Send your letters to the editor, British Dental Journal, 64 Wimpole Street, London W1G 8YS
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Priority will be given to letters less than 500 words long. Authors must sign the letter, which may be edited for reasons of space.

A bitter taste

Sir, the desperate shortage of local anaesthetic seems to have dragged on for months despite assurances from dental suppliers that matters would soon return to normal. Reading the regular updates on the BDA website, it would appear that the responsibility for this crisis lies solely with Dentsply following their abrupt (and apparently unplanned) cessation of production. This irresponsible action shows a blatant disregard for their customers but more importantly for our patients.

Dentsply's lack of loyalty to UK dentistry deserves a response from us, and I know I shall be seeking alternatives to all of the many Dentsply products I currently use in my practice.

This leaves a very bitter taste!

K. Fallon
Glasgow
doi: 10.1038/sj.bdj.4813887

CASP and CONSORT

Sir, as part of a recent CPD study session focussing on critical appraisal of evidence and the implications for dental public health; a group of us reviewed the paper *The prevention of 'dry socket' with topical metronidazole in general dental practice* (*BDJ* 2006; **200:** 210-213) by H. Devlin *et al.* using a standard 'CASP' critical appraisal tool developed for assessing randomised controlled trials.

The Critical Appraisal Skills Programme (CASP) is a well known and widely used programme within Learning & Development at the Public Health Resource Unit. http://www.phru.nhs.uk/casp. Since 1993, the programme has helped to develop an evidence-based approach in health and social care, working with local, national and international groups.

We are really pleased to see research carried out in general practice and recognise that the study was done with great commitment from the authors. It is crucial that general dental practitioners are encouraged to organise, run and publish clinical trials such as this that enable clinical developments to take place for the benefit of patients. However, as a result of the structured critical appraisal exercise, a number of key points and suggestions emerged that we felt should be shared with a wider audience.

Firstly, we felt that a more closely targeted research question could have been identified, to better clarify what question the study set out to answer. It was not possible to determine whether either of the interventions described (intra alveolar application of metronidazole gel or a placebo) could reduce the incidence of alveolar osteitis compared with what we believe to be the routine clinical practice in the UK of no agent being inserted into a socket post operatively. We suggest that either the control should have been no intervention or there should have been a third arm of the trial with no intervention for comparison. We recognise this would require a change in methodology to ensure blindness of the observer.

Secondly, it is usual for well conducted randomised control trials to follow up all participants in order to compare the effects of an intervention, whereas this study only followed up individuals who returned with symptoms, thereby reducing the validity of this particular study. We noted however that the authors did refer to this and other limitations of the study in their discussion.

The *BDJ* adopted the CONSORT guidelines for reporting on Randomised Controlled Trials in 1999. These include the production and publication of a flowchart following the participants through the trial. A flowchart is a great help to busy readers to enable them to appraise the trial. http://www.nature.com/bdj/about/consort.htm

Thirdly, although smoking was identified as a possible causal agent in the development of dry socket, and patients were advised not to smoke during the healing period, no assessment of smoking behaviour was reported at follow up for those who did return with symptoms. Given the recognised public health implications of the effects of smoking, this is an unfortunate omission.

We found the 'CASP' tool very helpful in structuring our assessment of the paper and would like to propose that consideration be given to this or a similar framework being adopted by both authors and reviewers to assist with the writing and assessment of scientific papers. We also suggest that CONSORT guidelines for randomised control trials be routinely followed by *BDJ* authors and reviewers both to assist the reader and to promote the highest standards of published research.

Several of us have been authors of papers and referees for peer reviewed journals in the past (including the *BDJ*) and would have welcomed such guidance.

H. Falcon
On behalf of: A. Crosse, J. Donaghy, V. Harrison, L. Hillman, A. Lawrence, M. Smith, S. White
Oxford

Dr H. Devlin responds: Thank you for your interest in our work and for the opportunity to respond to the points raised by our colleagues.

We believe that our study was quite clearly focused or targeted in terms of the population studied, the intervention given and the outcomes that were considered. The study arose from discussions amongst general dental practitioners who wanted to find out whether topical metronidazole gel might reduce the incidence of dry socket in their practices. It was a considerable undertaking as they completed pilot studies and obtained funding and ethics committee approval. A manufacturer of metronidazole and a suitable placebo gel was found, the mode of gel delivery was designed and the blinding procedures put in place. Patient recruitment took a further three years. Using a non-intervention control would have been impossible to conduct as a double blind study as both operator and patient would realise that nothing was being placed in their socket. From our preliminary studies, the incidence of dry socket following non-intervention was already known, and incorporating such a group would have considerably lengthened the study.

