LETTERS TO THE EDITOR

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ANAESTHESIA

Over prescription

Sir, a recent study highlights the most likely reason for a child undergoing general anaesthesia (GA), in the NHS, is for dental extractions.[1] This report was unsurprisingly greeted with shock by both public and media. However, little is mentioned of the continued over prescription of GA for dental extractions in adults, particularly with regard increased GA-related morbidity and mortality in adults.

We continue to prescribe GA rarely for dental surgery (Table 1), and this is achievable with appropriate prescription of IV sedation when indicated. An internal audit confirms that 76% of our patients require sedation for the dental extractions when assessed using the indication for sedation need tool.[2]

Our data supports that with adequate IV sedation provision, GA prescription can be minimised thus improving safety for patients. With the intended commissioning shift of oral surgery to primary care, commissioners must understand that many patients require anxiolysis to undergo often quite difficult and unpleasant surgical procedures. Cost implications for the provision of sedation, including team training and facilities, are significant and not reflected in current NHS remuneration or contracting of services. If this underfunding for sedation in primary care persists, more patients will be referred to secondary care for GA, reversing the positive trend in patient safety reported here.

T. Renton, G. Gerrard, O. Obisesan, I. Jackson, by email

GROSS MISCARRIAGE OF JUSTICE

Sir, I wish to express my growing worries over what I see as the rapid deterioration of justice at the General Dental Council.

The recent PCC hearing concerning a doubly qualified professor doctor/dentist is of particular concern. I would like to bring to your attention three main points that I have gleaned from papers relating to justice that have surfaced from this hearing:

- The registrant being doubly qualified had already been judged by the General Medical Council who dismissed the six index cases against him, removed their conditions and imposed undertakings only. Is the GDC superior to an august body of medical peers?
- The GDC so-called expert witness was not in fact an expert in the registrant's field of dentistry. Does this mean that anyone with a lack of subject knowledge but an equal qualification can put in an opinion?
- The contemporaneous patient notes were disregarded and the word of an esteemed and honourable member of the profession speaking under oath was doubted and he was called a liar as was his expert witness. If that is the case, what chance do any of us have of defending ourselves?

This appears to me to be a gross miscarriage of justice which in some terms could be called a 'witch hunt'. Looking dispassionately at this case one can see the oncoming demise of the GDC through their pressing the self-destruct button and what is worse the public's faith in what is in the main a trustworthy and honourable profession is being challenged. As someone who has served on the GDC for nine years in happier times, I am very worried about the future. Is anyone able to call the GDC to account?

M. Bell, by email [received in November]

DOI: 10.1038/sj.bdj.2015.57

Table 1 Table of anaesthetic prescription for third molar surgery/dental extractions (% patient cases not teeth)

Reference locality, year and n	%LA	%Sedation	Out pt GA	In patient GA
King's 2014 n = 5,158	59	38	3	
Birmingham teaching hospital 2013 n = 151[3] Birmingham General Hospital 2013 n = 151	74.7 42.4	14 19.9	11.3 37.7	
Leeds teaching hospital 2003 n = 883-971[4]			60-53	
Cardiff Dental Hospital 1998 n = 444[5]	40-50	10-20	32	44
France 2008 n = 180[6]				100

1. Manning S. Stop the rot! Why thousands of British children are having their teeth taken out in hospital. *The Independent* Tuesday 21 October 2014.
2. Coulthard P. The indicator of sedation need (IOSN). *Dent Update* 2013; **40:** 466-468, 470–471.
3. Pearson D, Dietrich T. Predicting the choice of anaesthesia for third molar surgery – guideline or the easy-line? *Br Dent J* 2013; **214:** 174–175.
4. Jamileh Y, Pedlar J. Effect of clinical guidelines on practice for extraction of lower third molars: study of referrals in 1997 and 2000. *Br J Oral Maxillofac Surg* 2003; **41:** 371–375.
5. Edwards D J, Brickley M R, Horton J, Edwards M J, Shepherd J P. Choice of anaesthetic and healthcare facility for third molar surgery. *Br J Oral Maxillofac Surg* 1998; **36:** 333–340.
6. Trost O, Kadlub N, Robe N *et al.* Third molar surgery under general anesthesia: a review of 180 patients. *Rev Stomatol Chir Maxillofac* 2008; **109:** 91–95, 95-97.

DOI: 10.1038/sj.bdj.2015.58

SELECTIVE LITERATURE USE

Sir, the article by Paul Batchelor *Is periodontal disease a public health problem?* (*BDJ* 2014; **217:** 405-409) is very interesting and raises a number of key issues. However, the section on 'How effective are current care modalities?' is selective in the literature it uses, some of which is misrepresented and this gives completely the wrong message. I therefore cannot let this lie.

