

competent (or adequately knowledgeable in dental anatomy) to perform this double check safety verification. Furthermore, when dental/oral surgeons operate under general anaesthesia, dental nurses are NOT allowed to assist in an operating theatre environment and the assistant nurses are always general nurses.

Current rules do not allow dental nurses to attend the operating theatres, as their training syllabus does not fulfill the requirements for operating room attendance.³ I believe this needs to be debated by educators and regulators if we are to eliminate the possibility of future never events.

B. A. Beyqi, by email

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ORAL HEALTH

Reverse referral

Sir, the oral health of 102 patients (age 14–88) admitted for 24 hours of intravenous antibiotics for odontogenic infections was considered over 12 months in a Surrey district general hospital. Orthopantomograms were used to assess dental disease and restorative status. Three patients required ITU admission.

The average number of carious teeth (over two thirds into dentine) was 3.1; endodontically treated teeth was 0.9 and 2.3 teeth had radiographic evidence of apical pathology. The most common infected source tooth was the mandibular first molar and 10.7% of infected source teeth were root filled. No significant radiographic bone loss patterns were identified. The average number of restored (non-root filled) teeth was 5.0.

Whilst assessment of oral health using radiographic examination alone is insufficient, it nevertheless provides a general overview of the dentition in a secondary care setting. Full oral health screenings are seen as irrelevant, time consuming and often intolerable when patients are systemically unwell from odontogenic infection. The data show that patients admitted tend to have untreated decay in multiple teeth which may be a source of future odontogenic infection, and very few source teeth have had endodontic therapy.

Patients are usually treated solely for the infected source tooth and discharged with the hope that the rest of the dentition will be managed by primary care services. However, on questioning, the overwhelming majority of such patients have no primary care dentist due to financial, social and psychological reasons; these patients may thus return with similar episodes of infection and morbidity which presents a cost burden on public health care facilities.^{1,2} There has been a 62% increase in the number of patients who require admission for surgical treatment of spreading odontogenic infections.³ The number of admissions and bed days as a result of drainage of a dental abscess almost doubled between 1998–99 and 2005–06.⁴

Whilst referrals to maxillofacial departments for routine dentoalveolar services from primary care are common, a reverse pathway should also be firmly established to ensure patients presenting in secondary care are followed up by primary care or community dental services on discharge.

F. Jamil, London

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Turn off the tap

Sir, I would like to make further comments to J. Hartley's letter on *Spit don't rinse*.¹ One response to this letter cited the evidence from some well-designed studies,² while another quoted from a paper recommending the 'spit don't rinse' message as an integral part of oral hygiene instruction.³ However, an additional environmental benefit has not been mentioned.

Research by SaveWaterSaveMoney has revealed that 64% of 7–10-year-olds admitted to leaving the tap running while brushing their teeth. Turning the tap off while brushing and not rinsing the mouth out when finished are two simple yet effective ways of saving water in the bathroom. Not only could it save around 12 litres of water every time, it also saves money.⁴

The long-term effects of 'spit don't rinse' will not only preserve teeth, but also save water. That's why spitting is better for the environment too!

C. A. Yeung, Bothwell

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ORTHODONTICS

Fast and furious

Sir, P. Huntley (*BDJ* 2015; **218**: 2–3) sadly reflects how many confuse even basic differences between short-term orthodontics (STO) and Fastbraces, which is a comprehensive orthodontic system designed to be easy to use and with less apical resorption¹ than traditional systems, offering a significant time saving and innovative approach where a rectangular wire is used in a triangular bracket giving 3D control from day one.

Increased complications in traditional orthodontics are associated with their longer treatment times extending beyond a year.² Unfortunately, older traditional rectangular bracket mechanics tend to be high-force and simply do not recommend rectangular wire usage routinely from day one.³ Thus, traditionally it is loose sloppy round wires that are used initially with mainly tipping mechanics, the very same type of STO treatment some specialists have recently been declaring are *higher risk*, waving apices around etc.⁴ There are no round wire disadvantages in the FastBraces system.

The single reference quoted by Huntley relates to ligatures in round wire ortho systems, a study clearly nothing to do with FastBraces' unique triangular brackets and rectangular wire 3D torque system from day one. It is not often one has a system new to the UK that has a great track record and where some 80% of orthodontic cases can be completed well and safely by the humble GDP; this neatly rebalances orthodontics with other common dental disciplines where only maybe 20% of perio, endo, restorative, oral surgery etc complex cases need referring out to a higher trained and valued specialist.

When it comes to ethics, one must also wonder are some orthodontic specialists who imply all ortho cases should be referred to them, totally altruistic in their motives – a recent USA survey found