(C) Liaise with cardiologists/cardiac surgeons as appropriate
(D) Allow the patient to make the ultimate decision whether or not AP will be used.

This is a significant departure from the NICE 2008 recommendation against antibiotic AP.[2] It essentially mirrors guidelines from the European Society of Cardiology (ESC)[3] and the American Heart Association (AHA)[4] and is in keeping with the legal precedent provided by Montgomery.[5]

However, we have some reservations. SDCEP adopted the ESC and AHA definition of invasive dental procedures, ie procedures requiring manipulation of the gingival or periapical region of the teeth or perforation of the oral mucosa. In their consultation document, they gave the same list of exceptions as ESC/AHA.

In their published advice, however, BPE screening and supragingival scale and polish have been inexplicably added as examples of 'non-invasive procedures'. This is of considerable concern.

BPE screening involves periodontal-probing of all teeth to identify the deepest pocket in each sextant. Several studies have shown that periodontal probing can cause significant bacteraemia with organisms that cause IE.

Most supragingival calculus accumulates at the gingival margin and causes gingival inflammation. Instrumentation to remove this often results in gingival manipulation and bleeding.

Numerous studies have shown that scaling (including supragingival scaling and polishing) can cause significant bacteraemia with IE-related organisms. We are unaware of evidence demonstrating the safety of these procedures and dentists and hygienists following ESC and AHA guidelines normally provide AP cover for these procedures (as did UK dentists prior to the 2008 NICE guidelines).

We agree with SDCEP that patients at 'increased risk' of IE should have this level of risk explained to them. However, the illustrative figure provided by SDCEP (1/10,000/year) relates to the general population and is much lower than the actual level for those at increased (34/10,000/year) or high-risk (50/10,000/year) – called the 'special consideration sub-group' by SDCEP – as shown in a recent study referenced within the SDCEP document.[6]

It would be misleading, therefore, to use a figure 30-50 times too low to illustrate the level of risk for these patients. Similarly, whilst SDCEP described the 'special consideration sub-group' as representing a small fraction of those at 'increased-risk', the same study identified 365,875 individuals at 'increased-risk' in England (2000-2008) with 96,021 (26%) in the 'special consideration sub-group'.[6]

Furthermore, the number at high-risk is growing inexorably as those at moderate-risk undergo cardiac interventions that convert them into high-risk ('special consideration sub-group') cases.

We hope these issues are quickly addressed so that clinicians can confidently adopt the SDCEP advice nationwide.

M. H. Thornhill, J. B. Chambers, B. D. Prendergast, M. Dayer, T. J. Cahill, P. B. Lockhart, and L. M. Baddour, by email

1. National Institute for Health and Care Excellence (NICE). Prophylaxis against infective endocarditis 2016 [NICE Clinical Guideline No 64]. Available at http://www.nice.org.uk/guidance/cg64/chapter/Recommendations (accessed 23 September 2018).
2. National Institute for Health and Care Excellence (NICE). Prophylaxis against infective endocarditis 2008 [NICE Clinical Guideline No 64]. Available at http://www.nice.org.uk/guidance/cg64 (accessed on 23 September 2018).
3. Habib G *et al.* ESC Guidelines for the management of infective endocarditis. *Eur Heart J* 2015; **36**: 3075–3128.
4. Wilson W *et al.* Prevention of infective endocarditis: guidelines from the American Heart Association. *Circulation* 2007; **116:** 1736–1754.
5. Montgomery v Lanarkshire Health Board (Scotland). 2015. Available at https://www.supremecourt.uk/decided-cases/docs/UKSC_2013_0136_Judgment.pdf. (accessed 23 September 2018).
6. Thornhill M H, Jones S, Prendergast B *et al.* Quantifying infective endocarditis risk in patients with predisposing cardiac conditions. *Eur Heart J* 2018; **39:** 586–595.

DOI: 10.1038/sj.bdj.2018.875

Malocclusion

Modern clinical research

Sir, I must protest at the contents of John Mew's letter (*BDJ* 2018; **225:** 95–96).

What he says is untrue. His licence to practice was not removed by the GDC for promoting 'orthotropics' but for other very good reasons concerning his professional conduct. His two hearings can be reviewed on line at https://olr.gdc-uk.org/hearings?name=MEW,%20John%20Roland%20Chandley#filterresults.

It is also quite untrue that his erasure has prevented him from providing the evidence that his treatment methods are effective.

Before his licence to practice was removed, he had 30 years in which he could have attempted to do so. Instead he tried to convince me and my academic colleagues that it was our responsibility to undertake this!

Not only myself, but also the late Professors Houston and Moss spent a great deal of time trying to persuade Mr Mew that, in an age of prospective randomised clinical trials, any retrospective analysis of selected cases which Mr Mew believed he had treated successfully by his methods was pointless and did not conform to contemporary standards of clinical research, all to no avail.

C. Stephens, by email

DOI: 10.1038/sj.bdj.2018.876

British National Formulary

Instant interactions online

Sir, it has come to my attention that there is a surprising lack of awareness amongst general dental practitioners that the British National Formulary (BNF) is no longer issued to dental practices free of charge.

The BNF can be accessed at no cost through an app and the Internet.

At first, I was deeply sceptical and somewhat cynical with regard to this migration away from print copies to a digitised version of the text.

However, having used the online version, I can immediately see a number of potential benefits for our patients.

On the homepage, there is a clear submenu to the left entitled 'Interactions – Browse the list of drug interactions, arranged alphabetically'. I would emphasise that similar information has always been available in the print copy. However, it does appear more accessible and clear in the digital version.

A recent *BDJ* paper detailed the potential for serious harm and death in prescribing miconazole oral gel to patients on warfarin.[1] A simple search of the drug miconazole in the interactions tab would quickly produce a red box, explaining that the anticoagulant effect of warfarin is increased by the antifungal, that the reaction is 'severe' and that the MHRA 'advises avoid'.

Dental practices can still purchase an individual print copy of the BNF (£57.50) but I would question the wisdom of this when the online version is updated monthly and the print copy is only updated biannually.

I would implore all dentists involved in prescribing to make full use of this valuable resource so that we can work towards reducing prescribing errors.

A. Mehdizadeh, by email

1. Pemberton M N. Morbidity and mortality associated with the interaction of miconazole oral gel and warfarin. *Br Dent J* 2018; **225:** 129–132.

DOI: 10.1038/sj.bdj.2018.877