Most general dental practitioners will not have ready access to laboratory tests of renal function or of haemostasis, and perhaps until more experience is gained in the treatment of dental patients receiving therapy with this useful drug, bearing in mind that such patients will also have serious medical problems, it may be best to refer such patients needing surgical dentistry to hospital.

So, when checking a medical history we should watch out for this new and interesting drug and think carefully about the implications for dental treatment.

M. de Mendonca, Brighton

I would like to thank Tracy Alston BSc, Medical Information Officer at Boehringer Ingelheim Limited for her invaluable assistance in preparing this letter.

1. Griffiths M, Scully C. New anticoagulants. *Br Dent J* 2012; 213: 98.
2. Davies R. Increase in referrals. *Br Dent J* 2012; 213: 375-376.

DOI: 10.1038/sj.bdj.2013.5

NO MORE FUN

Sir, after 29 years in practice, keeping up to date and working as a PCT Dental Adviser across three boroughs in London for 14 years, I commissioned an artist friend of mine, Walter Hayn to illustrate how I feel (Fig. 1). Since the 2006 contract and with the excessive red tape over us, there is no more fun in dentistry.

M. Hussain, Catford

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A GLOBAL RISK

Sir, while I am sure that your readership is fully aware of the importance of good air quality in the surgery, are they convinced that they have good air quality in their own surgery? A recent survey of 60

dental practices in Harley Street and its environs suggest not. The advice given to dental practices by the DH in their Health Technical Memorandum 01-05 concentrates entirely on the decontamination processes in the surgery together with water quality to the spittoon and other dental equipment.¹

The only reference to air flow in this document is in the decontamination area, typically positioned along one wall of the surgery. The simple advice given is that there should be adequate airflow from the clean side of the area directed to the dirty end and then vented to the outside. Such advice stems from Victorian values which advocated fresh air as a health benefit when what is actually happening is that *some* of the contagions and particulate matter and *all* the heating is being pushed outside (in winter) with the risk (in summer) that all the contaminated air simply returns through open windows.

Harmful particles and gases from dental practices come from photographic solutions, casting alloys, polishing agents, etching agents, amalgam and sterilising agents – just to name the key sources. These are a global risk for all dentists in any type of practice premises.

A recent independent air quality test carried out in a Hertfordshire dental surgery, which for all intents and purposes complies with the DH's Technical Memorandum, found the same air quality problem and specifically levels of ethanol and propanol were three times higher than the recommended maximum, and tetrachloroethene twice as high. The potential long-term health damage includes degenerative cognitive skills, eye/nose/skin irritation, respiratory problems, chronic asthma and beryllium disease.

This same dental practice installed an air purifier which reduced these levels to well below published safe levels, and to zero in some cases in a matter of hours, thus providing a near sterile room.² Dentists' normal work will produce emissions for the foreseeable future, causing health risks, and who knows which harmful pathogens patients can introduce to the surgery, not to mention the impact of the outdoor air quality or the building structure itself. Each practice has a duty of

care for all their employees and patients to reduce the emissions to a safe level.

A. Wales

By email

1. Department of Health. Health Technical Memorandum 01-05: *Decontamination in primary care dental practices*. 1 December 2009. Available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_109363
2. Genano Total Air Care. www.genano.co.uk

DOI: 10.1038/sj.bdj.2013.7

IMMENSELY USEFUL

Sir, Kandiah and Tahmassebi failed to demonstrate any benefit using a Wand for local anaesthetic over conventional technique for anaesthesia of first permanent molars in children (*BDJ* 2012; 213: E15). I have found it immensely useful in three specific areas of maxillofacial practice which might be suitable for investigation as Dr Veerkamp suggests in his commentary (*BDJ* 2012; 213: 460-461).

Combined with topical tetracaine at the site of the first needle puncture I have found that the Wand gives completely painless local anaesthetic for repairing of facial lacerations and removal of basal and squamous carcinomas from the face. It is particularly useful around the nose, an otherwise very sensitive area to inject.

Using the Wand I have been confident to carry out arthrocentesis to the temporomandibular joint on awake patients. This makes the procedure easier as the patient can cooperate by moving their mandible as requested. My own very crude audit has shown improved short term symptom reduction over using general anaesthesia possibly due to patient cooperation and more prompt treatment.

I commend the use of the Wand for these procedures. It is not suitable for everyone, however. I was unable to persuade my dermatologist colleague; he said it did not matter to him if the patient suffered pain with injection.

A. Sadler

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SKIN CANCER AWARENESS

Sir, a 75-year-old lady was referred to the OMFS department by her GDP, who had noted two large lumps on her nose, which