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.

LETTERS

A PREPOSTEROUS CLAIM?

Sir, I'd be interested to hear your opinion on this case. I treated a patient last year, under IV sedation for extreme anxiety, after which she left the practice and amended a prescription I had given her for one bottle of chlorhexidine mouthwash by adding a zero. Of course when the chemist saw that the '1 × bottle' had been amended to '10 ×' she was arrested. The case (quite inexplicably) went all the way to magistrates court where she admitted to committing fraud but claimed that the midazolam I had administered had caused her to do so and hence she wasn't responsible. I was called as a professional witness and after giving my oath explained that although her memory of events may have been impaired it was preposterous to claim that the sedative had made her commit a crime. However, after spending three hours in the court and a further hour of deliberation the verdict was returned 'not guilty'. I can't help feeling that maybe the wrong decision was made? If I was at all cynical I may even suggest that the cost of the proceedings (which would have dwarfed the cumulative value of nine bottles of mouthwash) would probably only just have been covered by the tax dollars that I have recently submitted to the Inland Revenue!

J. Rowarth
Newcastle-upon-Tyne
DOI: 10.1038/sj.bdj.2012.227

AN ENTREPRENEUR FIRST AND FOREMOST

Sir, I have been an avid reader of the *BDJ* for many years. Your recent editorial *A job for life or for living* (*BDJ* 2012; 212: 101) was a thought provok-

ing article. I run a new dental practice called Astradental in Nairobi, Kenya. I lived in the UK from 2004 to 2010 as a PhD Student and have been remembering the NHS contracts with nostalgia and wishing we had something similar here in Kenya. My client mix is 90% private and 10% insured. My experience is that it is hard work to build private dental clients but once they are happy with your work, they can commission more 'interesting and costly' dental work than the insured clients, thereby allowing me to escape the clean, cut and fill treadmill.

The challenges are those of any private business and I do not really think about being loyal to the vocation or not. There are no safety nets to my work so if it was to stop being rewarding substantially, I would not hesitate to change course. Thus I view myself as an entrepreneur first and foremost, businessperson second and a dentist third. I chose to run a dental practice because I love it. This is the only reason in my humble opinion for anybody to undertake life working in that cave they call a mouth.

L. Mutara
By email

DOI: 10.1038/sj.bdj.2012.228

STERILITY TESTING OF DEVICES

Sir, the recent publication of a study¹ attempting to elucidate time dependent recontamination rates of sterilised dental instruments is laudable in its attempts to challenge the Department of Health (England) guidance for decontamination in dental practice (HTM 01-05). It is, however, important to place the results of the work and accompanying editorials into context by considering the limitations of such

studies undertaking sterility testing of medical devices or products.

The definition of sterility in the context of surgical instruments (this includes dental instruments) is defined in the British, European and International standards^{2,3} and is expressed as a sterility assurance level or the probability of a single viable micro-organism on an item after sterilisation by a validated process. This is taken as the probability of 10^{-6} of a single microbe on an item after sterilisation. Or put more simply, a probability of not more than one viable microorganism in 1×10^6 sterilised items.

This standard definition has technical implications for sample size determination when undertaking tests for sterility of medical devices as described in the manuscript. Or in other words, testing five devices wrapped in one type of wrapping from one batch, from one run and from one steam steriliser does not provide a sufficiently robust sample size to achieve a statistically valid probability of detecting sterilisation failure (ie a breach in the wrapping material). In addition, the microbiological techniques for determining sterility are fraught with issues related to the limits or sensitivity of the detection methods used. No data were presented on the validation of microbial recovery techniques used in the study; ie was the method used in the manuscript capable of detecting 10, 100 or 10,000 microbes per mirror tested? This is especially important when departing (eg Tris EDTA) from the usual recovery media (such as tryptone soya broth) for these sorts of experiments.⁴ In terms of reproducibility of 'the normal clinical conditions' of the storage conditions no data were presented on air flow rates, humidity or levels of particulates

that may impact on packaging integrity. Indeed air conditioning is the exception rather than the norm in dental practices.⁵

I would, however, concur with the authors' assessment that the integrity of wrapped sterilised instruments as processed in the manuscript is more likely event related ie related to the conditions and environment in which they are stored and not time related. The methodology reported neither refutes nor confirms the sterility of the stored instruments in this study. Interestingly, I'm unaware of a time related storage requirement for instruments in Scottish dental practices processed in a similar manner described in the manuscript.

