ENDODONTIC COUNTERPOINT

Sir, I read the article *Devoid of dentistry* (*BDJ* 2012; **212:** 163-164) and I would like to raise a counterpoint. With regards to endodontic treatment, the author stated that students may never have attempted or completed root canal treatment.

At Peninsula Dental School we are set a quota for a number of different clinical procedures, which we have to fulfil before being allowed to proceed to finals. With specific regards to endodontics, we are required to complete a minimum of six root canal treatments, two of which must be molar teeth, before we can consider finals.

This gives students adequate operative experience of root canal treatment. I don't seriously believe that any dental school would allow a student to graduate without having carried out a minimum number of endodontic treatments.

As for cannulating a forearm for IV sedation, I personally would want to attend further training before sedating a patient. I believe the General Dental Council asks that any dentist providing conscious sedation has undergone 'appropriate training'. In reality this means that they have completed a course covering the numerous aspects of theoretical and practical sedation with supervised sessions. It just isn't feasible to cover this in dental school.

A BDS gives the dental undergraduate the basic foundations to build on. The appropriate level of dental knowledge as detailed in the GDC's *First five years* curriculum covers the key aspects of dentistry for the student. Continual learning is paramount in dentistry and development of techniques and acquisition of new skills continues throughout one's career. Continuing professional development and revalidation are here for a reason.

F. R. Stoops, 4th year dental student

DOI: 10.1038/sj.bdj.2012.474

CUTLERY CONTROL

Sir, the letter *Kitchen standards* (*BDJ* 2012; **212:** 154) highlighted how excessive the present HTM 01-05 regulations are.

It is not something I would wish to dwell on when eating out; I have more pressing matters in trying to find a sensibly priced good wine to accompany the meal; but as I put the fork in my mouth, my mind briefly asks various questions: how many mouths has that fork been in? How many of those mouths had active periodontal disease present with spontaneous bleeding and more importantly was that fork adequately sterilised since the last customer?

It makes me think about the lengths I have to go to to sterilise a mouth mirror.

Surely at the least the fork should be bagged up before being placed on that crisply starched tablecloth or maybe the takeaway has got something going for it! Come to think of it, maybe takeaway dental care might negate the need for HTM 01-05!

P. R. Williams, Lowestoft

DOI: 10.1038/sj.bdj.2012.475

DIRECT REFERRAL

Sir, I recently conducted an audit into basal cell carcinoma (BCC) excisions performed by a maxillofacial surgeon at the hospital unit where I am completing my DF2 year. An example of a BCC is shown in Figure 1.

Of the 247 BCC lesions which were excised within one year, 228 (92%) were removed from the head and neck. Over half of the excisions were removed from areas generally visible to a dentist during an examination and 26% were within the field of the dental light.

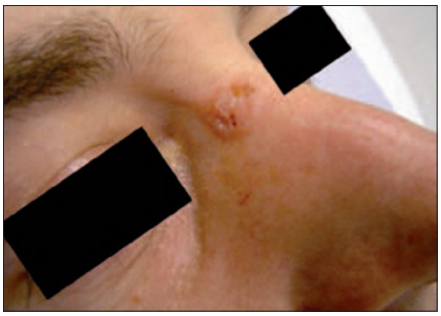

Fig. 1 BCC in a young patient, easily visible in the beam of a dental light

Interestingly, of the 247 cases, not one patient was referred in by their general dental practitioner. It may be possible that none of these patients had needed to see their dentist before they visited their GP, or perhaps the lesion was picked up by the general dentist who referred to the GP as opposed to the specialist directly.

This is a useful reminder that as medical healthcare professionals we can also refer directly to the secondary care specialist and that our extra oral examination can be just as important as the intra-oral one.

S. Patel, Surrey

DOI: 10.1038/sj.bdj.2012.476

BISPHOSPHONATE CONSIDERATIONS

Sir, bisphosphonates are widely used for their undoubted beneficial effects such as protection against bone fractures in osteopenic or osteoporotic people. Bisphosphonate-related osteonecrosis of the jaws (BRONJ) is one possible adverse effect – an avascular area of necrotic bone in the maxillofacial area, with or without exposed bone, that has been evolving for more than eight weeks in patients without a previous history of irradiation in the maxillofacial region and is seen mainly in people receiving intravenous BPs, used largely to treat hypercalcaemia in people with malignant disease.[1-3] There is a huge literature on this aspect of relevance to dentistry. Patients not infrequently seek advice on this medication, and their decisions may be influenced by other drug effects.

As with many new drugs, other adverse effects of bisphosphonates are increasingly being recognised, with atypical bone fractures,[4] atrial fibrillation,[5] cancers (oesophageal and colorectal)[6] and now possibly inflammatory eye effects such as scleritis and uveitis[7] appearing in the ever-lengthening list of potential adverse effects. Potential users may wish to consider these issues when deciding on medication.

C. Scully, Bristol

A. Robinson, Singapore

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