

Please note that all letters must be typed. Priority will be given to those that are less than 500 words long. All authors must sign the letter, which may be shortened or edited for reasons of space or clarity. All letters received are acknowledged.

## Xylotox labelling

Sir, — AstraZeneca would like to make the following comments in response to the letter by Mr Perini, concerning the change in labelling of Xylotox 2% E80 (lidocaine with adrenaline).

We would firstly like to take the opportunity to reassure our customers that the formulation of the product has not changed in any way.

Every product must have the full registered trade name of the product (i.e. that is listed on the product licence), clearly marked on the outer packaging and individual components. The registered name of the presentation is *Xylotox 2% E80*.

This appears on the outer packaging and also on the individual ampoules. In addition, the amount of adrenaline is also quoted on the outer packaging and is expressed as adrenaline tartrate, equivalent to 12.5mg/ml base.

In response to recent customer feedback concerning the change in labelling of the product, we are currently planning to amend the labelling on both outer cartons and individual ampoules, to clearly indicate the strength of both the lidocaine and the adrenaline. We hope that these amendments will make the labelling clearer for our customers.

We would like to re-iterate that no change in the formulation of the product has occurred, and that the product can continue to be used in accordance with current medical practice.

**R. Rowsell (Medical and Regulatory Affairs Director for AstraZeneca UK)  
Kings Langley**

## Look hear!

Sir, — I read Champion and Holt's article on dealing with hearing impaired children (*BDJ* 2000; 189: 151) with great interest. Having some considerable hearing impairment myself, I feel well qualified to comment on the article. In addition to the excellent brief summary, my additional thoughts are:

1. Ensure the operator is at the same height as the child rather than towering over him or her.
2. Suggest to the parent that they resist from helping for the moment (assuming you have gathered background information

about the type of communication favoured by the child).

3. Keep sentences short and if the child has not understood on the third repeat rephrase the sentence or write something down.
4. If the operator wants to communicate from a position behind the headrest it is better to swing round and talk to the child face on. It is difficult to lip read upside down!
5. Hearing impaired children do not like noises behind them — it is frightening. Better to keep this down to a minimum.

Some years ago, a profoundly deaf boy came into my practice with his mother who was clearly over-caring of him. I asked the mother to be seated and to let me see if I could communicate with her son. The first thing I said was, 'How old are you?' and his reply was 'Very well thank you,' which immediately tells you the level of hearing and what to do about it. The next thing to do is to speak slowly and clearly and move your lips but not in such a way that it is patronising.

Very often a child is so used to a parent answering for him or her that they forget to concentrate and once they can communicate everybody is happier all round and the parent can sit back and enjoy the visit instead of straining forward to try and anticipate a problem.

One last point, if a child is wearing one or two hearing aids, the operator's hands may cause them to whistle. Try and avoid this or you can ask the child to turn the hearing aid down; this, however, could then limit conversation. With all operating procedures, only one person has total control of the situation and that is the clinician and it is one occasion where the dental nurse should perhaps play a silent role to avoid confusion in instructions and actions.

I hope these few comments may be helpful to younger colleagues handling such patients.

**J. J. Crabb  
York**

## Dental anaesthetic referrals

Sir, — T. Webb of Rhyl makes some interesting observations (*BDJ* 1999;187:440) on my recent paper 'Referrals for dental anaesthetics — how many really need GA?' and subsequent correspondence (*Br Dent J* 2000; 188: 3) to which I should be grateful for the opportunity to respond.

First, I am grateful for the implicit compliment in the recognition that in reporting my findings, I have indeed demonstrated how an effective assessment of referrals

should work. I am not as optimistic, though, that such rigorous scrutiny is as widespread as it appears we would both wish. The most recently published review of the use of general anaesthesia in primary dental care exposes the existence of unacceptable practice stating that '... preliminary assessment has not always been adequate. In some cases, the decision to use general anaesthesia appears to have been taken lightly, as a convenient option.'<sup>1</sup> So I would perhaps be somewhat more sceptical on this point.

