recommend the use of the described controlled rotational movements for the removal of any multirrooted tooth with reasonably straight roots. This straightforward technique ought to be added to the general dentist's armamentarium. No extra equipment is required and you and your patients may well be thankful for any such method that makes exodontia easy (*easier*)!

J. A. Loudon
NSW

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IMPLANTS AND DEMENTIA

Sir, your interview with Professor Donos (*BDJ* 2012; **213**: 479–481) stimulated me to ask the most important question of all. What happens to people with high maintenance implants when they develop dementia and are unable to look after themselves?

As a dentist working in Central London in the special care dental service I know the answer, and it's not pretty.

Over the past year or two I have started to see a number of people with dementia and implants. All of them are uncomfortable, and none of them is practising adequate oral hygiene. The dentists who fitted the implants and follow Professor Donos' recall/hygiene procedure lose touch with them. In any case, the patients often can't afford to pay for follow-up, and we can't do very much on a domiciliary basis anyway.

Care staff notice that the overdenture or fixed appliance has a nasty exudate from the fitting surface. They are unable to clean the appliance properly because the resident won't cooperate. Often they won't remove the overdenture because they are frightened of the strange objects protruding from the gum, or the patient won't let them, for fear of losing the denture. Forget aided flossing or interdental cleaning.

Not only are the gums under the appliance infected, but the different 'feel' of

the implants causes concern, especially when the odd couple of teeth are placed around the mouth, and the adjacent natural teeth have decayed to roots.

Radiographs show peri-implantitis, of course. What's the answer? Oral surgery referral for a sick 95-year-old for fairly unpleasant surgery, who can't provide informed consent?

Looking at the number of dentists placing implants, I can see this cohort is the tip of the iceberg.

Older people are a real dental time bomb, even more so with increased life expectancy.

I recently looked at the dental status of residents in a local care home: 75% had decayed teeth, and 54% had very poor oral hygiene. (Special care dentists will be nodding their heads at this – words can't describe how bad these people's mouths are.)

In this situation I urge implantologists to think about the ageing of their patients, as well as the beauty of their restorative jewellery.

Perhaps the answer is to stick to implants where all the intraoral parts can easily be unscrewed when the patient is old and unable to look after themselves. Obviously a silly suggestion, but one which I hope will stimulate thought.

As for me ... I'll stick to my gaps in the premolar areas thanks!

D. Howarth
By email

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INCREASING INTEGRATION

Sir, the opinion piece by Professor Giddon (*BDJ* 2012; **213**: 497–498) draws attention to the increasing integration of medical and dental education exemplified by the proliferation of academic institutions combining faculties of medicine and dentistry. The University of the Witwatersrand, Johannesburg, has had for a number of years a Faculty of Health Science, incorporating as equal partners Schools of Oral Health Science, Clinical Medicine, Pathology, Public Health and Therapeutic Sciences. The University of Western Ontario in London, Canada, combines the teaching of the two professions under the umbrella of the Schulich School of Medicine and Dentistry. The

University of Medicine and Dentistry of New Jersey, USA incorporates the two professions under its combined single title. The University of Alberta, Edmonton, Canada incorporated its Dental Faculty into the Faculty of Medicine and Dentistry, subdivided into various medical departments, with the School of Dentistry recognised as an equal partner with the Dean of Dental Affairs being a Senior Associate with the Dean of Medicine. The first two years of the four-year MD and DDS programmes are taught together. Moreover, the dental students are inducted into blood pressure assessments, and, with medical students, take a course in patient tobacco cessation guidance. The Harvard University protocol of training general practice dental residents to provide preventive primary care as oral physicians sets the pattern for the future practice of dentistry as a partner in medicine in providing comprehensive healthcare for their patients.

G. H. Sperber
Edmonton

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QUESTIONABLE VALUE

Sir, recent *BDJ* content has raised important CPD issues.^{1,2} The enormous amount of paper consumed in feedback forms (often completed in seconds at the end of a CPD programme) duly collected and exchanged for verifiable CPD certificates surely must be a concern, as well as of questionable value. Yet this can often be the only method used to confirm this most important process currently used to facilitate re-registration pan-professionally.

Is this really sufficient to maintain a professional edge when it is known that biomedical knowledge doubles every 20 years?³ Are these traditional methods that are widely used in various formats to update knowledge and skills pertinent to dental practice in the year 2013? The essential need from a general dental practice standpoint and of course, that of other modalities, is that any system that purports to increase the knowledge base will also help to apply and deliver this to clinical decisions and practice and hence benefit patient treatments as Kelleher points out.² It has been suggested that