Despite the additional inconvenience and increased difficulty in recruiting patients, let us assume that we had asked all patients to return for follow-up after a routine extraction. Would

you classify those patients who failed to attend as symptomless or eliminate their large numbers from analysis? There can be variability in diagnosis of dry socket by different observers as not all patients present with the classical signs and symptoms. How would we have ensured consistency of diagnosis amongst the different observers? Due to these methodological considerations, we used a similar line of attack to that of other researchers in this field. The CONSORT guidelines and flow-chart are designed to highlight inappropriate patient exclusions, numbers of patients withdrawn, high loss-to-follow-up and other potential problems. Our intervention (extraction and gel application) occurred once, therefore presentation of numbers of patients who failed to complete the drug trial or numbers of patients who withdrew are unhelpful.

The public health implications of smoking are well known, and patients were advised not to smoke during the healing period. I agree with the many studies that have shown that dentists and hygienists have an important role to play in smoking cessation intervention. High quality training and adequate remuneration of dental personnel is essential for this to work effectively in general dental practice. However a recent article[1] *in the* BDJ *concluded that 'the majority of dentists have received no training in tobacco cessation strategies'.*

*Although we did not use the 'CASP' tool, we are also trying to achieve and promote the hig*hest *standards of published research.*

1. Johnson N W, Lowe J C, Warnakulasuriya K A. Tobacco cessation activities of UK dentists in primary care: signs of improvement. *Br Dent J* 2006; **200:** 85-89.

doi: 10.1038/sj.bdj.4813888

Obliged to reply

Sir, as one of the authors of the article by Macluskey, Slevin, Curran and Nesbitt (*BDJ* 2005, **199:** 671-675) commented on by Ali *et al.* (*BDJ* 2006 **200:**359) I feel obliged to reply to clarify some of the issues raised. It was not the purpose of the article to try to compare patterns of referral between a surgical practice and a hospital setting. Referrals to the surgery practice are mainly from general practitioners who would obviously assess patients prior to referral. Of course, practitioners would send more complex cases to a hospital setting. A surgery setting would also refer on more complex cases to the hospital setting. None of the cases could, by law, be treated under general anaesthetic in the surgery setting. Taking this into consideration a higher percentage of cases were considered 'simple cases'. The patients that did not require removal of wisdom teeth were not entered into the figures at the surgery practice.

I am concerned regarding the implications of the comment that treating patients under sedation gained an additional fee. Surely it must be considered unethical to administer a drug or procedure to a patient if it were not clinically necessary. The same could be said for the administration of a general anaesthetic for financial gain.

The author of the letter commented on the low level of complications; at the surgery setting this was judged by the patient returning with a complaint directly related to the surgery. During the survey period no patient returned. That is not to say that no patient had a complication as they may have returned to the referring dentist and therefore been treated locally. It was not the purpose of the paper to assess this aspect of treatment.

Regarding the suggestion of surgical/oral surgery practices becoming the centres of teaching for oral surgery: this was not the suggestion of the authors of the paper. I am sure the authors of the letter would have no complaint or problem if undergraduates were, under outreach programmes, sent to orthodontic, endodontic or community practices. Of course all these settings would have to be carefully vetted by the teaching authorities to make sure they are up to standard. Why not a similar approach to oral surgery practices? Why do so many maxillofacial surgeons seem to fear surgical dentistry practices?

The authors of the letter seem not to have realised the purpose of the paper and focused on points that the paper was not trying to assess. I would offer an open invitation to the signatories of the letter to visit Belfast and meet the surgical dentists who work in practice. I think they would have a better understanding of the position. Northern Ireland is now covered with six surgical dentistry practices with 10 surgeons working in these practices. We all have a good relationship with our hospital colleagues coping with the surgery that can be completed in practice allowing the hospitals to cope with the more complex cases. I look forward to a meeting and will let you know the outcome.

