INSPECTION ANOMALY

Sir, in March I asked the Care Quality Commission (CQC) what their programme for inspection of clinical dental technicians (CDTs) who work independently is. After a long and convoluted correspondence I have learnt that CDTs do not fall within CQC's remit.

The principal reason for this is that CDTs are not listed within the Health and Social Care Act 2008. A second issue could arise in future because care workers only need to register if they are considered to conduct treatment of disease, disorder or injury (TDDI) as defined in Schedule 1 of the Regulated Activities Regulations. Basically this means invasive procedures. Interestingly, dental technicians are listed under the Act but if they conducted TDDI they would be acting illegally.

I understand that CQC have pressed the Department of Health to deal with these anomalies, but even then, unless the work of CDTs is deemed sufficiently invasive for them to register and then be liable for inspection they will continue not to be inspected. Arguably this is not in the interest of patients, CDTs or our profession as CDTs are becoming a respected arm of the dental profession.[1]

Clearly the Government needs to address this issue urgently.

R. Clark

1. Leyssen W, Clark R K F, Gallagher J E, Radford D R. Developing professional status: an investigation into the working patterns, working relationships and vision for the future of UK clinical dental technicians. *Br Dent J* 2013; **214:** E3.

DOI: 10.1038/sj.bdj.2014.768

practices which derived 50% or more of their income from the NHS, failed attendances accounted for an average of 81 hours of lost time per full-time-equivalent dentist per annum, and 69 hours per dentist in practices with lower NHS commitments. Furthermore, many dentists reported an increase in the number of patients failing to attend appointments since the prohibition on such charges.

However, a note of caution needs to be sounded as the re-introduction of charges may have associated costs and adverse outcomes, including reductions in patient goodwill, related complaints, counter claims for compensation by patients kept waiting and precipitating legal claims for perceived failures of care. Also any policy which is insensitive to the personal circumstances which precipitated the failure to attend (eg illness, personal stressors, factors beyond the control of the patient, dental phobias, etc) is likely to be viewed negatively by both patients and regulators.

One further factor the profession must consider is the political pressure on politicians as they are probably more likely to lose votes by supporting such charges than gain them. The profession, therefore, appears to be in a Catch 22 situation on this issue. It seems likely that only a clear, judicious and fair charging policy is likely to receive qualified support from all the stakeholders.

P. V. Mc Crory, Stockport
A. V. Jacobs, Bury

1. British Dental Association. *Failure to attend.* Available at: http://www.bda.org/dentists/policy-campaigns/research/workforce-finance/gp/FTA-research.aspx (accessed August 2014).

DOI: 10.1038/sj.bdj.2014.766

Dentolegal hot potato

Sir, the new contract in 2006 brought with it the 'UDA' which has been highly criticised and commented on. However, a greater problem was the removal of the guidance on the type of treatment to be offered on the NHS. We moved from one extreme of a very prescribed list with 'items of service' to the other extreme of a completely open-ended contract where it was up to the individual dentist to decide what was 'clinically appropriate' and which treatment modalities would be offered on the NHS.

Dentists have had to act as the 'judges' in what is clinically appropriate and cost effective for the NHS. In medicine these controversial decisions can be left to a third party and then funding allocated appropriately. In dentistry, the lack of a clear boundary or limit to NHS services has left us in a situation in which if we decide a treatment using a certain material or equipment is too costly to offer on the NHS we are advised that it is unethical to then offer that same material or treatment modality privately, take the example of rotary endodontics.

When going through treatment options, the dentist is holding a dentolegal hot potato when they start mentioning technologies that are available privately but not on the NHS. A trend is emerging in NHS practices where the clinician is taking the 'safe option' and only offering the NHS option at their practice. Any items which simply can't be completed with the 1990s tools and materials we still use get referred on to specialists or fully private dentists.

Recently, I went to a CPD session on advancements in endodontics and the use of cone beam CT. The sad fact is that without provisions in the new contract for new (more expensive) technologies to be commissioned and whilst a cheaper option to 'secure oral health' still exists, new technologies will not be adopted as part of the NHS. But without clear guidance on the 'scope' of NHS dentistry it is also preventing a dentist from offering the treatment privately at the same practice and hence limits patient choice.

Current and future versions of the contract still leave it to the dentist to individually make the decisions which commissioners are too afraid to make themselves. It is unfair to put the dentist in that position. This means that difficult decisions are coming directly from the person who both treats you *and* collects your dental charge, leading to mistrust in the profession which holds us back even further.

