LETTERS TO THE EDITOR

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RIGHT OF REPLY

Cochlear implants

Sir, I read the letter 'Cochlear Implants' by S. Harrison[1] with great interest. The main function of cochlear implants is to convert the mechanical sound energy into electrical signals.

Since the energy is converted into electrical signals there is a good chance that similar energy may interfere with the proper functioning of the cochlear implants. The author has cited the website which states that the speech processors should be kept at least 50 cm away, and preferably out of the room, when radiographic examinations are undertaken. However on searching the PubMed literature we found at least one paper[2] suggesting that panoramic radiographs do not have any adverse effect on the functioning of the cochlear implants. The same paper mentions that electrocautery should be performed cautiously especially at level 7 or above as it destroys the cochlear implant circuits making them non-functional. Young[3] also suggested to take precautions in using ultrasonic scalers and electrocautery in such patients. The information presented in the letter cannot be completely relied upon as it is not supported by scientific literature. Also it should be noted that the cochlear implants, which are just another type of nerve stimulator, are also affected adversely by locally given microwave diathermy.[4]

M. Juneja, Boston, Massachusetts
N. Juneja, New Delhi, India

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2. Roberts S, West L A, Liewehr F R, Rueggeberg F A, Sharpe D E, Potter B J. Impact of dental devices on cochlear implants. *J Endod* 2002; **28:** 40–43.
3. Young C A. Cochlear implants. *Br Dent J* 2002; **193:** 364–365.
4. Frampton S J, Ismail-Koch H, Mitchell T E. How safe is diathermy in patients with cochlear implants? *Ann R Coll Surg Engl* 2012; **94:** 585–587.

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GUIDELINE COMMENT

Infective endocarditis

Sir, We read with interest the opinion paper by Thornhill *et al.*[1] about the NICE review of its guideline on prophylaxis against infective endocarditis. We were somewhat surprised that it seems to question the NICE review process and the scientific evidence upon which it is based.

Having reviewed all of the latest evidence, the NICE committee (which included topic experts in cardiology, dentistry and microbiology) has recommended no change to its 2008 guidance. Their findings, set out in a consultation document,[2] identify a long-standing increasing incidence of infective endocarditis across the world, not just in the UK. A close reading of the NICE consultation document shows their analysis of the recent paper by Dayer *et al.*,[3] which triggered the review. They found that it overestimated the increase in infective endocarditis incidence since 2008, failed to show any causal link to dental treatment and was at high risk of bias.

Whilst we accept that infective endocarditis is a devastating disease with high morbidity and mortality, the NICE review has again concluded that antibiotic prophylaxis for dental treatment to prevent infective endocarditis remains inappropriate.

We hope that when its recommendations are finally published they will be widely disseminated and accepted by all healthcare professionals and the mixed messages which still exist for some patients will be removed.

W. Thompson, Lancaster
N. O. A. Palmer, Liverpool

1. Thornhill M H, Lockhart P B, Prendergast B, Chambers J B and Shanson D. NICE and antibiotic prophylaxis to prevent endocarditis. *Br Dent J* 2015; **218:** 619–621.
2. National Institue for Health and Clinical Excellence. Prophylaxis against infective endocarditis. May 2015 - Clinical Guideline 64.1 - Draft for consultation.
3. Dayer M J, Jones S, Prendergast B, Baddour L M, Lockhart P B, and Thornhill M H. Incidence of infective endocarditis in England, 2000-13: a secular trend, interrupted time-series analysis. *Lancet* 2015; **385:** 1219–1228.

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A riposte

Sir, I write to respond to the misinformation published in the letter in a recent issue of the BDJ (*BDJ* 2015; **219:** 146–147) by Dr P Neville.

The Irish Prison Service has a well-developed healthcare service with published standards, including protocols for both emergency and routine dental care. Contrary to what was stated, all the closed prisons in Ireland have at least one dental surgery on site. In the five Dublin prisons, for example, there are 21 treatment sessions available each week for prisoners.

No doubt this will be reflected in the review commissioned by the Inspector of Prisons, Judge Michael Reilly, to which Professor Andrew Coyle, Emeritus Professor of Prison Studies, University of London has contributed, and which is due for publication shortly.

J. Nunn, Dublin

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Unheard voices behind bars

Sir, The letter from Neville (*BDJ* 2015; **219:** 146–147) has raised a number of issues in prison dentistry.[1] However, these issues are not unique in the Republic of Ireland. For example, very few prisons have had oral health needs assessment carried out and this has led to commissioning based largely on guesswork. Recently, the Scottish Government has recommended that a survey of the oral health of prisoners in Scotland should be undertaken every five years to monitor improvements and inform service design.[2]

The nature of the prison environment makes the delivery of care as equally challenging as the oral health of the patients. The high turnover of prisoners in some institutions, particularly in remand or short-stay institutions, where short sentences or frequent transfers between facilities mean courses of treatment can go unfinished as prisoners are moved on. In 2012, the British Dental Association issued the individual booklets *Oral healthcare in prisons and secure settings* for England, Scotland and Wales where many of the ongoing issues in prison dentistry were highlighted.[3]

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