A second traumatic incident is not uncommon in active young boys. However, in this particular instance he had been relaxing, or slouching as his mother put it, at home on the sofa playing a game on his iPad 2. Such was his excitement or absorption in the game that he dropped the iPad 2, hitting his tooth and decoronating it. We believe that this may well be the first incident of dental trauma by iPad 2 and wish to bring it to the attention of the profession so that the dangers of ownership may be taken into consideration when treating and advising patients!

We prescribe a mouthguard for those who play contact sports. Should we now consider doing the same when we know that our patients own an iPad 2 and in the knowledge that an obvious danger to the developing dentition exists? Perhaps we should consider referral for lessons in deportment as injury is surely less likely when slouching is removed from the equation? Can we take any positives from the incident? Is there now a potential gap in the market for mouthguard provision to the iPad 2 owning population? And significantly, it is surely another point in favour of encouraging an active lifestyle in our patients given the obvious danger to the developing dentition when sedentary in one's own sitting room.

N. Docherty, R. Welbury
Glasgow

DOI: 10.1038/sj.bdj.2012.729

SYSTEMIC HEALTH SCREENING

Sir, reviewing the literature reveals an abundance of suggestions as to how the dental professional can investigate issues related to patients' systemic health.

Screening for hypertension, diabetes, HIV, obesity and excessive alcohol consumption are but a few that have been discussed.[1-5] The mindset underpinning these ideas is noble, as the dental profession is in an ideal situation to interact with patients who may not visit any other primary health care provider.[4,6] Systemic considerations by dentists can be valuable additions to improving the nations' health, particularly in detecting asymptomatic conditions.[7] One example is Engström *et al.*,[8] who excellently demonstrated the value of screening for hypertension in Sweden, and there seems to be no real reason why this effect could not be duplicated in the UK.

We are aware of referral letters contacting general practitioners and where necessary facilitating pathology requests, however, the dental professional in the UK seems reluctant to participate in these potential interventions.[1,3] Sproat *et al.*[9] list possible limitations to hypertension screening, though many of these can be applied to other similar interventions. Reviewing the literature in the UK and abroad outlines barriers, mainly related to referral and lack of guidelines related to screening in dentistry. Guidance is surely needed to ensure our role doesn't expand exponentially and impractically to consider factors far beyond our resources.

We can exercise individual discretion, of course, possibly relating to conditions affecting the provision of oral health foremost.[2] Examples include checking blood sugars of a patient with refractory chronic periodontitis for example, or measuring the blood pressure of an obese 50-year-old who has admitted to not taking their prescribed antihypertensives. Modern clinical practice strives to be evidence-based and using our discretion is insufficient to fully facilitate optimum patient care beyond the oral cavity. In the UK, we should strive to echo the efforts implemented internationally.

With even basic guidelines in place, we could be assured of the value of referrals we may generate whilst being sure we are appropriately using our limited clinical time. Does anybody else feel the need for clear guidance to ensure we can optimise our patient care beyond their dental health, whilst not venturing beyond our traditional role?

A. R. Geddis
Leeds

1. Greenwood M, Lowry R J. Blood pressure measuring equipment in the dental surgery: use or ornament? *Br Dent J* 2002; **193:** 273–275.
2. Lamster I B, Eaves K. A model for dental practice in the 21st century. *Am J Public Health* 2011; **101:** 1825–1830.
3. Shepherd S, Bonnetti D, Clarkson J E, Ogden G R, Young L. Current practices and intention to provide alcohol-related health advice in primary dental care. *Br Dent J* 2011; **211:** E14.
4. Roked Z, Moore S, Shepherd J. Alcohol misuse: screening and treating in primary care. *Faculty Dent J* 2012; **3:** 73–77.
5. Comyn C, Kendall N, Wright D. Should dentists be concerned about the weight of their patients? *Prim Dent Care* 2012; **19:** 7–10.
6. Strauss S E, Alfano M C, Shelley D. Identifying unaddressed systematic health conditions at dental visits: patients who visited dental practices but not general health care providers in 2008. *Am J Public Health* 2012; **102:** 253–255.
7. Glick M. Treating asymptomatic patients. *J Am Dent Assoc* 2005; **136:** 1632–1634.
8. Engström S, Berne C, Gahnberd L, Svärdsudd K. Efficacy of screening for high blood pressure in dental health care. *BMC Public Health* 2011; **11:** 194.
9. Sproat C, Beheshti S, Harwood A N, Crossbie D. Should we screen for hypertension in general dental practice? *Br Dent J* 2009; **207:** 275–277.

DOI: 10.1038/sj.bdj.2012.730

DOUBLY IMPOSSIBLE

Sir, I wish to endorse wholeheartedly the views of Varley, Kanatas and Carter (*An impossible position*; *BDJ* 2012; **212:** 153–154) in their wish to improve access of appropriate care for those patients on bisphosphonates. I would like to add to this 'impossible position' from my perspective for those patients who are on or about to commence high dose intravenous/oral bisphosphonates as part of their oncology care for their multiple myeloma or for their metastatic bony lesions from breast, prostate or renal carcinoma.

