COMMENT

Letters to the editor

Send your letters to the Editor, *British Dental Journal,* 64 Wimpole Street, London, W1G 8YS. 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.

Hygienist appointments

Pain vs non pain

Sir, I have written to many dental bodies regarding the subject of 'pain vs non pain' caused by the dental hygienist. I have worked in dentistry for 23 years, 13 of these as a dental hygienist. The same complaint keeps getting raised and I think it must be dealt with.

There were always issues when I was a dental nurse that the hygienist was 'brutal or a butcher' and now as a hygienist I have to deal with these issues on a daily basis. I was never taught in my training that pain and force was considered good practice. It should be down to technique. Every week when dealing with new patients I get the same story that the patient hasn't come back to the dentist due to a bad hygiene visit or dreads coming back so puts the appointment off. This is not good for either the practice or the patient.

I pride myself on tailoring each appointment to the individual and this is even on a 15 minute NHS appointment. If a patient is very nervous then less is more; it is no use pushing treatment onto the patient when you know they cannot cope with it. Build the patient's confidence up by doing a little scaling at a time. Sensitive patients you can hand scale or use local anaesthetic and with patients with perio then they will have pockets so there will be plenty of room to debride the area and disturb the biofilm. If you are hurting the patient then you will be ripping into the attached gingivae. Many a time I get patients saying to me it was a terrible experience. When I examine the patient's mouth they may have a BPE of 1s and 2s with very little calculus so I am totally shocked and very annoyed as this should not be the case. I think many hygienists feel they are not considering the patient's needs and only trying to fulfil their own of what they think is expected of them. It is very clear to see if a patient is uncomfortable. I would hope that if this subject is discussed then it would make hygienists reflect on their own manner and how they perform their treatment on the patient.

L. Kennedy, by email

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Dental education

All of the picture

Sir, it was refreshing to read the response of foundation trainee dentist G. Kane[1] to a paper published recently.[2] Oxley *et al.* were felt by Kane and others to be rather critical of the standard of newly qualified graduates.

I find myself applauding the spirit shown and the desire to stand up for one's peer group. A young person entering our profession will have to fight many battles in which such feistiness may be of inestimable value and for years the dental profession has lamentably lacked unity and moral backbone across a range of issues.

Maybe in G. Kane, gender unknown, we have a leader of the future?

However, at the end of the letter, while feeling that trainees develop excellent reflective skills among other things, s/he states the importance of remembering that 'clinical skill is only a quarter of the picture'. Here I must raise my slight concern that, if this really is a widely held idea among the younger members of our profession, I worry that they may have to spend much of their professional lives most ably reflecting on why their patients, failed treatment dangling, are storming the practice exits.

Clinical skills do indeed comprise a broad range – from simple kindness and empathy right through to the highest levels of technical knowledge and dexterity and include the very subjective – like an elephant, clinical acumen can be hard to define, but you certainly know it when you see it. Or are on the receiving end of it!

Clinical skills are **all** of the picture – though the other abilities valued by G. Kane may well frame those skills to their best and most effective advantage.

J. J. Sellers, Rochester

1. Kane G. Dental education: Reflective practitioners. *Br Dent J* 2017; **222:** 745.
2. Oxley C J, Dennick R, Batchelor P. The standard of newly qualified graduates – foundation trainer perceptions. *Br Dent J* 2017; **222:** 391–395.

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Public health

Extraordinary heroism

Sir, I applaud those courageous individuals who are working tirelessly in low and middle income countries as part of the humanitarian assistance programmes to help ease the plight of those in refugee camps. I have myself gleaned invaluable insights through working as a public health consultant, and seeing the extraordinary heroism, determination, stoicism and strength of staff working around the clock to serve patients with a wide range of general health issues and conditions. Many, even within the dental public health sector, are unaware of the inextricable relationship between systemic and oral health and the impacts of general diseases, such as blood disorders, diabetes, renal failure, obesity, infective endocarditis, Crohn's disease, ulcerative colitis, tuberculosis, etc. These diseases share even the same lifestyles, behaviours, social, political, economic and religious determinants of health, inflammatory pathways because the mouth is the gateway to the body. It is time to put an emphasis on dental education programmes that integrate topics such as democracy, social justice, the rule of law, gender equity, human rights, citizenship, cultural diversity, health literacy, community development and

engagement, citizens' participation in health planning and decision-making processes and empowerment of women to take control of their own health and wellbeing issues and realising their rights to access health and social care services and the obstacles that prevent them from doing so and tackling their own determinants of health.

