The Editor-in-Chief responds: I thank Dr Gould for his letter. The journal does not shy away from criticism and as regular readers will be aware is a place where adult debate is encouraged in order to promote and develop a healthy and ethical professional exchange. Dr Gould requests a response to specific matters raised in his letter. It is my belief that many of these were addressed and our reasons for making the changes we did were explained in my editorial, to which he refers.[1] *The matter of CPD is in danger of going around the same circle again and again with well-rehearsed arguments and it is therefore not my intention to use valuable column inches to reiterate these.*[1,2]

However, in relation to my two sentences regarding criticisms of any journal CPD scheme as being 'merely a "box ticking exercise"' Dr Gould has inferred that 'as one of the few who have had correspondence published that highlights this very characteristic' I was referring to him personally. This was a generic point which has arisen many times in conversations, email correspondence and in presentations; not solely in published content in the BDJ. *I am, frankly, genuinely surprised to read that he should take this so much to heart as I was certainly not referring to him personally. Consequently, nor was I or could I have been suggesting that he is unethical, nor was I being consciously insulting towards him, however much he might feel that I was. He was not specifically in my mind at all and I trust that this publically clarifies the matter.*

As to the validity of a verifiable activity I think it is disingenuous to state that in relation to lectures the requirement of documentary evidence 'is met by the organiser confirming physical presence'. Just as many critics of journal CPD (or 'virtual participation' CPD as Dr Gould terms it, presumably including participation on his own company's website in this description) point to box ticking exercises so they also identify attendees of lectures sleeping through them, sending texts or engaging in various other activities none of which include paying attention to the presentation. I think it is disappointing too that in analysing the editorial he fails to comment on my statement that the 'overwhelming majority of users get the overwhelming majority of questions correct'. I suspect that the same majority, in reading this, will feel that they act perfectly ethically in conscientiously reading the papers, answering the questions and studying the answers and would themselves feel not unreasonably slighted that their genuine time spent on this CPD activity is snubbed as being of some lesser value. The quoted figure of the 'average time spent reading the journal was 38 minutes' refers to all readers (print version approx 20,000 copies per issue; online version in excess of 100,000 unique readers per month) and so does not specifically refer to those undertaking CPD.

Importantly, the GDC has not ever, and does not now make any mention of 'pass marks' in relation to any verifiable CPD activities and has not taken the opportunity to do so in its most recent updated version published in September 2013. To suggest otherwise is in my opinion an incorrect interpretation.

Dr Gould states that the GDC's review of CPD received only '387 responses (less than 0.04% of dental registrants)' and asks if this is a reflection of the importance of CPD to registrants. He may also like to know that he is the only person who has written to the BDJ *on the subject of the editorial since it was published. I think this doubly answers his question, at least with regard to picking over the detail in preference to getting on with the objective which is lifelong learning.*

We have extended the courtesy to Dr Gould of publishing his letter in full, which at 825 words is greatly in excess of our usual limit of 500 words as we feel that it is an important topic and to demonstrate our commitment to publish critical as well as complimentary content. I have pledged to continue to review the content, conduct and quality of our CPD offerings, will do so, together with our partners, and will factor Dr Gould's constructive criticisms into our discussions. While we do not wish to stunt any further debate we would ask that future correspondence covers new ground and respects the 500 word limit.

1. Hancocks S. CPD – changing access and raising standards. *Br Dent J* 2013; **214:** 483.
2. Hancocks S. Does D put the dilemma in CPD? *Br Dent J* 2012; **212:** 461.

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AN EFFECTIVE PIPELINE

Sir, Professor Kay's editorial (*BDJ* 2013; **215:** 199) highlighted the importance of being able to succeed in a career for which one shows both talent and commitment. It also stated the importance of visible role models and equal opportunities to rise to the top of one's profession. Professor Kay emphasised these issues from a female perspective and also promoted the potential for equal opportunities afforded by the Athena SWAN Charter which is managed by the Equality Challenge unit.

The School for Oral and Dental Sciences in Bristol provides an example of how it is possible to change the historic trends that are referred to in that editorial. We were awarded a Silver SWAN award in April 2013. While we are, without doubt, a school like those described (we admit around 70% of female undergraduate students each year and eight out of 22 staff at senior lecturer level or above are female) we are committed to the principles of Athena SWAN and a culture of equality for both women and men. Ten years ago fewer than half of our undergraduate students and three out of 22 members of staff were female; now 22/42 (51%) full time equivalent academic staff (across all levels) are female. We believe that we have an effective pipeline which is supporting female dental academics as they reach and maintain senior roles.

