COMMENT

# Letters to the editor

Send your letters to the Editor, *British Dental Journal,* 64 Wimpole Street, London, W1G 8YS. Email bdj@bda.org.
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## Referrals

### Apicectomy

Sir, as a specialist endodontist I am disappointed when my non-surgical root canal treatments are not successful. But I can accept that a slightly sub-100% success rate is in line with evidence-based literature and because I possess the confidence, skills and equipment to subsequently resolve the issue via a surgical approach. What I find harder to accept is that in the Wessex area where I work, all NHS apicectomy referrals are directed only to specialist oral surgeons.

Perhaps whether apicectomy should be considered endodontics or oral surgery depends on interpretation but good agreement exists across these two disciplines about what constitutes the 'Gold standard' best practice in apicectomy.[1-3] Recently published (in both the endodontic and the oral surgery literature) guidelines state that a modern[1,3] apicectomy requires magnification. It recommends cutting the affected root end with no bevel, curetting out the granulation tissue and preparing a retro cavity with ultrasonic-powered, angled cutting tips. After inspection of the cut root end with micromirrors, a root end filling (not amalgam) is placed. The wound is closed with non-resorbable sutures which ought to be removed at a review appointment after four days. Modern apicectomies performed in this way carry a significantly better chance of success (circa five times) compared to procedures attempted under more traditional, now outdated approaches.[4,5]

I am familiar with this modern protocol and with this armamentarium but in recent weeks I have seen a few patients with symptomatic infected teeth that have histories of prior 'apicectomy'. None of them demonstrated any signs of a retrograde filling yet these 'apicectomies' were performed within the last few months and years by oral surgeons. Inevitably I got to wondering if oral surgeons are aware of/adhere to best practice protocol and whether they are sufficiently equipped to do so?

For what little it is worth I have worked in environments where I have shared space with oral surgeons where there was not a single ultrasonic-powered, angled cutting tip in the oral surgery department.

Since we would all agree that NHS commissioning of apicectomy provision with public money ought to get a service that is being delivered along modern proven approaches, would they then feel it appropriate that specialist endodontists were also approved for apicectomy referrals?

*P. Raftery, Havant*


1. Evans G E, Bishop K, Renton T. Update of guidelines for surgical endodontics – the position after ten years. *Br Dent J* 2012; **212:** 497–497.
2. British Association of Oral Surgeons. Information. Available at: http://www.baos.org.uk/Resources.cfm (accessed December 2016).
3. Fahey T, O'Connor N, Walker T, Chin-Shong D. Surgical endodontics: a review of current best practice. *Oral Surg* 2011; **4:** 97–104.
4. Kruse C, Spin-Neto R, Christiansen R, Wenzel A, Kirkevang L L. Periapical bone healing after apicectomy with and without retrograde root filling with Mineral Trioxide Aggregate: A 6-year follow-up of a randomized controlled trial. *J Endod* 2016; **42:** 533–537.
5. Tortorici S, Difalco P, Caradonna L, Tetè S. Traditional endodontic surgery versus modern technique: a 5-year controlled clinical trial. *J Craniofac Surg* 2014; **25:** 804–807.


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### Impacted canines

Sir, it was with interest and a degree of disappointment that I read the paper by Patel and Taylor (*BDJ* 2016: **221:** 561–564) regarding the late referral of impacted canines.

I have been working part time in general dental practice in Surrey for 35 years. Over the last ten years I have been to numerous post-graduate courses and BDA meetings throughout the region when orthodontic consultants have preached the importance of detecting and not only referring cases of impacted canines but also the benefit of extracting the deciduous canine illustrated by dramatic serial radiographs. I am sure that this is also included in their lectures to F1 (vocational training) courses (indeed in the MOS course that I give each year to an F1 contingent I mention the benefit that can often be had by extraction of the deciduous canine in my section on surgical exposure of ectopic canines!).

I note in the article that much of the blame was placed on specialist orthodontists, probably due to their very long waiting lists. Having said that, I would assume that whilst a child was on the specialist orthodontist's waiting list he or she would still be attending their own general dental practitioner for routine check-ups. In my opinion I consider it is incumbent on a general practitioner who feels that the opportunity for this simple interceptive measure is running out that he or she should carry on and extract the deciduous canine. If they are not sure there is always the opportunity to show the radiograph to a local orthodontic consultant to confirm the treatment plan.

*M. Wardle, by email*

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## Regulation

### Bureaucratic behemoth

Sir, I hope you don't mind me contacting you in this way, but I have an issue that I feel is a widespread threat to our profession. I have been a caring, ethical, preventive, minimally invasive practitioner for many years now without having had a single complaint made against me. I have spent thousands of pounds and thousands of hours (!) training with Mike Wise, The American Academy and many other leading clinicians over the years to ensure that my knowledge and skill base is of the highest order and that I am practising up to date evidence-based dentistry. Three years ago after one complaint, from one patient about one tooth and one bad outcome, and initially one set of (admittedly 'old-fashioned' handwritten) records, the GDC launched an



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investigation against me that I believe to be grossly inappropriate and totally unrelated to the clinical issues involved. They have made a raft of unpleasant allegations against me and suggested that I am a 'danger to the public' based on these records alone. They have chosen to ignore my unblemished previous history, two immaculate CQC reports and several glowing recommendations from patients and staff. I have gone to considerable lengths in the last two years to vastly improve my record-keeping (SOE has been installed at the practice, I have had a number of external audits done by an expert at DPS and I have also done much in the way of CPD and remediation and reflective logs) but the GDC has chosen to ignore this and continue to pursue the case. At no point has anyone (including my legal team) made any attempt whatsoever to explore the actual clinical issues involved. My legal team (who I know are doing their best) have pretty much said that I am indefensible because my initial records were poor. This is akin, in my view, to making a definitive diagnosis on a patient based on some old records without even examining them. Frankly, this Kafkaesque procedure has destroyed much of my passion for a profession I once considered noble. If I was of an age and in a position to retire, I would.