M. F. Al Qutob, London

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Pharmacology

Common side effects

Sir, how many of us take the time to read the information leaflets provided with everyday drugs and medicaments used in dentistry? It may be of interest, and even entertaining, to read the product and patient information leaflet provided by Septodont in their packs of Lignospan Special (2% lidocaine with 1:80,000 adrenaline). The leaflets contain inaccurate information that could be quite alarming to patients. For example, the following side effects are stated as '*common*', reportedly affecting between 1-10 of every 100 patients treated: cardiovascular collapse which may lead to cardiac arrest, arrhythmia, conduction disorders, hypotension and convulsions. Assuming these side effects occur in different patients, we could apparently be looking at up to 50% of the population having a life-threatening medical event every time they receive a local anaesthetic. Perhaps the GDC's minimum CPD requirements on basic life support should be revisited?

We note the highly conservative information sheet has led to a widespread misconception that the number of local anaesthetic cartridges should be limited to three in a healthy adult. To the contrary, the BNF suggests a maximum dose of 25 ml of 2% lidocaine with 1:80,000 adrenaline or 500 mg, which equates to approximately 7 mg per kg for an adult weighing 70 kg. The 7 mg per kg limit is consistent with that quoted in many authoritative texts, and equates to 11 cartridges in a 70 kg adult – this limit clearly exceeds a sensible dose in almost all dental applications, although puts the 'three cartridge' ceiling into perspective; Septodont's recommendation equates to a dose of less than 2 mg per kg for the very same 70 kg adult.

In what appears to be a complete contradiction, the maximum dose recommended for a child is stated in the same information leaflet as 'no more than 5 mg per kg'. To suggest that a 30 kg child can receive a higher dose than a 70 kg adult seems most peculiar.

Millions of local anaesthetic injections are delivered without incident in dental practice each year, although anyone reading the above would be forgiven for believing that lidocaine should be withdrawn with immediate effect. C. F. took the liberty of contacting Septodont in January 2015 to express concerns over the information provided, and was advised that changes would be made to the leaflets – to date this has not happened. To offer *BDJ* readers reassurance, C. F. went on to contact Dental Protection in order to seek advice on how to proceed if a manufacturer provides information that conflicts with other published guidance and current clinical practice, and was informed that if the manufacturer has acknowledged that errors exist, then following guidance in the BNF is sensible practice. Whilst caution does indeed have to be exercised to ensure patients with low BMI or hepatic impairment receive appropriate amounts of a drug which when used in excess is highly toxic, we do hope *BDJ* readers will continue to deliver appropriate amounts of local anaesthetic to their patients so as to ensure their dentistry remains pain-free.

C. Freeman, R. Bolt, Sheffield

Michael G. Cann, Managing Director of Septodont Ltd, responds: Septodont are world leaders in dental pain management with products licensed in many countries.

Patient safety is at the heart of everything that we do, so accordingly, advice to practitioner and patient evolves, with documentation being revised on a regular basis, in line with regulatory requirements and updated clinical best practice.

All documentation included within the Lignospan 2% Special 1/80 000 2.2 ml carton is necessarily approved by the MHRA (Medicinal Health Regulatory Agency) in the UK, forming a part of the licensed product presentation.

Septodont submitted its most recently updated documentation at the end of last year and the patient information leaflet is currently under review by the MHRA and is expected to be approved imminently.

Irrespective of the included documentation, the safety profile of Lignospan 2% Special 1/80 000 2.2 ml stands as our key priority and continues to reassure the many users of the drug, both in the UK and around the world.

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A topical solution?

Sir, within our practice setting, topical local anaesthetic has been found to be of great use, particularly when used for the benefit of children and anxious patients. The topical anaesthetic used in our practice has been a 17.9% benzocaine gel (bubble gum in flavour), which appears to work well for our cohort of patients for a number of reasons.

As part of the clinical governance process, it had been identified that the product we use should be used within 14 days after opening. However, and as far as we are aware, this product is only supplied in a 30 ml pot, and as a result of this we are finding that we are needing to discard part-full pots of gel.

We would be grateful for any comments from readers, and in particular, whether there may be companies marketing or distributing similar *benzocaine* products in the UK, with either a longer shelf life time or in a smaller dispensing pot or unidose syringe formats?

S. Gandhi, S. Martin, Birmingham

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