Letters to the Editor

Send your letters to the Editor, British Dental Journal, 64 Wimpole Street, London W1G 8YS
Email bdj@bda.org

Priority will be given to letters less than 500 words long. Authors must sign the letter, which may be edited for reasons of space.

Readers may now comment on letters via the BDJ website (www.bdj.co.uk). A 'Readers' Comments' section appears at the end of the full text of each letter online.

WHERE DOES CHANGE BEGIN?

Sir, in reply to the letter in a recent edition of the *BDJ*, *Different priorities* (*BDJ* 2011; **211:** 447-448), I should like to add my comments. I am the Dental Coordinator for Christian Relief Uganda (www.christianreliefuganda.org).

I was present at the conference in Manchester where Dr Holmgren spoke.

For six years we have run pain relief dental clinics in the rural areas and some of the prisons of Uganda, which include oral health education programmes and talks against the malpractice of infant oral mutilation. We do this in cooperation with the indigenous dentists, enhancing their skills by bringing UK dental personnel out to Uganda, who work alongside them as they treat their own people.

Our supporters have funded the further dental education of several Ugandan dentists who plan to approach government to begin work on policy change.

Working with a Ugandan visual aids company, we have designed culturally appropriate oral health education posters and booklets which our Ugandan colleagues use at outreach clinics.

Where does change begin? We have chosen to start with the roots. Who can tell where the branches may reach?

B. Koffman
Christian Relief Uganda
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COUNTERSIGNATURE CODE

Sir, I write regarding the editorial *Antibiotic stewardship* (*BDJ* 2011; **211:** 443). This excellent editorial not only serves as a warning on how serious bacterial resistance is becoming but also outlines important steps which should be taken as a matter of urgency to protect the public going forward. Using a combination of close adherence to antibiotic prescribing guidance, additional information provided by the Medicines Information Service where appropriate and 24 hour patient review, I now prescribe antibiotics approximately twice annually (full time, predominantly NHS general dental practice). I also note that in a recent *BDJ* paper (*An outcome audit of three day antimicrobial prescribing for the acute dentoalveolar abscess; BDJ* 2011; **211:** 591-594), close adherence to prescribing guidance was reported to have produced a very good antibiotic prescribing profile of only 2.9% of patients presenting with pain at a primary care department.

Furthermore, initial results from a (quite possibly non-representative) survey of antibiotic prescribing habits of dentists using a well known online dental discussion site suggest that approximately 66% of practitioners are using local measures alone for management of non-systemic acute apical periodontal abscesses. Approximately 20% of practitioners reported using antibiotics in conjunction with local measures (a proportion of this group may be in the process of 'converting' to local measures only). If these figures are approximately correct, then it suggests that there is probably good adherence to prescribing guidance.

Despite this, and bearing in mind the editorial referred to above in particular, I am of the opinion that a 'dual key' approach should be adopted for antibiotic prescribing in primary dental care. In this approach, when primary care dentists wish to prescribe antibiotics, they would contact Medicines Information or an appointed network of specialists (with out of hours cover) to discuss the patient's clinical status.

Following the discussions, if both clinicians agree that immediate prescribing of antibiotics is indicated, the support service would issue the primary care dentist (NHS or private) with a 'countersignature' code which would be included on the prescription along with any other agreed details of the support service contact.

In circumstances where there was disagreement, a third opinion would be sought from a third clinician. This system would provide additional protection to the patient and the primary care dentist. In the longer term it is conceivable that an artificial intelligence application could be developed for the purpose and thereby replace the need for a manned 24 hour service.

Unlike peak oil which is yet to be reached, I suspect peak antibiotic effectiveness has been passed and the situation is still deteriorating with very serious implications for our children.

P. Mc Crory
By email
DOI: 10.1038/sj.bdj.2012.102

COMMUNIST WITCH HUNT

Sir, we have recently had our pedal bin updated to comply with CQC and HTM 01-05 guidelines and discovered it had 'soft clinical waste' written in Braille upon it, presumably so as not to discriminate against a blind dentist disposing of his waste.

Society seems to have changed from one where problems were identified and solutions found, to one which seems to mimic McCarthy's 1950s communist witch hunt. If the risk management is to be believed, there should have