It seems to me that the GDC has become an unfit for purpose, bureaucratic behemoth, built and fuelled by parasitic lawyers, that does precious little to protect patients and serves mainly to protect itself and those who profit from it. I think the current legal 'feeding frenzy' in medicine is doing a great disservice to patients and I feel the Government and the profession should be fighting hard to change this culture.

*Name supplied*

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## Antimicrobial resistance

### Refresh your memory

Sir, today is 18 November 2016, the European Antibiotic Awareness Day. I sincerely applaud today's eloquent *BDJ* editorial[1] which recapitulates the crucial importance of proper antibiotic management in dentistry and raises awareness of this issue that is so, so important for humankind.

Microbes almost always steal a march on us humans, and the weaponry as well as the armamentarium available to us in defence against these ferociously lethal enemies is rapidly dwindling for a variety of reasons. Shortly we are bound to run out of our weaponry and it is critical we resort to rational prescribing to save our armoury.

The ground rules of rational prescribing of antibiotics are clearly articulated in the recently released Antimicrobial Stewardship Toolkit mentioned in the editorial and at https://www.gov.uk/guidance/dental-antimicrobial-stewardship-toolkit, and elsewhere. I implore all clinicians to visit this site for a few minutes to refresh their memory on strategic and rational antibiotic prescribing.

*L. Samaranayake, by email*

1. Hancocks S. Antibiotics don't cure toothache. *Br Dent J* 2016; **221**: 595.

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## Smoking cessation

### The role of e-cigarettes

Sir, I am writing in reference to the *Potential quitters turn to e-cigarettes* Upfront news article[1] that was published in a recent issue of the *British Dental Journal* which seemed to imply that e-cigarettes were undermining smoking cessation attempts. This article was written in reference to a Health and Social Care Information Centre report[2] which described the continued fall in the use of the Stop Smoking Services (SSS) and suggested that this 'may be partly' due to increased use of e-cigarettes.

This publication was very timely, because almost within the same week, a study which addressed this exact topic was published in the *BMJ*.[3] This study, the first of its kind, estimated the population impact of e-cigarettes usage by undertaking a time series analysis to explore an association between use of e-cigarettes and changes in quit attempts at a population level. Some key conclusions of this study were that:

- E-cigarette use by smokers (in England) was positively associated with the success rates of quit attempts
- No clear association was found between e-cigarette use and the rate of quit attempts or the use of quitting aids (except for NRT obtained on prescription, for which there was a negative association with e-cigarette use).

The authors of the *BMJ* paper estimated that in 2015 there were 54,288 additional short- to medium-term quitters compared with no use of e-cigarettes in quit attempts, and on the assumption that approximately two-thirds of these may relapse in the future, that e-cigarettes may have contributed about 18,000 additional long term ex-smokers in 2015. The authors point out that although these numbers are relatively small, they are clinically significant given the huge health gains of stopping smoking.

This is obviously an important area and continued careful surveillance of the data relating to e-cigarette usage, quit attempts, and smoking cessation is required. It is also critically important that we investigate further the oral health effects of e-cigarettes, to contribute to these complex discussions.

*R. Holliday (Newcastle), P. Preshaw (Newcastle), L. Bauld (Deputy Director of the UK Centre for Tobacco and Alcohol Studies [UKCTAS])*

1. Potential quitters turn to e-cigarettes. *Br Dent J* 2016; **211:** 284.
2. Health and Social Care Information Centre. Statistics on NHS Stop Smoking Services. England, April 2015 to March 2016. Available at: http://content.digital.nhs.uk/catalogue/PUB21162 (accessed December 2016).
3. Beard E, West R, Michie S, Brown J. Association between electronic cigarette use and changes in quit attempts, success of quit attempts, use of stop smoking cessation pharmacotherapy, and use of stop smoking services in England: time series analysis of population trends. *BMJ* 2016; **354:** i4645.

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## Anaesthesia

### LA in pregnancy

Sir, the use of local anaesthetics (LA) in the treatment of pregnant women is a difficult area as there is an absence of evidence because of ethical constraints preventing randomised controlled studies. Current advice is to avoid non-essential dental treatment until after pregnancy, and where treatment is required to aim to perform it in the second trimester. The reason for this is that in the first trimester organogenesis occurs and small degrees of insult may lead to significant damage to the developing foetus.

The difficulty with comparing the use of LA as opposed to not using them is further complicated because it is usually an adjunct to carrying out a secondary procedure, so a control group not having treatment under LA would also include the group that did not have actual treatment. Therefore, any complications noted in the mother and child would include some of the complications of lack of treatment of the dental problem (eg caries, dental abscess etc).

A recent article reported a prospective, comparative observational study following 210 pregnancies exposed to dental LA in the first trimester compared with 794



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