Where I work as a consultant in special care dentistry (SCD), the SCD and oncology teams have worked very hard and closely to be proactive in the care of this cohort of patients. We now have a streamlined/fast-tracked referral system which endeavours to see these patients as an absolute priority *before* commencing their bisphosphonate treatment, as they are at an even higher risk of developing bisphosphonate related osteonecrosis of the jaws (BRONJ) following exodontias, or, spontaneously.

Although they are being referred from an oncology consultant to a SCD consultant, and 50% of the time are seen in a hospital location, there is a catch. I am employed as a consultant in primary care and as such these patients are subject to the normal NHS patient charges as they would be on the high street (other than normal exemption). For many of these patients these charges come at a time when they are not receiving their usual salary, when they are already having to come to terms with their diagnosis, difficult treatment and prognosis, on top of the

extra finance of multiple hospital visits, car parking charges and ever increasing cost of fuel, often in our area up to a hundred miles for a round trip to access a regional centre care.

To make additional decisions around the possible loss of a number of teeth, or in some cases a posterior dental clearance, to reduce the risk of BRONJ and cope with the treatment can be one decision too many with which to cope. A significant amount of time is usually required to give appropriate holistic and pastoral support for their decision making. Then to add to this that they need to pay for the 'privilege' of receiving this care, I think is of concern. I am not suggesting that dental treatment should be free for life as the constraints on funding for NHS care are of course significant for the foreseeable future. However, free dental care for their time of most need would seem appropriate in my eyes.

G. Greenwood
By email
DOI: 10.1038/sj.bdj.2012.731

FLAWED PENSION SCHEMES

Sir, career average earnings pension schemes seem acceptable for general dental practitioners considering most of us will wind down in our older years of working life. This system is great in theory but in practice the system is flawed, especially for GDP associates.

The annual reconciliation report (ARR) is a declaration by the principal regarding the associate's pensionable earnings for that year alongside their own. We place our trust in principals to complete these declarations accurately and honestly. A discrepancy between declared and actual pensionable earnings may result in the associate receiving less pension than their entitlement.

Having experienced this several times, GDPs should be urged to check their schedules and check with NHS BSA that the correct figures have been declared for their performer number.

Miscalculations are being made either through principals' lack of understanding of NHS pension rules or through fraudulent behaviour. Despite much publicity from the BDA about this, it seems many NHS associates have not taken it upon themselves to firstly verify their declared earnings let alone challenge it if a discrepancy is noted. The pension one accrues as a GDP is wholly dependent on the figures entered on these forms.

Informal discussions with numerous dental associates leads to me to believe that the majority of them place no great emphasis on pensions either through ignorance or lack of understanding. This may ultimately be detrimental to their pension fund yet be an additional 'unearned bonus' to their principals.

J. Balachandran
By email
DOI: 10.1038/sj.bdj.2012.732

UNJUSTIFIED VINDICTIVENESS

Sir, there is anger and frustration nationally about the role of NHS Choices and the frustrating lack of editing rights and ability to challenge comments put on there. I would like to update your readers regarding our recent experience with a vindictive patient who commented adversely and unfavourably towards us.

We had not had any comments put on NHS Choices until recently when a patient of our practice was denied access to NHS services as they had failed to attend repeated appointments. Under our agreed policy with the PCT (in contract) we were allowed a 'two strikes and you are out'. The patient came in and gave my manager grief over this issue. Alerted by the commotion of the patient's raised voice, I remained hidden within earshot to listen to the conversation. My manager behaved remarkably coolly and in line with our difficult client management training, organised by our PCT! The patient left and said that she would let it be known that we were a rubbish practice.

Two days later we were statutorily informed by the PCT that a comment had been placed on the NHS Choices website. The comments were awful, saying that the staff were rude and impolite and so on. These are not reflective of our practice. The adverse comments are easily visible to any prospective new patient and only two clicks away when you Google our practice and my name. We obviously knew who it was.

We had previously carried out three patient surveys/audits in the past five years, two in-house and one independently carried out by Dr Foster Intelligence on behalf of our PCT over a six month period. In all three surveys we scored above 90% satisfaction across of all areas of patient contact with our practice.

I contacted the moderator of NHS Choices and put my case across, outlining our good feedback history and applied to have the comment struck off as it was clearly unjustified vindictiveness against us. The request was denied and I was told it has to remain; to this day it is still there. Having heard from my LDC that this was an ongoing frustration with other GDPs nationally, I decided to do something about it. The only way was to drown the patient's comments by proactively asking patients in the subsequent week if they would comment on NHS Choices about their experience with us.

I was then contacted by the PCT informing me that I was an outlier in the high volume of comments on NHS Choices which were positive. I was informed that they would not likely be allowed to remain. I was livid! This is unfair! After explaining the issue, I asked for the details of the ombudsman overseeing NHS Choices. As I said I would take this further it looks like the PCT have now decided to allow the positive comments to remain.

We have successfully drowned the adverse comments in a sea of praise about 18 clicks deep.

This whole episode questions the value of NHS Choices. I have had to resort to gamesmanship to challenge someone else's unjustified comments and protect our reputation.

M. Hussain
Catford
DOI: 10.1038/sj.bdj.2012.733

GUN PELLET RADIOPACITY

Sir, a 51-year-old patient was referred to the maxillofacial department by his general dental practitioner due to 'an object lodged between UL7 and UL8'. On attendance he gave no history of injury to the area, and was symptomless. On examination it was noted there was a