LETTERS TO THE EDITOR

Send your letters to the Editor, British Dental Journal, 64 Wimpole Street, London, W1G 8YS
Email bdj@bda.org. Priority will be given to letters less than 500 words long. Authors must sign the letter, which may be edited for reasons of space. Readers may now comment on letters via the *BDJ* website (www.bdj.co.uk). A 'Readers' Comments' section appears at the end of the full text of each letter online.

ARF HIKE

Together we are stronger

Sir, in light of the current situation with regards to the GDC, the British Academy of Cosmetic Dentistry, following the BDA's lead, would like to encourage more dental professionals to come together and make their voices heard.

The alarming proposed increase in ARF combined with a most unhelpful advertisement in the *Daily Telegraph* and various other disheartening events have necessitated a call for action from the profession. Not only are we being asked to pay 64% more for our registration to practise in the UK, but it seems the regulatory body that should be offering support and guidance is in fact facilitating complaints which could be solved in a more effective and cost-efficient manner at a local level. With more than one report from the Professional Standards Authority suggesting that the GDC falls short of acceptable regulatory standards, it is no surprise that many believe the GDC is no longer 'fit for purpose', as the recent BDA survey has shown.

We believe that by employing a unified approach and collective action in dealing with this problem, we can help the GDC and the Government realise their approach is flawed and not in the best interest of the dental profession or public, and that significant changes need to be made.

We are working with groups like the BDA, ADI, BAAD, BADN, BADT, BARD, BDA, BDBS, BLOS, BOS, BSDHT, BSOS, BSP, ESAO, and DLA in an initiative that brings together as many national dental organisations as possible, so that a clear and concise message is sent to the GDC and the Government, not just about this fee hike, but about the profession's unhappiness with the performance of the GDC. As more groups commit their signature or logo to future communications with the GDC and the Government, the message we send out will be unified, louder and clearer.

Individual registrants can also make a difference by completing the consultation questionnaire on the GDC website (http://www.gdc-uk.org/GDCcalendar/Consultations/Pages/Consultation-on-the-Annual-Retention-Fee-(ARF)-Level-for-2015.aspx) or by signing one of the various petitions designed again to provide a singular, stronger voice for registrants (eg http://epetitions.direct.gov.uk/petitions/66982).

We plan to keep the profession informed as the situation develops, through the e-newsletters and social media postings of various groups. We also hope that everyone who feels we could do more to help at this time gets in touch.

Z. Kanaan, BACD President

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ORTHOTROPICS

Will we never be free?

Sir, I was bemused to find myself reading the book review of J. Mew's book in the 9 May edition of the *BDJ* (**216:** 493) whilst the radio news announced another controversy regarding the publication of controversial research on statins in the *BMJ*. During my 25-year career as an orthodontist I have lost count of the number of times Dr Mew has had his controversial views published in the *BDJ*. Now he has self-published a 354 page book which costs £140, and is of 'limited relevance to the general practitioner or dental student, but specialists will be able to reach their own conclusions...' There is no information about from where this book can be obtained so it will not be easy for me indeed to do so. Is this really worthy of half a page of copy in our scientific journal? If there were a prospective controlled clinical trial to show the superiority of the techniques he has been promoting for so many years I would of course use them for the benefit of my patients, for that would be my professional duty.

Today I find that the 23 May edition of the *BDJ* contains an 'Opinion' article by M. Mew (**216:** 555-558), the standard bearer of the next generation of orthotropics believers. My heart cries 'Will we never be free?' but my mind replies 'Peter keep an open mind and look at the evidence'. I will look at the evidence and will await further research. Perhaps it will come from the London School of Facial Orthotropics (of which J. Mew is a Professor) whose 'premises consist of one clinical room and one private consultation room'.[1] Although part of the *BDJ*'s mission statement is '... stimulating interest, debate and discussion', may I politely suggest that the *BDJ* has fulfilled its duty in this context?

P. N. Huntley, Solihull

1. CQC Inspection Report dated 29 October 2013.

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Pragmatic not defeatist

Sir, I would argue that there is no need for Mr Mew to invent a new name for what is commonly (in the orthodontic world at least) known as 'long face syndrome' or 'adenoid facies'. The debate about what causes this appearance has been ongoing for about 100 years. There is some evidence that changes in the shape of the mandible occur post-adenoidectomy but also there is evidence that the shape of the face is NOT related to the degree of nasal breathing; the difficulty in trying to find the truth is due to the complex interplay between multiple factors that are both genetic and environmental. Mr Mew has developed a treatment therapy based on his ideas and, irrespective of the theory behind it, we need to see how successful it is.

If one accepts that having a soft diet, chronic nose breathing and not swallowing correctly are causing some malocclusions (Mr Mew thinks about 30% according to statements on the Internet which seems an unlikely figure) then good luck to anyone trying to change them. One must not let the elegance, or otherwise, of a theory drive a therapy with a low success rate. I don't think this is defeatist, just pragmatic.

A. I. Pearson

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Cherry-picked references

Sir, I read the article *Craniofacial dystrophy. A possible syndrome?* by M. Mew (*BDJ* 2014; **216:** 555-558) with interest in the hope that the orthotropic fraternity could provide us with something new.

Unfortunately, like all other articles

RAISING STANDARDS

Sir, I was both interested in and saddened by the paper in the *BDJ* (2014; **216:** E22) on apical periodontitis (AP) and the technical quality of root canal treatment in an adult sub-population in London.

Thanks to the Young Dentist Endodontic Award (http://www.roottreatmentuk.com/html/young-dentist) I have been privileged to meet some exceptional young dentists with well-honed endodontic skills. From my experience, the best entries for the award are from graduates who have made a point of practising endodontic treatments while they were students, going above and beyond the requirements of their curriculum, or who have had inspirational support from a trainer during their foundation training.