I also agree that it can be relatively easy to steer reasonably compliant children and adults away from DGA. But surely, these are the very people who should not be put forward for DGA in the first place, if we can indeed assume that current GDC guidance to referring dentists is operating effectively.<sup>2</sup> I wonder if the author misses the point somewhat — that the real skill lies in successfully steering those more reluctant away from DGA.

I understand that there is a fine line to be drawn, as the author says, between accomplishing the possible, and risking future compliance. However, looking at all the most recent authoritative comments on the matter, it would appear that mainstream opinion seems to take the view that DGA is to be avoided *where possible* (my italics). It is perhaps significant that this is an unambiguous and repeated aim not tempered by the over-liberal use of words like 'if' or 'but' or 'on the other hand...'. Those driving regulation of, and guidance to the profession in these matters, seem to be fairly clear where the greater and more unacceptable risk lies, when considering the sort of difficulties to which the author refers.

Furthermore, I would contend that the information published in my paper seems to suggest that many patients can be rather more resilient in this respect than we have previously thought. And while I cannot dispute the assertion that the success in avoiding DGA might be somewhat tarnished if a patient subsequently becomes a dental phobic, I can guess where in the debate those who have seen one of their loved ones killed or injured by exposure to DGA might sit. For we must not forget that though it is a tiny risk in relative size, the need to avoid the potential enormity and devastation of the consequences of anaesthetic injury is the main driver in this whole debate.

The author makes a very interesting point in referring to my observation that many phobic patients relate horror stories about their previous DGA experiences. It is probably true that GA induction techniques have been refined so much in recent years as to bring about a situation whereby such clumsy experiences would now be very rare. Given that the author's view appears to be

that the main problem now seems to be patients' fear of local anaesthetic technique, it seems a little strange to expose the virtues of good GA induction as the way of avoiding the creation of phobia as the answer. Have I missed something, or would it not be more sensible to look at ways of improving our local anaesthetic and other techniques?

How much more we might have achieved if only we as a profession had invested the same effort in developing the adjuncts and learning the skills to improve our local anaesthetic and sedation techniques to the same extent as our anaesthetist colleagues have in their discipline.

I also recognise the point the author makes that people canvassed for their views might feel quite happy about alternatives to DGA being considered and later feel unhappy about the outcome. However, this was not, in fact, the case. The range of verbatim replies which were canvassed and received after treatment was finished (completed or discontinued) was not presented in the original paper but should the author wish to contact me, I would be very happy to discuss them in rather more detail.

I could not agree more with the point that the author closes with — that a well resourced and high quality general anaesthetic service will continue to be needed for the foreseeable future, although I wonder if our individual visions of it might be quite different.

I am very pleased that the emerging professional view seems to lean more and more towards an assumption that I long ago adopted, and espoused in my paper — that irrespective of what might have gone before, DGA must not be ordered for any patient unless there are clear and compelling reasons for it, and it is clearly demonstrable that no viable alternative exists.

**G. Tyrer**  
**Llanfrechfa**

- 1 A Conscious Decision. A review of the use of general anaesthesia and conscious sedation in primary dental care. July 2000; Department of Health
- 2 Maintaining Standards. Guidance to Dentists on Professional and Personal Conduct. November 1998 and May 1999; General Dental Council.

## York report

Sir, — The publication of the draft York report on the Internet has led to a number of articles commenting on fluoridation and dental fluorosis. The editor of the *BDA News* states that 'in the UK the cosmetic effects of fluorosis for the majority are slight whereas the cosmetic and, importantly, the health effects of tooth decay are more serious.'<sup>1</sup>

As a convinced fluorideophile, I appreci-

ate and approve the health benefits afforded by increasing the coverage of water fluoridation. However, as a general practitioner who has to manage the effects of fluorosis, I am deeply concerned at the increasing human costs involved, especially as the draft York report states that the 'Fluoride level has a significant positive association with the prevalence of fluorosis of aesthetic concern.'

