773

UPHOLDING STANDARDS

Sir, your recent editorial, *Lessons from a Greek roadmap* (*BDJ* 2011; **211**: 149) has raised a concern that I have about our, ie the UK, and indeed, your relationship with those people who are unfortunate enough to live in Euroland.

I fully understand your difficulties with navigating; may I recommend

the maps produced by a well-known tyre maker (if they have ventured that far south) or indeed ask that you, as Editor-in-Chief of our esteemed journal, consider taking your holidays in future, solely for reasons of your personal safety, in regions that are better surveyed.

But, that said, I am concerned that you have not upheld the standards that I, and members of the BDA would expect from an Editor-in-Chief.

You refer to your pleasant day on the beach and in returning for dinner in AN hotel where you were probably the only British persons present, you write that you were 'DRESSED FOR LEISURE'. Surely, Sir, this is most inappropriate and, I regret to say, also a poor reflection on Euroland inhabitants. As a Great British person, and Editor-in-Chief of the *BDJ*, is black tie for dinner when 'abroad' too much to ask?

Is it any wonder that these poor souls find themselves in the current financial predicament without such standards to uphold?

S. Geddes, Wales

DOI: 10.1038/sj.bdj.2011.774

FACIAL SWELLINGS

Sir, a 72-year-old female presented to her general medical practitioner with an acute onset (over four hours) of facial angioedema (AE) involving the tongue, lips and floor of mouth. She had been on Lisinopril for four months for treatment of hypertension. On examination, her upper lip was significantly swollen to at least double the normal size (Fig. 1).

Fig. 1 Diffuse painless swelling of the upper lip

Her airway was not compromised and she had no other symptoms.

There were no other identifiable causes of the AE and the patient made

a rapid recovery overnight with oral steroid and antihistamine treatment. Lisinopril was changed to a calcium channel blocker alternative.

Angioedema (AE) often presents as facial swelling, but can progress to involve the tongue, oropharynx and supraglottic regions. Although classified as a rare side effect, AE is associated with the use of angiotensin converting enzyme inhibitors (ACEI) such as Lisinopril.

The onset of AE with the use of ACEI can range from within the first 3-4 weeks to several years of treatment.¹ High risk groups include Afro-Caribbeans, those older than 65 years of age and patients with known drug-related allergies.²

Patients who present to general practice with facial swelling with no obvious oral-dental disease should have their past medical history checked and in particular the use of ACEI should be highlighted as a possible cause.

A. Ujam, J. Maryosh, Kent

1. Sondhi D, Lippmann M, Murali G. Airway compromise due to angiotensin-converting enzyme inhibitor-induced angioedema: clinical experience at a large community teaching hospital. *Chest* 2004; **126**: 400-404.
2. Kostis J B, Kim H J, Rusnak J *et al*. Incidence and characteristics of angioedema associated with enalapril. *Arch Intern Med* 2005; **165**: 1637-1642.

DOI: 10.1038/sj.bdj.2011.775

WHOLLY UNSUPPORTIVE

Sir, your correspondent S. Ramaraj (*BDJ* 2011; **211**: 151) reflects on cultural insensitivities. I would reflect that managerial insensitivities are not always culturally rooted.

My mother was herself terminally ill when my father was diagnosed with terminal cancer in July 2004. I was working in a salaried NHS post at that time and my immediate clinical manager was on maternity leave. I requested of the dental service's interim general manager to be able to travel (300 miles) to be with them as soon as my work schedule allowed. This worked out to be in early September. Leave was immediately granted on the strength of relative urgency and its definition would be sorted when I returned. I agreed to keep in touch while away from work.

Sadly, my father passed away the day I travelled in September and his

immediate affairs then took two weeks to conclude. Once back at work, I was told that one week was to be defined as 'Compassionate Leave' and the other week was to be 'Annual Leave'!

Several people wondered why I hadn't just phoned in sick! Well, I wasn't sick and at such times, one's mind is hardly on such strategies. I had always assumed subconsciously that an employer like the NHS would be wholly supportive at such times.

Once I returned, the occupational health staff asked if I had read the Trust's Special Leave Policy and considered that the second week should have been defined as 'Carer's Leave' to which it appeared I was entitled. I raised this with the manager who steadfastly declined to change the position and decision.

On those grounds, I raised a Grievance and with the able assistance of the BDA, took it through the two of the three internal stages/hearings without success. This did little to assist a grieving process and in July 2005, my mother passed away. I was then signed off by my GP for what turned out to be seven weeks to close her affairs.

The third stage hearing was held after I returned to work and involved another manager who finally found in my favour. Not surprisingly, the fourth and final stage of the Grievance would have involved an external panel.

At that final hearing, the manager concerned opened proceedings by asking me brightly 'So how is your mother now...?' and after I answered, 'Did you get Compassionate Leave this time?'

It was one of several factors which contributed in 2008 to me leaving not only that post but also the NHS after 24 years service.

R. D. B. Dickson

By email

DOI: 10.1038/sj.bdj.2011.776

OUT OF TOUCH

Sir, I am writing to you in response to the letter titled *Evidenced by experience* by A. E. Castle (*BDJ* 2011; 211: 153) I would like to make a few points here as the author seems to be out of touch with the current concepts in evidence-based dentistry.

I would like the author to read the NICE guidelines on reviewing and grading evidence.¹ As per the guidelines, evidence by experience is the least valid of all the evidence levels.

A. E. Castle recommends that zinc oxide eugenol-based liners are used under amalgam restorations. For most clinicians, dental school provides the first introduction to these materials, and some clinicians continue to use the materials first introduced when they were in school. It seems that 50 years ago ZOE was the liner of choice and the author has stayed loyal to it. Presently liners are no longer routinely used under all amalgam restorations except for those very close to the pulp.^{2,3} A. E. Castle says that 'DYCAL is not able to withstand the condensation pressure of packing the amalgam'. This statement is wrong, as currently available DYCAL is able to withstand the condensation pressure as per the manufacturer's guidelines.⁴

Finally the letter writer says that 'application of Duraphat varnish to the perimeters of the cavity prior to inserting the amalgam will leave it with an effective seal'. Duraphat is soluble in saliva and oral fluids and it will in no time leach out of the margins of the restoration and leave the restoration susceptible to micro-leakage. It would be irresponsible on the part of the dentist to attempt such an experimental use of Duraphat varnish for which there is no such manufacturer recommendation or any evidence.

A. E. Castle justifies it as evidence-based as s/he has used it successfully, but I don't know what parameter s/he used to measure the success.

Z. Imran

Dundee

1. NICE: Guideline Development Methods. Available at: http://www.nice.org.uk/niceMedia/pdf/GDM_Chapter7_0305.pdf
2. Cox C F, Suzuki S. Re-evaluating pulp protection: calcium hydroxide liners vs. cohesive hybridization. *J Am Dent Assoc* 1994; **125**: 823-831.
3. Weiner R S, Weiner L K, Kugel G. Teaching the use of bases and liners: a survey of North American dental schools. *J Am Dent Assoc* 1996; **127**: 1640-1645.
4. Dentsply product details. Dycal. <http://www.dentsply.co.uk/Products/Restorative/Cements/Dycal.aspx>

DOI: 10.1038/sj.bdj.2011.777