Fig. 1 Laceration (sutured) wound on the right side of the face caused by camel bite

We report a case of a 29-year-old male patient who was bitten by a camel when giving it an injection for scabies. He bled profusely after the bite, receiving first aid care and vaccination at a nearby hospital. On examination the patient was fully conscious, all vitals were stable and there was a 5 cm lacerated wound on the right side of his face (Fig. 1). There was bleeding from the right ear and three separate wounds in the scalp on the left side representing the size of camel teeth. His mouth opening was slightly restricted because of pain, deviation of the mandible on the right side, with weakness of the marginal mandibular and buccal branch of the facial nerve.

Intraorally the patient had disturbed occlusion with premature molar contact on the right side. A CT scan of the facial bones revealed a fracture of the right subcondyle. The fracture site was exposed, reduced and fixed using two, four-holed titanium mini plates of 2 mm diameter. The patient received antibiotics and analgesics postoperatively, and regular follow-up for five years was satisfactory. We consider this to be a rare case because of the uncommon mechanism of injury with compression of the right side of the mandible and left side of skull vault between the two big jaws of the camel without causing injury to the external pinna. As the condyle is the weak point in the mandible it was easily fractured preventing transmission of forces to the cranium.

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Oral surgery

Too much information

Sir, 'If there wasn't blood everywhere ... gums flapping, bones bleeding, the root's disappeared!' These thoughts are probably quite common in the minds of dental surgeons conducting apicectomies. However, it is somewhat unusual in twenty-first century dentistry to actually voice them to a patient. Nonetheless, these were the very words spoken to my wife recently at a well-known Glasgow practice. She was understandably alarmed to hear such a detailed description of the carnage in her oral cavity.

While it is important to keep parents fully informed during dental surgery,[1] there is such a thing as too much information – and, indeed, too much contemporaneity. Such running commentary hardly instils in the patient a sense of the dentist's professionalism;[2] in fact, it paints a vulgar picture of the dentist's competence, given that it was the dentist who started the bleeding, the flapping, and the disappearing. My wife might have said something to this effect had she been able to answer back. Fortunately, the surgery seems to have had a good outcome despite the dentist's low score in terms of (over-)communication skills. Hopefully any of your readers with a similar penchant for gory imagery will alter their manner accordingly.

D. Shaw, by email

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Antibiotic prophylaxis

Questions about NICE

Sir, the article by Thornhill *et al.* (A change in the NICE guidelines on antibiotic prophylaxis *BDJ* 2016; **221:** 112–114) raises some fundamental questions about NICE.

While NICE guidelines should always be precisely that – guidelines rather than protocols – and clinicians should exercise clinical judgement in the context of an informed discussion with patients and their close ones where appropriate (what is new?), the purpose of NICE is surely to provide unambiguous, evidence-based recommendations. Patients should have a reasonable expectation that they are managed in a way that is consistent across the profession. Whatever one's position might be in the 'cover', 'no cover', or 'cover sometimes' debate (which still remains largely opinion based), at least the 2008 iteration of CG64 achieved clarity and unambiguity (it also directed attention to what in my mind is the most important issue in all of this – namely high standards of oral hygiene and rapid management of sepsis). The July 2016 iteration does anything but; in fact it dangerously re-focusses the debate on prophylaxis rather than on those crucial preventive factors and leaves the clinician wondering 'who is right?' We do not even have a current UK antibiotic prophylaxis regime should we decide to cover (although Thornhill *et al.* provide guidance in their article). To add insult to injury, if not for the opinion piece in this Journal, most practitioners would probably not even be aware of this important development. This really is not good enough.

Thornhill *et al.* are to be congratulated for their thoughtful and thought-provoking piece; NICE should look to its laurels.

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Paediatric dentistry

No added sugar

Sir, currently as a dentist treating only children I am struck by the confusion over 'no added sugar' drinks amongst parents and carers. On a daily basis, on questioning of drinks consumption, I find time and time again I am having the conversation over sugar free or no added sugar drinks. The clever marketing campaigns appeal to families with a most recent advert including the slogan 'drink more water' for a popular squash brand! This specific commercial shows a handy pocket size cordial that can be added to a water bottle while on the go. This leads to parents and carers very easily giving their children highly cariogenic drinks, in increased frequency, whilst believing they are tooth safe. As we all in the profession are only too aware this can cause rapid tooth destruction, especially to the primary dentition through both caries and tooth surface loss.[1]

The state of children's teeth in the UK has already been brought to the general public's attention through various documentaries focussing on paediatric dentistry and also the 'sugar tax' debate.[2] However, there is still a general lack of understanding with regard