LETTERS TO THE EDITOR

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Email bdj@bda.org. Priority will be given to letters less than 500 words long. Authors must sign the letter, which may be edited for reasons of space. Readers may now comment on letters via the *BDJ* website (www.bdj.co.uk). A 'Readers' Comments' section appears at the end of the full text of each letter online.

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

1. Harrison S. Patient safety: Cochlear implants. *Br Dent J* 2015; **219:** 98.
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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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]

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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The National Association of Prison Dentistry website (http://www.napduk.org) has recently been expanded and is now a major resource for prison dental professionals. As well as providing information on upcoming events, it contains a member area with a comprehensive reference section including policy documents, academic articles and a members' forum.

Prisoners have ready access to legal services, and complaints can be frequent, time consuming and costly. There has been an increase in interest shown by specialist dental law firms who now actively advertise their services to patients in prison. Prisoners in HMP Wakefield successfully brought an action against the Wakefield District NHS Primary Care Trust in 2011 over dental services resulting in costs to the NHS of nearly £350,000.[4]

C. A. Yeung, Lanarkshire

1. Neville P. Prison dentistry: Irish prisoners' oral health. *Br Dent J* 2015; **219:** 146–147.
2. Scottish Government. Oral Health Improvement and Dental Services in Scottish Prisons: Guidance for NHS Boards. July 2015. Online information available at http://www.gov.scot/Publications/2015/07/2508/0 (accessed September 2015).
3. British Dental Association. Oral healthcare in prisons and secure settings. Online information available at https://www.bda.org/dentists/policy-campaigns/research/patient-care/prisons (accessed September 2015).
4. BBC News. Wakefield Prison inmates claim dentistry compensation. 22 October 2011. Online information available at http://www.bbc.co.uk/news/uk-england-leeds-15414995 (accessed September 2015).

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THE WORD FROM DOWN UNDER

Whole mouth health

Sir, dental caries is, in 2015, still a pressing public health matter in Great Britain,[1] as well as here in Australia and worldwide. I was an NHS dentist (1958–1980) and always very busy treating caries. In 1980 I returned to Australia, recommencing practice but retiring in 1991 until, in July 1996, our granddaughter was diagnosed with early decay in an upper anterior tooth. Angrily I committed myself to this mission: Prevent oral diseases in children.

In January 1997 I was appointed as District Dental Officer, East Arnhem Land, in the remote tropical Northern Territory (NT) of Australia. In early 2001, during a recording annual DMFT in a NT district school, for the third consecutive year I observed the 6-7-year-old classroom's mouths were caries free! The conversation I then had with their two teachers explained why. I was told that these pupils had been served breakfast before the first lesson. Then after squeezing toothpaste onto their toothbrushes they were told to 'go outside to the water troughs, brush your teeth and rinse...and rinse and rinse your brush under the tap'. The teachers implied by the first 'rinse' to rinse your mouth, but the children misinterpreted that statement and literally rinsed... and rinsed and rinsed the brush under the tap! Of course, what they had unknowingly left in their mouths were the active ingredients in the toothpaste! Serendipity had stepped-in to maintain their dental health!

The concept evolved over time and in 2007 I renamed the approach: 'treat your whole mouth'. Since then, finding that children respond very keenly to the notion of painting, it has become 'paint your mouth'. My experience shows that this really does dramatically reduce DMFT. Inspired by this I have produced a series of eBooks for not only children but also adults. These are designed to be educating, entertaining and interactive.[2] Special needs and vulnerable children would also greatly benefit from this simple yet cost-effective approach.[3]

G. Pettit, Adelaide

1. Hancocks S. Coalescence. *Br Dent J* 2015; **219:** 47.
2. Health Education eBooks (various) Mouthwise Oral HealthCare. Available online at http://www.paintyourmouth.com/health-education-ebooks-english-titles/ (accessed September 2015).
3. Simons D, Pearson N, Dittu A. Why are vulnerable children not brought to their dental appointments? *Br Dent J* 2015; **219:** 61–65.

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Consent down under

Sir, I am Cardiff graduate (1999) practising in Australia since 2003 and, as with the authors of *Consent - a new era begins,*[1] I am also a dento-legal adviser for Dental Protection, but based in its Brisbane office. The opinion piece explored the recent Montgomery case and its possible impact on the approach to consent in the UK which has strong echoes of, and an almost identical description of a 'material risk', as the watershed Australian case of Rogers *v* Whitaker (RvW) roughly 25 years ago. As I also maintain clinical practice I have made the same 'journey' that UK colleagues may well be embarking upon in understanding and applying the 'particular patient' test.

In the immediate period following RvW there was concern in Australia that the pendulum had swung too far in terms of the level of expected understanding of each patient's needs, fears, hopes, concerns and expectations – even when meeting and treating patients for the first time. Predictably enough the judgement was seized upon by claimant law firms and allegations regarding a failure to warn quickly became a regular feature of medical/dental negligence claims, although in the years that followed, several important legal cases have qualified and softened the apparently open-ended expectations.

In Australia the regulatory guidance regarding consent was changed fundamentally by RvW but in contrast the GDC's guidance in the UK was in place long before Montgomery and in a sense the law has caught up with the profession. Many contemporary clinicians are already adopting a more patient-centred approach to consent in response to our consumerist culture and perhaps reflective of the current generation of practitioners for whom 'doctor knows best' was never the norm.

It is virtually impossible to extrapolate from the Australian experience to the UK as the medicolegal landscapes starkly contrast. Significant tort law reform took place in Australia in the wake of the paralysing medical indemnity crisis in the early 2000s which dramatically reduced medical (and dental) litigation in Australia almost overnight resulting in the current relatively benign litigation environment. In contrast, at almost exactly the same moment in time, the UK was moving in the opposite direction and the Woolf reforms were transforming the UK into a global hotspot for clinical negligence litigation, led by the 'no win – no fee' law firms.

The Montgomery ruling is best viewed as an opportunity, not a threat. Clinicians who try to engage and actively involve their patients in decisions have little to fear from Montgomery and will be largely unaffected. However, it may well be different for those clinicians who maintain a paternalistic approach, as we saw in Australia. If material risks are discussed, and (importantly) this fact is adequately recorded in the clinical notes, Montgomery need not open the floodgates for claims based wholly on a failure to warn of material risks, however excited the claimant law firms might become initially.

A. Weston, Brisbane, Australia

1. D'Cruz L, Kaney H. Consent - a new era begins. *Br Dent J* 2015; **219:** 57–59.

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