In the recent Westminster Health Forum 'Dentistry 2014',[1] it was mentioned that dentists with enhanced skills are actually just 'dentists'. I would like to go further and state that dentists with 'enhanced skills' are actually just dentists 'with modern day tools and materials'.

A. Ahmad, West Sussex

1. Dentistry 2014: commissioning, regulation and the dental contract. More information online at: http://www.westminsterforumprojects.co.uk/forums/showpublications.php?pid=761 (accessed July 2014).

DOI: 10.1038/sj.bdj.2014.767

RESTORATIVE DENTISTRY

Tin foil filling

Sir, a former prisoner came to our clinic. According to the patient, he had been imprisoned and was released five months ago. While being in jail, more than seven months ago, he 'suffered from toothache and he also found a cavity in his tooth'. As he was denied access to dental assistance, he manufactured a self-made tooth filling using toothpaste and tin foil. In fact, he constructed a Class I inlay for tooth #37!

He explained that, at first, he folded a piece of tin foil so that it could match the shape of the cavity. Then, he applied a layer of toothpaste to the cavity and afterwards he placed the tin foil inlay. Finally, he applied slight pressure and thus condensed the materials and also shaped the occlusal surface.

His restoration was still intact when he visited the clinic and the tooth appeared to be asymptomatic (Fig. 1). The toothpaste probably acted as cement, as it hardens over time. It could have also released fluoride and caries did not progress further. The margins were generally acceptable. Moreover, the colour and the texture of the restoration resembled a new, well-polished amalgam filling. Apart from taking the patient's history, only a caries-implying discolouration located at the non-cavitated lingual groove would lead a clinician to the replacement (or maybe just a repair!) of this restoration.

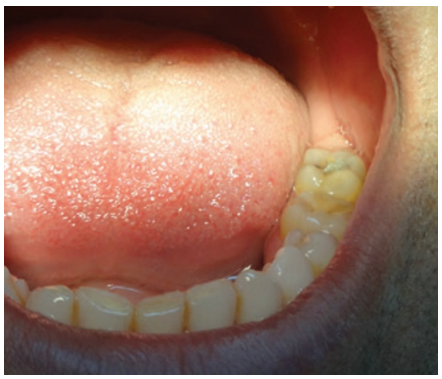

Fig. 1 The homemade Class I inlay

Although rarely encountered nowadays, the idea of using tin foil as a filling material is not new at all; in fact, there was a book published back in 1897 by H. Ambler that reviews this exact use of tin foil and traces it back to 1783.[1] However, the patient's ingenuity remains remarkable.

Clinicians should also have in mind that amalgam-resembling restorations are not always what they seem to be and additional attention may be required.

I. Makaronidis, Athens

1. Ambler H. *Tin foil and its combinations for filling teeth.* Philadelphia: The S. S. White Dental MFG. Co., London: Claudius Ash & Sons, Limited, 1897.

DOI: 10.1038/sj.bdj.2014.769

ORAL MEDICINE

Amlexanox

Sir, I read with great interest the letter on erosive lichen planus (*BDJ* 2014; **216:** 545) and would like to share a similar condition due to silver amalgam restorations. A patient reported with severe pain and burning sensation intra-orally on the left posterior region. On examination we found white striated lesions on the buccal mucosa and retro molar area with intervening areas of superficial erosion and that the left mandibular molars had silver amalgam restorations of two years standing. The lesion was diagnosed as an erosive lichenoid reaction. The amalgam restorations were replaced with tooth-coloured restorative material and topical application of amlexanox gel was prescribed. A week later the lesion had subsided and the patient was completely free of symptoms.

Amlexanox is an anti-inflammatory immunomodulator used to treat recurrent aphthous ulcers and several inflammatory conditions which reduces ulcer erythema, pain, and lesion size.[1,2] Its exact mechanism of action is not known although attributed to the reduction of inflammation by inhibiting the release of histamine and leukotrienes.[3] It is known to be safe when used as an intra-oral paste.[4] It is available as 5% gel preparation in India (5% Lexanox, Macleods Pharmaceuticals, Ltd. India) and also in some countries as a tablet that adheres in the mouth.[4] Topical application of steroids for erosive lichen planus/lichenoid reaction is also used. However, this may cause local immunosuppression, and lead to candidosis.[5] This possible side effect is not seen in amlexanox which therefore appears to be a good drug of choice in cases of erosive oral lesions. However, further investigations are warranted.

Vasudev Ballal, Jothi V, Manipal

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DOI: 10.1038/sj.bdj.2014.770