

as moderate caries risk when they should have been in the high caries risk category.

Is there any official parameter for low/medium/high risk? As I am under the perception that when there are lesions of more than nine, high sugar intake and living in a low fluoridated area we should place the patient under a high caries risk with a three-month recall and the use of high fluoridated toothpaste. But what about those patients with nine or more lesions but who live in fluoridated areas and have reduced their sugar intake?

*K. Raj, by email*

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## NHS dentistry

### Slow the troubling trend

Sir, as a doubly qualified maxillofacial trainee who qualified as a dentist in 2005, then a doctor in 2011, I have had the misfortune to see contracts imposed on both of my professions by successive governments. The 2006 dental contract came under much criticism due to its rushed implementation, cost cutting measures and little emphasis on prevention, and the new contract due to be implemented in 2018/19 is currently being piloted in practices across the country.<sup>1</sup>

Having first looked at trends in cervicofacial infections requiring surgical treatment in 2006,<sup>2</sup> we completed a prospective survey of all those presenting in Leeds, Mid Yorkshire, York and Hull across a one month period completed in April 2016, ten years following imposition of the new contract.

The number of patients presenting with cervicofacial infections requiring surgical treatment in this 30-day period was 66, over a 4 × increase in the same period ten years ago. Fifty-six percent presented directly to accident and emergency without primary care input compared to 48% previously, and overall, 44% had no registered dentist compared to 56% ten years ago.

These results are alarming, and although the reasons are presumably multifactorial, it does lead to concerns about further pressures on an already troubled system. Death from dental sepsis is rare in the United Kingdom,<sup>3</sup> but every dental abscess must be considered potentially life threatening if left untreated.

The increased workload on accident and emergency, in addition to the unplanned activity in emergency theatres, can only be assumed to negatively impact care elsewhere. We must ensure as a profession that any new dental contract addresses the issues of access and preventative dental care to hopefully slow this troubling trend, and ease the burden on an already stretched system.

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## Paediatric dentistry

### Let's support each other

Sir, it was with great delight that I opened the pages of the *BDJ* to see a three-page spread dedicated to BSPD's Dental Check by One (DCby1). Thank you to you and your editorial team for picking up on this important campaign so promptly. It was additionally rewarding to note the positive responses from all your interviewees who not only supported the campaign but reported on inspired and committed approaches to managing young children in the dental chair.

One of your interviewees dissented in one aspect only and this was in relation to access. Currently, in his or her practice (the interviewee chose to remain anonymous) there was no capacity to treat additional children. However, I understand that a commissioning concept has been proposed to all NHSE regional leads. If agreed, this would include a mechanism for allowing the 25% of practices who have met their UDA target to receive additional UDAs in order to see young children.

For Dental Check by One to become a reality, the support of dental practices – both private practices and practices with NHS contracts – is essential. BSPD looks forward to a strengthening collaboration with primary care. Through you, can I invite your

readers in general dental practices to use our DCby1 logo and we will support each other as we work together to bring down the number of children requiring GAs for dental extractions.

For more information about the campaign and to download the logo, please visit <http://bspd.co.uk/Resources/Dental-Check-by-One>.  
*C. Stevens, Vice President BSPD, Manchester*

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## Dental education

### Missing something vital?

Sir, this letter highlights some of the advantages of incorporating vital signs in the initial assessment of patients. Notwithstanding an increased workload for dental students and their supervisors, teaching it may provide valuable information about patients' general health and wellbeing. Assessment of vital signs is certainly crucial in the prevention and management of medical emergencies. Given an increase in ageing population in the UK, it is apparent that dentists in primary care are seeing a higher number of patients with medical problems, diagnosed and undiagnosed. Assessment of vital signs as part of initial examination may help in identifying signs of previously undiagnosed medical conditions such as cardiorespiratory diseases, hypertension etc. This may prompt referral to medical colleagues for further investigations.

Another related example is the assessment of body temperature to rule out fever in patients presenting with oral infections and make informed decisions including antibiotic prescriptions and the need for referral to the hospital for treatment as inpatients. However, it is not unusual in dental practice environments to rely on patients' perceptions regarding the presence and severity of fever. It would be helpful to ensure that thermometers are routinely available in general practice dental settings. Incorporating this element in the initial medical assessment of patients will not only help students to consolidate their skills but also contribute further to improved clinical care without any significant financial implications.

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