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

1. Jeavons P. Familiar forceps. *Br Dent J* 2010; **208**: 96.
2. Quinn J H. Use of rotational movements to remove mandibular molars. *J Am Dent Assoc* 1997; **128**: 1705–1706.
3. Natali A, Pavan P, Carniel E, Dorow C. Viscoelastic response of the periodontal ligament: an experimental-numerical analysis. *Connect Tissue Res* 2004; **45**: 222–230.
4. Provatidis C G. An analytical model for stress analysis of a tooth in translation. *Int J Eng Sci* 2001; **39**: 1361–1381.

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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
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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

5–10% of professional life should be so allocated to achieve this.^{4,5}

Clinicians need solutions to be most effectively applied at the time clinical problems occur, or at least very soon after. The priorities for such information can vary from solutions needed at the time to guide a particular decision or action, through solutions needed before seeing the next patient with a similar problem, to the solutions that may interest us but have no active clinical implications in our practice. Under pressure, it is usually only the first category that is addressed.

How to achieve this? Professionally derived literature packs, for instance, on various topics intended specifically to increase understanding and knowledge of certain procedures techniques or management have been shown often to have little or no effect and fail to influence treatment decisions and practice in healthcare professionals.⁵

There are many such questions that need consideration with regard to the overall process and hopefully the upcoming GDC revalidation proposals will be a beginning in addressing the larger picture. Martin Kelleher's suggestions of a completed multiple choice follow up would go some way towards stimulating reflective learning on the topics delivered at the very least, and perhaps these methods will influence behaviour.

A matter of especial concern in a profession such as ours that has hugely varied levels of CPD among those who belong, with – despite everything – some having no commitment at all, but nevertheless considering they can 'get by' and largely still using knowledge and techniques obtained during their early training. Evolution and culture change will perhaps be difficult in many areas!

K. F. Marshall
By email

1. Hancocks S. Does D put the dilemma in CPD? *Br Dent J* 2012; **212**: 461.
2. Kelleher M. The difficulties of making 'CPD verifiability' a legitimate measure of learning outcomes. *Br Dent J* 2012; **213**: 383–384.
3. Wyatt J C. Use and sources of medical knowledge. *Lancet* 1991; **338**: 1368–1373.
4. Wyatt J C. Keeping up: continuing education or life long learning? *J R Soc Med* 2000; **93**: 369–372.
5. Marshall K F. CPD learning. *Br Dent J* 2000; **189**: 287.
6. Evans C E, Haynes R B, Birkett N J *et al*. Does a mailed continuing education package improve physician performance? *JAMA* 1986; **226**: 501–504.

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ACCLIMATISING CHILD PATIENTS

Sir, I read with interest the interview with Prof Tim Newton (*BDJ* 2012; **213**: 423–425) and was especially interested in his top five tips for the dental team in dealing with patients' anxiety. The fifth tip was concerned with the treatment of children and Prof. Newton recommended getting children into the surgery to acclimatise them. I wonder whether I might be permitted to offer a couple of additional suggestions based upon over a quarter of a century of experience in treating children?

If it should ever become necessary to provide operative treatment for a child then I have found it invaluable to explain the entire procedure at the diagnostic appointment and then to get the child back for a second operative appointment (preferably in the morning when they are less tired). It is a very useful technique to desensitise the child by allowing them to handle the instruments which will be used on the second visit. I allow them to lick the end of a cotton wool bud which has been coated with flavoured surface anaesthetic and to feel the sensation of a needleless syringe pressing against their gum. I always use a Vibraject when giving locals and I always turn it on and let the child feel the buzzing sensation against their gum. If they are allowed to play with the syringe and Vibraject at the diagnostic visit then they will not be tempted to look when you repeat the procedure with a needle attached at the operative appointment. An injection given using Vibraject is virtually undetectable so the tooth can always be uneventfully anaesthetised and the child will not notice that second time round they actually had an injection. I also find it useful to demonstrate the slow and fast handpieces. If a large rosehead bur is placed in a slow handpiece the child can touch the rotating bur with the ball of their finger without feeling anything more than a tickle (try it on your own finger if you don't believe me!). The air rota can be safely demonstrated by touching the ball of the child's finger with either the side of a tissue-protecting end-cutting bur or alternatively the tip of a safe-ended endodontic access bur.

The two or three minutes spent doing these simple demonstrations can save

many minutes and a lot of stress at the operative visit. One last tip – when talking to a child always kneel down so that you are at their eye level. This makes you much less threatening.

M. W. M. Hawkins, Gillingham
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FAT FACES AND SWELLINGS

Sir, there has been much in the literature and indeed national press recently that has raised serious concerns about the overuse and misuse of antibiotics. In fact the BDA has produced a very useful booklet on that subject but may I be bold enough to suggest another area where we might be using them unnecessarily.

A couple of weekends ago I was doing a three-hour, on-call session for my local NHS Trust. I find this interesting as I get to see acute emergencies that I don't see very often which I put down to the fact I have been at the same practice for 35 years and the majority of my patients have very good dental health.

On this occasion I saw a male in his twenties presenting with a fat face with a fluctuant swelling around a grossly carious lower right first molar. The normal treatment would be antibiotics followed by review and extraction at a later date. All my practising life this has not been my view so once again I gave the patient an ID block very slowly followed by an even slower intra-ligamentary injection around the swollen tooth. Complete anaesthesia was achieved, the tooth elevated with a Couplands, a large amount of pus was released and aspirated away and the patient left very happy, had no post-operative problems and was given no antibiotics. Though this may go against traditional teaching, it has always worked well throughout the whole of my practising life and I have seen some spectacular fat faces and swellings in that time!

P. R. Williams, Lowestoft
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