In preparing for the SWAN application we undertook qualitative interviews with female members of academic staff and one of the messages to come from that was that, as Professor Kay suggests, academic staff within dental schools are ambitious and keen to progress. However, those interviewed also reported that what was required was equality for all and it is this that we are working to maintain. Our action plan for the application was developed to ensure that we continue to encourage and support equality and our working

group is in place to facilitate that (both our application and the action plan can be found on the school's website). One of the co-chairs of the group has done what is suggested by Professor Kay and taken part in two rounds of application assessment – without doubt, both here in Bristol and nationally, there is evidence that good employment practice is increasing for women who are working in STEM subjects in both higher education and research.

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DOUBTFUL WISDOM

Sir, the recent Opinion piece by Mansoor *et al*. on NICE guidelines[1] raises the issue of wisdom teeth and whether to remove them. As referred to in their article, we followed patients with asymptomatic lower third molars for a year[2] and observed the development of symptoms and the number of teeth extracted. Indeed over 5% of all teeth studied were removed after one year; however, a small number of these had no recorded justification for removal.

Whilst the research base for what happens if third molars are left may not be strong, we do know that taking out asymptomatic wisdom teeth is often associated with some fairly unpleasant side effects. In addition to those mentioned, we should not forget quality of life issues. We previously found that time off work, ability to chew food, ability to swallow, and loss of self-esteem were also of concern to the patient.[3] When we sought to identify the most significant factor (by asking all OMFS consultants in Scotland, all dentists in Tayside and retrospectively asking 120 patients to rank the side effects they experienced after third molar removal), clinicians ranked pain as the most significant complication, whilst patients identified interference with eating.[4] Thus a number of additional complications appear to exist which may impact upon the patients' well-being.

A randomised controlled trial on this subject would face many challenges not only relating to logistics and ethics but it would have to compensate for differences in access to dental services and in the history of past and current dental disease experienced by the subjects involved in the study.

Further research is clearly still required to improve the evidence base from which to make the conclusion that asymptomatic third molars should be left alone. The wisdom of this is currently in doubt.

M. Fernandes
G. R. Ogden

1. Mansoor J, Jowett A, Coulthard P. NICE or not so NICE? *Br Dent J* 2013; **215:** 209–212.
2. Fernandes M J, Ogden G R, Pitts N B, Ogston S A, Ruta D A. Actuarial life-table analysis of lower impacted wisdom teeth in general dental practice. *Community Dent Oral Epidemiol* 2010; **38:** 58–67.
3. Savin J, Ogden G R. Third molar surgery – a preliminary report on aspects affecting quality of life in the early post-operative period. *Br J Oral Maxillofac Surg* 1997; **35:** 246–253.
4. Ogden G R, Bissias E, Ruta D A, Ogston S. Quality of life following third molar removal: a patient versus professional perspective. *Br Dent J* 1998; **185:** 407–411.

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HPV CONCERN

Sir, I am concerned about a new group of patients I have been seeing in my practice recently. There is a growing number of patients who have developed oral cancer in innocuous-looking lesions in the oral cavity. There is no tobacco/betelnut/paan habit or traumatic, sharp teeth present, and these are young patients, between 20 and 30 years of age.

One such patient was only 19-years-old when she came to me with a tongue ulcer. The chief complaint of the patient was about a small painless ulcer on the side of the tongue which had not prompted her to seek treatment initially. The ulcer did not heal and did not respond to treatment with mouthwashes, glycerine application, or any of the conservative modes of treatment.

The general practitioner kept treating her for more than two months but did not take it seriously and kept treating it, without referral to an oral medicine or oral pathology specialist. It was only when more symptoms developed, and the ulcer increased in size, that there was serious concern. Unfortunately, the general practitioner did not even think of cancer, as there were no related habits, and/or sharp traumatic margins of the teeth, so that by the time the referral was made the cancer had become well-developed and involved deeper areas.

When I examined the patient the cervical lymph nodes were also involved and I gave the diagnosis of squamous cell carcinoma immediately, taking a biopsy of the ulcer and sending it for histological examination. The report was 'squamous cell carcinoma, keratinising, moderately-differentiated' and 'surgical margins of resection involved by tumour'.

Surgery had to be extensive, with cervical node dissection, and it was very disfiguring.

Needless to say, the patient was mentally traumatised and went into depression. Unfortunately, the patient has stopped coming for follow-up. When I discussed the aetiology with the surgeon and other pathologists, human papilloma virus was the commonest answer. There has been a marked rise in such cases across the globe and sexual habits and practices seem to be the major cause. It is estimated that the frequency of oral cancer due to HPV is greater than for other causes such as tobacco usage.

A. M. Havewala
By email
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