He is led to the conclusion that the 'evidence for care modalities is poor'. I would agree with this statement for professional mechanical plaque removal and routine scaling and polish and the references he has selected to support this evidence. However, I would view these as aspects

of preventative dental treatment and not necessarily periodontal treatment *per se*.

However, the use of the Herrera *et al.* 2002 reference is wrongly used and misquoted. The statement used was 'We consider that it would be inappropriate to make definitive and specific recommendations regarding clinical practice based on the limited meta-analysis and the review of these 25 studies' but the context of this statement was in relation to whether the adjunctive use of antimicrobials could be recommended.

If he looks beyond the systematic review to the original studies included therein he will see that these compare the standard non-surgical treatment of root surface debridement (RSD) with RSD plus the adjunctive use of antimicrobials. Within these studies, both treatment arms produce significant and clinically meaningful improvements compared to the baseline situation. Similarly he will find countless studies from the 70s and 80s which compared surgical versus non-surgical periodontal treatments. Again a key outcome from these studies was that both gave significant and clinically meaningful improvements compared to baseline. There is also good evidence in the literature that patients who maintain good oral hygiene and undergo appropriate supportive care programmes tend to maintain improvements better than those who do not receive ongoing periodontal care.

It just goes to show that if you look hard enough you will find plenty of evidence that periodontal treatment, as most periodontists would understand it, does work.

G. S. Griffiths, Sheffield

Dr Paul Batchelor responds: I would like to thank Gareth Griffiths for his comments on the paper. The main aim of an opinion piece is to stimulate debate and to help ensure that current practices remain relevant to meeting the needs of patients. I am glad that Griffiths agrees with my conclusion that 'current care modalities are poor'. However, he subsequently splits care into two elements: prevention and treatment. This is an artificial distinction, particularly for treating periodontal disease. Indeed it is akin to a surgeon saying that the operation was a success but the patient died. For all chronic diseases, a rational description of the care processes is the overall long-term management of the condition. Griffith highlights that patient maintenance, that is what the individual does on a day-to-day basis, is the key determinant of the outcomes of professional periodontal therapies. That strongly reinforces the message I alluded to. Unless high standards of oral hygiene are achieved and maintained after curative periodontal treatment, then irrespective of what the dentist undertakes, the outcomes are poor. That was clearly demonstrated by the classic Gothenberg studies[1,2] where they showed that although good short-term periodontal results were achieved, the condition regressed unless intensive maintenance regimens were implemented, because most patients did not maintain good oral hygiene. Those results are supported by the systemic review by Watt and Marinho[3] on the ineffectiveness of changing oral hygiene behaviours in the long term. So before quoting some short-term measures of success of periodontal treatment, as Griffith does, it is crucial to address the key factor, namely ensuring patients can maintain oral hygiene on a day-to-day basis to ensure sound long term outcomes, as that has not been achieved. Furthermore, Griffith has not addressed the underlying issue of what constitutes periodontal 'disease'. As I highlighted in the opinion paper, the definition used by clinical dentists is influenced more by the needs of the profession than those of the public.

1. *Axelsson P, Lindhe J. The significance of maintenance care in the treatment of periodontal disease.* J Clin Perio *1981;* **8:** *281–294.*
2. *Lindhe J, Westfelt E, Nyman S, Socransky S S, Haffajee A D. Long-term effect of surgical/non-surgical treatment of periodontal disease.* J Clin Perio *1984;* **11:** *448–458.*
3. *Watt R G, Marinho V C. Does oral health promotion improve oral hygiene and gingival health?* Periodontology 2000 *2005;* **37:** *35–47.*

DOI: 10.1038/sj.bdj.2015.59

DENTAL EDUCATION

Blow a little harder

Sir, once again Martin Kelleher has written an opinion piece: *Current controversies in training and/or education of dentists in the UK* (*BDJ* 2014; **217:** 497–498) which makes this reader want to cheer his clarity of thought and common sense. In it he describes what appears to be so wrong, at least to many of the older generation of practising dentists, with the direction of travel that the current undergraduate training of our future colleagues appears to be taking in the UK. Perhaps Dr Kelleher would consider 'blowing a little harder on the embers of his (illustrious) career' to lead the profession back to the provision of 'appropriately skilled' and adaptable clinicians needed to 'address the various complex problems in our rapidly changing society'. What a blazing legacy that would be.

E. M. Robb, Bath

DOI: 10.1038/sj.bdj.2015.60