At an early stage, it's not difficult to identify those dentists who should be doing endodontic treatments and those who might choose instead to refer to more experienced colleagues.

The high percentage of patients in the study who had received poor quality root canal treatment and still had AP were perhaps fortunate to be asymptomatic. Just recently, a 55-year-old teacher presented here in acute pain following root canal treatment by her dentist who had also prescribed three courses of antibiotics. The source of the tooth's problem wasn't infection but the gutta percha extruding from the apices of two roots, by 6 mm through one root and by 10 mm through the other. The tooth had been savable prior to treatment but post-treatment, extraction was the only solution to help the patient become pain-free.

As we all know only too well, more and more patients are suing their dentist or complaining to the GDC, which means that as a profession, we all bear the cost of poor-quality treatments, whether it's meeting the rising costs of defence organisation membership or the rising annual retention fee.

But it's the interest of patients which is the priority and there is no doubt that more could and should be done to raise standards.

J. Webber
London
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on orthotropics, the article is based on conjecture with references 'cherry-picked' to support some now historical theories of the aetiology of malocclusion. Furthermore, no scientific evidence is provided as to how orthotropics could resolve any of the 'symptoms' mentioned in the article whilst the text contains much to worry current and former orthodontic patients and parents.

When will the orthotropics proponents provide some scientific evidence for their claims?

G. McIntyre
Dundee
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Eschewing science

Sir, I read with interest the opinion piece in the *BDJ* entitled *Craniofacial dystrophy. A possible syndrome?* by M. Mew (**216:** 555-558).

I have two main issues with this piece which I think are worth mentioning.

Firstly, concluding with the statement, 'Attempts to constructively critique or falsify this hypothesis with quality evidence and sound logic are welcomed', is somewhat misleading. It would suggest that this article has presented a valid, evidence based argument for the existence of the potential syndrome 'Craniofacial dystrophy'.

What you have is the author's opinion on how malocclusion compares to a referenced ideal occlusion/posture described by his father (J. Mew) over 30 years ago, also in this Journal. The article is full of interesting claims regarding 'signs' and 'symptoms' that are almost wholly unsubstantiated by scientific reference. One would hope that given the author belongs to a worldwide elite number of 'master level' orthotropic practitioners[1] practising facial growth guidance, that a substantially higher level of evidence for this syndrome could be provided.

As such, inviting readers to falsify the presented hypothesis seems to eschew the scientific process of initially testing whether or not the hypothesis is valid.

Secondly, when there are opinions given in the *BDJ* regarding potentially controversial patient related issues, it would help if this was done in point/counter-point fashion, similar to the recent pieces on short-term orthodontics.

I fully respect the opinion of M. Mew and his right to voice those opinions. However, I am concerned when patients on public Internet forums are directed to these opinion pieces by the author[2] and then this published work finishes by linking to a website where you can 'learn more' about a potentially serious and common 'syndrome' and its treatment. As it turns out, M. Mew and J. Mew are the sole orthotropists between London and the Ukraine registered with this website.[1]

I feel strongly that where an opinion piece with all the scientific rigour of a Facebook posting is published without an accompanying retort, it may result in damage to the reputation of the *BDJ* as a scientific journal.

N. Stanford
Liverpool

1. The Official Website for International Association of Facial Growth Guidance (Orthotropics). Find an Orthotropist. Available at: http://orthotropics.org/Discover_Orthotropics/find-an-orthotropist/ (accessed 31 July 2014).
2. jawsurgeryforums.com. Available at: http://jaw-surgeryforums.com/index.php/topic,3816.15.html (accessed 31 July 2014).

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ORAL SURGERY

The role of microbiology

Sir, we read with interest the details of the ARONJ masterclass and the seven key messages provided by Moore *et al.*[1] Whilst we support these messages it is important to stress the role of expert clinical microbiology input when managing infectious complications of ARONJ cases. In our experience a team approach between surgical colleagues supplying appropriate clinical specimens and laboratory work up from diagnostic microbiology laboratories is an essential facet of high quality clinical care.[2,3] Selection of appropriate antimicrobial class, route, dose and duration are vital for good clinical outcome and in minimising the risks of antimicrobial resistance.[4] This underlines the importance of the dental profession having access to clinical oral microbiology expertise which is sadly in decline in the UK.

A. Smith, H. Changez, P. Wright, C. Wales, I. Holland, C. MacIvor, J. McMahon
Glasgow

1. Moore A, Ruggiero S, Rogers S *et al.* ARONJ masterclass. *Br Dent J* 2014; **216:** 488–489.
2. Naik N H, Russo T A. Bisphosphonate-related osteonecrosis of the jaw: the role of actinomyces. *Clin Infect Dis* 2009; **49:** 1729–732.
3. Jackson M, Snall J, McFadzean R, Smith A, Rautemaa-Richardson R. A two-centre retrospective study on the microbiology of bisphosphonate associated osteonecrosis of the jaws. 20th European Congress of Clinical Microbiology and Infectious Diseases, 2010. Available at: http://registration.akm.ch/2010eccmid_einsicht.php?XNABSTRACT_ID=101124&tXNSPRACHE_ID=2&tXNKONGRESS_ID=114&tXNMASKEN_ID=900 (accessed 31 July 2014).
4. World Health Organization. Antimicrobial resistance: global report on surveillance 2014. April 2014. Available at: http://www.who.int/drugresistance/documents/surveillancereport/en/ (accessed 31 July 2014).

DOI: 10.1038/sj.bdj.2014.712