A. Smith
Glasgow

1. Barker C S, Soro V, Dymock D, Fulford M, Sandy J R, Ireland A J. Time-dependent recontamination rates of sterilised dental instruments. *Br Dent J* 2011; **211**: E17.
2. BS EN ISO 17665-1:2006 Sterilization of health care products – Moist heat – Part 1: Requirements for the development, validation and routine control of a sterilization process for medical devices.
3. ISO/TS 11139:2006 Sterilization of health care products – Vocabulary.
4. BS EN ISO 11737-1: 2006 Sterilization of medical devices – Microbiological methods – Part 1: Determination of a population of microorganisms on products.
5. Smith A J, Lockhart D E A, McDonald E, Creanor S, Hurrell D, Bagg J. Design of dental surgeries in relation to instrument decontamination. *J Hosp Infect* 2010; **76**: 340–344.

DOI: 10.1038/sj.bdj.2012.229

STILL DESERVES A PLACE

Sir, my attention has been drawn to the letter *Subperiosteal implants* by H. Beddis *et al.* (*BDJ* 2012; **212**: 4). This was of particular interest since I was involved as a senior maxillofacial technician in the construction of these devices when working with Professor T. Talmage Read. He was not only Dean of the Leeds Dental School until 1959, but a respected oral pathologist and innovative surgeon who pioneered the applications of these implants for patients with atrophic mandibular ridges and associated denture wearing problems.

Unfortunately, after his retirement, follow-up became sporadic so that no long term statistics are available, although I know of one case personally where the implant was still performing satisfactorily after 25 years. Indeed I had to make two new denture superstructures during this period due to the occlusal wear!

The technique used was broadly as described, but one problem of the 1950s was the limited choice of impression materials and though not ideal in accuracy terms, a thermoplastic composition was used which your senior readers will remember as 'compo'. Three impressions were taken and frameworks constructed on what were judged to be the best two models. Likewise at the second operation when the whole bony ridge area was reexposed the best fitting framework was chosen. Unlike the described case, retaining screws were not used as the healing and reattachment through the mesh structure was thought to provide adequate stability. The denture prosthesis was applied approximately ten days post-surgery.

The wider use of this implant in its original form highlighted some of the inherent problems, such as the relationship of the soft tissues to metal where the framework entered the mouth which could produce pocketing and associated infection such that the framework had to be removed. This dampened clinical enthusiasm and as stated the method has largely been abandoned in the UK, its demise being speeded by the arrival of endosseous implants and bone augmentation.

However, in America, as judged from the literature, development has continued. The correspondence mentioned the CT based CAD/CAM technology to produce a working model for framework construction thereby eliminating a first stage operation for impression taking, but perhaps more significantly, is the coating of the implant framework with hydroxyapatite. The latter is described as giving a better physical and chemical linkage to bone, plus an improved metal to soft tissue relationship at the mouth exit point. There is also the realisation that this technique is only applicable to the true atrophic jaw where no vestige of alveolus remains. It also appears that frameworks could now be made in titanium, although casting this metal does have its challenges.

In its modern guise perhaps the subperiosteal implant still deserves a place in the options list for the management of the atrophic jaw.

J. N. Kidd

DOI: 10.1038/sj.bdj.2012.230

RIDICULOUS LOGISTICS

Sir, I write in response to a letter published 10 February 2012 entitled *Coun- tersignature code* (*BDJ* 2012; **212**: 103). The author suggests that the answer to the overprescribing of antibiotics is to ensure every prescription is agreed upon by at least two clinicians. The logistics of this, in my opinion, seem ridiculous. The idea that every time a script is written, a phone call should be made to confirm its worth is not practical. This is another example of 'nanny state' intervention. Is it too much to ask that overprescribing be reduced through the education of practitioners? I think it is too early to give up on the judgement of individual dentists and hand over power to yet another governing body.

J. Hennessy
Shropshire

DOI: 10.1038/sj.bdj.2012.231

STANDING STRONG ON PRESCRIBING

Sir, I read with great interest the recent material on antibiotic prescription. I advocate the importance of 'going green' on antibiotic usage; indeed, I picked out this term from a letter to the *BDJ* editor a couple of years ago. Often in practice we are asked by patients for antibiotics and staff have often argued over this point of prescribing something on the temptation to simply 'keep people happy'. As I am in private practice here in Australia the patient dictates the choice of dentist yet if they try to run the 'show' by telling the dentist how to do their job it is not acceptable. They may in turn go elsewhere to find someone that does what they want but this is of course up to them. As practitioners we must stand strong with regards prescribing.

J. Loudon
Liverpool, NSW

DOI: 10.1038/sj.bdj.2012.232