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.

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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 endoseous 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 *Countersignature 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
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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.

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DOI: 10.1038/sj.bdj.2012.232