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.*


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## 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**

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