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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4. Thomas S J, Atkinson C, Hughes C, Revington P, Ness A R. Is there an epidemic of admissions for surgical treatment of dental abscesses in the UK? *BMJ* 2008; **336**: 1219–1220.

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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

unlike patients, 93% of orthodontists wouldn't want faster ortho treatments than two years, possibly related to the 63% of replies that worried faster would interfere with their fee collections, the paper says!⁵

Huntley states that undergraduate orthodontic curriculum experiences appear to be allowed to wither by those who teach it – would that be by the orthodontic specialists by any chance?

Ironically with the advent of credible and user-friendly ortho systems like FastBraces, all UK dental undergraduates could comfortably complete several fixed orthodontic cases from beginning to end in only months, injecting a new enthusiasm for such work and help students get even better 'value' for their £9,000 a year tuition fees.

FastBraces meets the wishes of 80% of GDPs' patients and meets them well. Of course for the more complex cases GDPs will still need to refer these to a friendly specialist as with other dental disciplines. With a lot more GDPs enabled to do routine ortho, expect more referrals not fewer and remember, orthodontics is normal dentistry, just like every other dental discipline.⁶ There's no need to over-complicate or monopolise it!

A. Kilcoyne, Haworth

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Dr Peter Huntley responds: I am not against the 'humble' GDP doing orthodontics. I am against misleading claims being made to promote the sale of appliances, something that the FastBraces website is a particularly good example of. In fact, I set up a local peer review group with some of my GDP colleagues

who do orthodontic treatment using both fixed and aligner systems and have seen many well-treated cases from members of this group. Anyone providing orthodontic treatment, GDP or specialist, should select cases for treatment that are appropriate to their knowledge and training, and should be able to deal with things when they go wrong. I think that most patients would be shocked to discover that training in the use of many of the 'fast' or 'short-term' appliances in most cases lasts for only one or two days.

I suggest that the reference by Wong et al.¹ is highly relevant to FastBrace brackets. They measured clinical tooth movement and showed that using ligation systems with lower friction does not increase the rate of tooth movement. There is evidence that FastBrace brackets are low friction but that does not mean that teeth move faster. In the misleadingly titled 'Teeth Move Easily' section of the FastBraces website, all of the articles quoted compare friction between FastBrace and other bracket types, not measurements of tooth movement.

The FastBraces website states that 'old' braces move the crown into alignment in the first year and the root in the second. Such two-stage movement is a feature of Begg and Tip-edge appliances but not the rectangular edgewise brackets pictured on the website – but then why let the truth get in the way of a good sales pitch? Much is made of the rectangular superelastic wires used by FastBraces 'moving the crown and the root at the same time'. However, such wires are widely used with rectangular brackets producing the same mechanical effect. If a round superelastic wire is used prior to this for a visit or two, this does not result in 'waving apices around', it is just a gentle way to begin alignment.

Other website claims are that 'extractions are not needed in the vast majority of cases' and 'post-treatment retention is for only 20 minutes a day' without any scientific evidence. Also stated is 'FastBraces Technologies embodies the belief that it is the right of every child and adult to go to their neighborhood dentist and get a beautiful smile without the dental mutilation of extraction'. Just what patients want to hear and very good for marketing, but where is the evidence? Teeth take the same amount of space in the dental arch regardless of the bracket that is moving them and the decision regarding the need for extractions should not be determined by appliance choice. Orthodontic treatment, like any type of

dental treatment, should follow a logical sequence starting with a diagnosis, which leads to a list of treatment aims. The orthodontic appliance is manipulated to achieve those aims, but the appliance is not the plan.

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HOSPITAL DENTISTRY

Publicise emergency options

Sir, as a young dentist working in a maxillofacial department of a teaching hospital, I find the bed crisis in hospitals and pressure on A&E particularly relevant to my current area of practice. In my experience, there is little seasonal variance in numbers of patients attending the emergency department with dental or facial trauma complaints. Certainly, there is no way to prevent a small increase in trauma cases during the winter months due to falls. However, dental abscesses are preventable all year round.

Time and time again, patients tell me 'I can't find a dentist'. Given the current pressures on A&E departments across the country with the amount of patients being treated in four hours at its lowest since records began, and more patients attending A&E than ever before, it seems pertinent that focus should be put on better publicising available out of hours and emergency dental options and increasing the provision in this sector, to divert these patients away from A&E. In my experience, there is most certainly demand.

J. Humphreys
Manchester

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ANAESTHESIA

Bilateral guidelines

Sir, much of the controversy over unilateral versus bilateral inferior alveolar and lingual nerve blocks (IANBs) surrounds the safety and efficacy of bilateral anaesthesia even though many surgeons use the procedure for perioperative and postoperative pain relief after day case general anaesthesia with no reports of unwanted effects.¹ The opponents of bilateral IANBs highlight the chances of suffocation or respiratory embarrassment due to lack of tongue control and collection of fluid in the oral cavity.² However, one study concluded that soft tissue trauma was higher in unilateral compared