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.

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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

Fig. 1
How
Martin
Hussain
feels about
dentistry

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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

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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

the patient reported had appeared within the previous six months with some itching and bleeding. Two individual lesions were noted, a 1 cm diameter cystic lesion at the nasal tip, and a 0.5 cm diameter nodular lesion at the left nasal alar. Both had a pearly edge, firm border and central telangiectasia, suggestive of basal cell carcinomas (BCC) (Fig. 1).

Fig. 1
Presentation
of the BCCs
at initial
consultation

Histology from biopsies revealed nests of BCC displaying a nodular growth pattern. The lesions were excised with a margin of normal tissue under general anaesthesia and the defect repaired using cartilage from behind the ear. Healing was uneventful and the patient is under review. The tip of the nose BCC was found to be of the nodular and infiltrative type with perineural invasion; that from the alar was of nodular type with no perineural invasion.

The most common malignancy in Caucasians is BCC, a slow-growing, locally invasive epidermal basaloid cell cancer presenting in patients of over 40 years. Family history of skin cancer, overexposure to sun, blonde hair, blue or green eyes and immunosuppressive therapy are all risk factors for developing BCCs. Moreover, the risk of further BCCs, as well as other skin cancers, is increased in patients with existing BCCs.¹ Early detection can improve functional and cosmetic results of resection surgery, by limiting facial tissue involvement.²

Usually presenting as pearly or waxy papules, features typical of BCCs include telangiectasia and rolled borders, crusting, oozing or bleeding. They have low morbidity and most follow a fairly indolent pattern. However, aggressive BCCs may ulcerate frequently and lead to destruction of surrounding areas on the face: of particular concern are those present-

ing around the nose, ears and eyes. They may be treated with a variety of methods including surgery, radiotherapy, imiquimod, fluorouracil and photodynamic therapy. Prevention of BCCs is mainly by reducing exposure to sunlight, avoiding sunbeds, wearing sunscreen of factor 15 and above, covering exposed skin and regular follow-up for patients with previous BCCs.⁴

The purpose of this letter is to raise GPs' awareness of the risk factors, incidence and appearance of BCCs as despite their prevalence, dentists may not be aware of the risk factors, diagnosis or benefits of early detection.⁵ Provision of preventive advice can be easily carried out in the dental surgery. Further education of GPs on the appearance of skin cancers is warranted to ensure prompt referral.

F. Aga, London

1. Wong C S M, Strange R C, Lear J T. Basal cell carcinoma. *BMJ* 2003; **327**: 794–798.
2. Baxter J, Patel A. Facial basal cell carcinoma. *BMJ* 2012; **345**: e5342
3. Crowson A N. Basal cell carcinoma: biology, morphology and clinical implications. *Mod Pathol* 2006; **19**: S127–S147.
4. Basal cell carcinoma. A.D.A.M. Medical Encyclopedia.
5. Neville B, Day T. Oral cancer and precancerous lesions. *CA Cancer J Clin* 2009; **52**: 195–215.

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MY NON-JOB

Sir, reluctantly I have found that I now have two jobs. The first is a real job: providing dental services to my local community. If I do this job well I am a significant asset to that community. If you wanted to, you could assess how well I do this job by judging the quality of advice I give and technical quality of treatments provided. You might also wish to confirm that my cross-infection control measures are effective and applied with diligence.

My second job is what is commonly known as a non-job. That is one that involves many hours of mind numbingly dull work, producing reams of documentation that rarely if ever get read.

Several government bodies are now charged with assessing how good I am at my job. Inspectors from these various agencies are now appearing with monotonous regularity at my practice wanting to see my policies and risk assessments on this, that and the other. All of this is

extremely time consuming as I am inevitably given more homework to do; such and such a policy has to be rewritten so as to be in the particular format that that inspector likes to see. Or, as a matter of urgency, training has to be undertaken on some peripheral or irrelevant topic.

The various inspectors' visits are inevitably preceded by a letter proclaiming particular agencies' commitment to driving up standards of dental care, yet none show any interest, whatsoever, in how well I do my real job. This is a shame because I'm much better at my real job than I am at my non-job.

My real job is full time, therefore to do my non-job I have to moonlight, which means to do it even to an average standard I have to give up most of my spare time. Like all people who do two jobs, and therefore spread themselves too thinly, there is a danger that I cannot do both well.

I recently had the opportunity to see, first hand, how state interference of this sort has affected another profession. We had a break-in at my practice premises and the police response was interesting. There was a lot of paperwork where much information was recorded, right down to such details as the religious affiliation of all members of my staff. What became apparent, however, was that nobody expected this process to lead to the arrest of the burglar. As an outsider, it appears to me that the police investigation of burglary has been made a non-job.

Could this happen to the dental profession? Could it become common for a patient to attend an appointment with a dentist for say, the relief of toothache, only to find that after much paperwork, and all policies and procedures have been complied with, they are sent away still in pain? Time will tell, but I believe that that is precisely what is going to happen, and with it our value to the community will be lost.

J. R. Mackay, Chalfont St. Peter

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