The latest BDA statement on fluoride<sup>2</sup> expresses the view that it is essential that public confidence in fluoride is maintained but unfortunately undermines its authority by claiming that excessive fluoride ingestion may only result in mild enamel opacities not normally discernible to the untrained eye. I submit that the only way we will win and maintain the confidence of our patients is by being honest with them, and attempting to overcome the disadvantages of fluoride and not by sweeping them under the proverbial carpet. The pages of the *BDJ* abound with papers discussing the relationship of fluoride toothpaste, water fluoridation, developmental defects and caries but it is not my intention to state what is obvious to any general dental practitioner.<sup>3,4,5</sup>

My purpose is to recognise a problem and offer a simple solution. The BDA statement offers excellent advice to limit the amount of fluoride ingested by under 7s by supervised brushing, use of a pea-sized amount of paste and the use of formulations containing around 500 ppm of fluoride. I propose that although the advice is correct, the age grouping is inappropriate and does not consider four essential issues:

1. The permanent incisors are at their most susceptible to fluorosis in a four-month window around the child's second birthday.<sup>6</sup> It is therefore essential that a child receives no fluoride supplement at all before 26 months with the exception of a carefully controlled optimum dose via the water supply. Increasing the no fluoride age limit to 36 months will make allowance for the later calcification of upper lateral incisors, canines and premolars when considered with the increasing abilities of the child with age.
2. Below the age of three years a child does not have the comprehension or dexterity to brush with fluoride toothpaste and then spit out (or rinse out) any excess. The only possible conclusion is that children under three years of age should not be allowed access to toothpaste with fluoride. Children under three years should be encouraged to emulate their older siblings and parents and begin to lean how to brush their teeth, but only with a non-fluoridated tooth paste. This obviously has important implications for the toothpaste industry.

3. Most parents make an effort to start brushing their children's teeth between 12 and 18 months old. If the child is allowed access to a small pea-sized amount of low fluoride (500ppm) toothpaste from age 3 years he/she has lost the benefits of topical fluoride toothpaste for a period of 18 months to two years. The potential benefit or prevention of development of caries for such a short period clearly does not outweigh the risk of any form of disfigurement, however small.
4. Children do not all develop at the same rate and the parents should be advised that their child can progress to a fluoridated toothpaste only when they are sure he can spit out excess. Children should continue with low fluoride toothpaste until the age of seven when they can maximise the topical effect by using an adult (1500ppm of fluoride) toothpaste.

Despite the difficulty of buying non-fluoridated toothpaste I have been advising this fluoride protocol for many years. Children at high risk to caries or those with a high caries rate can be treated with prescription of fluoride supplements (including fluoride toothpaste) specific to their needs.

I believe the simple expedient of using non-fluoridated toothpaste for children under three years will finally remove the skeleton of fluorosis from the closet and enhance the fluoride supplementation of the water supply with all its inherent health benefits

**J. Moorhouse**  
**Lymm**

- 1 *BDA News* 13: 29
- 2 Fluorides and the prevention of dental decay: a statement from the representative board of the British Dental Association. *Br Dent J* 2000; **188**: 654
- 3 Dini E L, Holt R D, Bedi R. Prevalence of caries and developmental defects of enamel in 9—10 year old children living in areas in Brazil with differing water fluoride histories. *Br Dent J* 2000; **188**:146
- 4 Bentley R M, Ellwood R P, Davies R M. Fluoride ingestion from toothpaste by young children. *Br Dent J* 2000; **186**:460
- 5 Rock W P, Sabieha A M. The relationship between reported toothpaste usage in infancy and fluorosis of permanent incisors. *Br Dent J* 1997; **183**: 165
- 6 Evans R W, Stamm J W. An epidemiological estimate of the critical period during which human maxillary central incisors are most susceptible to fluorosis. *J Public Health Dent* 1991; **51**: 251

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