Appropriate clinical management is then taken on any 'suspicious' lesions.

Recent announcements by the GDC that 'Oral Cancer: improving early detection' is to be included as a recommended topic in the CPD scheme is definitely a step in the right direction and one that we as a profession must build upon. By increasing awareness of the disease amongst our patients as well as continually educating our dentists in the latest methods and techniques, I feel that we will be one step closer to controlling cancer rates in our communities.

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DOI: 10.1038/sj.bdj.2012.843

THYROID PROTECTION

Sir, the American Thyroid Association (ATA) has recently published[1] its recommendations that thyroid protection should be provided to all patients undergoing head and neck radiography in order to reduce the risk to the thyroid gland from ionising radiation: 'With regards to dental X-rays, the ATA recommends the reduction of thyroidal radiation exposure as much as possible without compromising the clinical goals of dental examinations.'

The risk to the thyroid gland from ionising radiation has been well documented. Dr Elaine Ron of the Radiation Epidemiology Branch, National Cancer Institute, USA, and her colleagues in their enormous 1995 study of thyroid cancer[2] following exposure to external radiation of the head and neck region concluded that: 'The thyroid gland in children has one of the highest risk coefficients of any organ.'

Whilst a relatively rare disease (2,300 cases are diagnosed in the UK each year), the number of thyroid cancer cases in the UK continues to rise, with the highest rate of increase being in the cohort of young females (15-35 years of age).[3]

Current US,[4,5] European[6] and UK[7] guidelines appear to be clear and unequivocal on the necessity for shielding the thyroid gland during dental radiography. In the course of delivering radiography and radiation protection training ('IR(ME)R' courses) throughout the UK, I encounter a widespread lack of knowledge amongst my dental colleagues either that such a risk exists or that national and European guidelines recommending the use of thyroid collars during routine dental radiography are still extant – despite no longer requiring the use of 'lead aprons'.

In light of the recent publication of the ATA's recommendations, is it perhaps time for us as a profession to review the necessity of using thyroid protection on our patients whilst undertaking diagnostic imaging? (See Fig. 1.)

I. Hamilton
By email

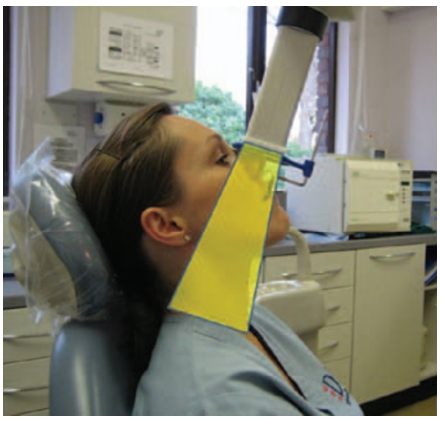

Fig. 1 Upper anterior periapical radiograph. The likelihood of illuminating the thyroid gland in the primary beam increases if the patient has a shallow palate or raises their head

1. American Thyroid Association. *Policy Statement on Thyroid Shielding During Diagnostic Medical and Dental Radiology.* June 2012. www.thyroid.org/wp-content/uploads/2012/06/ATA_Policy_Statement_June_2012.pdf (accessed August 2012).
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DOI: 10.1038/sj.bdj.2012.844

BARRED FROM CONSIDERATION

Sir, the GDC's requirement for all dental nurses to be either qualified or on a training programme is having unintended consequences for our profession.

Local colleagues and I have employed nurses with recent qualifications from a local training college only to find they have little knowledge of how to handle dental materials and are unable to do even basic charting. Without this latter skill they risk the wrong treatment being done to a patient and they are therefore unsafe working in a practice despite possessing a qualification approved by GDC, whose principal role is the protection of the public.

In contrast, I recently needed to employ a part-time dental nurse, a position which would be ideal for a lady who used to be a dental nurse before raising a family and now wishes to do a few days' work. Such ladies are normally highly dependable as well as having a breadth of life experiences which count for so much when interacting within a team and with the patients. Several such ladies would have been ideal but they were unable to consider the post as they have no formal qualifications and it is unreasonable to require them to undertake a 'recognised training programme', at extra cost and in their own family time, for something which they can do standing on their head.

Additionally, each of us GDPs works in our own quirky way and finding the right nurse can be a fine art.

The GDC's well-intentioned rules are therefore forcing a whole group of potential team members to be barred from consideration for positions to which they are ideally suited. This can surely not have been the intention of the GDC and so I propose an alteration to the GDC's rules: dental nurses who have had several years of experience before taking a career break should be allowed to return to work under the supervision of a nominated dentist; that dentist would then be entirely accountable for the actions of that nurse; there could also be a form of in-house assessment which could gain recognition from the GDC.

By adopting this scheme, the profession would welcome back a whole group of eminently suitable (but not officially qualified) nurses, dentists would be able to work with a nurse who matches their quirky ways, and the protection of the