M. W. Curran
By email
doi: 10.1038/sj.bdj.4813889

Identifying deficiencies

Sir, Kearney-Mitchell *et al.* posed the question 'can dentists working within primary care agree a set of criteria to trigger a referral following school dental screening?' (*BDJ* 2006; **200:** 509-512). They are to be congratulated on answering this most clearly. I am concerned however that based upon their statement that this is 'an important step in quality assuring the screening process' that the six referral criteria that were finally accepted following application of the Delphi process might be taken as *the* sole referral criteria for dental screening. While few would disagree with the six, the omission of caries in the primary dentition is in my view significant and makes the use of the Delphi technique to establish the set of referral criteria for use in future screening programmes questionable (should this be the authors' intention).

There is ample evidence from BASCD data that the care index in the deciduous dentition is low. Indeed the authors' referred to this in their paper. There are many possible reasons for this, not least the systems (both old and new) for the remuneration of dentists within the NHS. It is a matter of debate however whether this is satisfactory from a clinical perspective as Professor Pine's response to her critics demonstrated (Research letters *BDJ* 2006; **200:** 505-507). It is not surprising however that whatever the reasons, justifications or motives for this state of affairs that a group of primary care dentists would regard caries in the primary dentition as less important. There is some evidence however that caries in the primary dentition can be a predictor for caries in the permanent dentition (for example see Li Y, Wang W. Predicting caries in permanent teeth from caries in primary teeth: an eight-year cohort study. *J Dent Res* 2002; **81:** 561-566). Caries in the primary dentition can indicate the need for targeted prevention aimed at the permanent dentition (even if there is no intention to treat the caries in the deciduous dentition).

Since screening programmes are designed to identify individuals with or *at risk* of developing a disease process, omitting the presence of caries in the primary dentition as a referral criterion would seem to be a regrettable and detrimental omission.

The consensus approach used here is only as good as the group's collective view. It is that which the Delphi technique demonstrates. Surely in these days of evidence-based practice that is not good enough. The collective view might be supported by the evidence; equally it might not. Witness in the same issue of the journal, Mike Martin's leading article that heralded 'a victory for science and common sense' over the long held 'consensus view' as to when antibiotic prophylaxis is required.

Kearney-Mitchell *et al.* claimed that their study represented an important

step in the school dental screening quality assurance process. It undoubtedly established a consensus for a set of referral criteria among primary care dentists for dental screening. What the methodology apparently fails to do is to objectively review the evidence to include the criterion, reject it or indicate the need for further research (perhaps the consensus approach should only be used as an interim where little or no evidence exists – if this was the authors' intention it was not explicitly stated).

The authors may argue that there is little point in referring children with caries in the deciduous dentition to a dentist who is unlikely to restore it, but surely to identify referral criteria based upon the status quo simply maintains it. The true first step in the quality assurance of dental screening must be to establish referral criteria based on evidence or to seek to obtain that evidence where it is lacking. Once identified the criteria and the justification for their selection must be communicated to all involved in the chain from child/parent/school through to the dental practitioner.

Robust and effective quality assurance programs are designed not to simply maintain the prevailing state of affairs but rather to identify their deficiencies and improve them on a continuous basis. In my view the 'first step' in the quality assurance of dental screening fails that objective.

R. S. Moore
Liverpool

The authors respond: The Oral Health Unit of the National Primary Care R&D Centre thanks Dr Moore for raising some interesting issues around school dental screening. In response, it is important to say the paper referred to[1] reports the first steps of a comprehensive research programme, at the core of which is a large population-level randomised control trial designed to test the effectiveness of different screening models. The outcomes of the study reported in the BDJ *informed the design of a screening model that did not include caries in the primary dentition as a trigger for referral following school dental screening. In the trial the relative effectiveness of this model was tested against a more traditional model of screening in which children were referred if 'in the opinion of the referring dentist the child would benefit from further investigation'. This model clearly allowed screening dentists to refer children with caries in their primary teeth if they felt it to be appropriate. The trial also included a model in which the parents of children were given an advice leaflet and encouraged to take their children to a dentist if they had concerns. It seemed wholly appropriate to the research team to include within the trial, a model that met the aspirations of those dentists who might be expected to treat the majority of children referred from the school dental screening programme.*

The findings of the Delphi study reported in the BDJ *supports the findings of other research and reflects the observation that a random sample of GDPs and CDS dentists working in the North West of England did not feel that children would benefit from being referred from screening if they had caries in their primary teeth. The authors wish to make no judgement about the relative merits of a screening intervention that does not include caries in primary teeth as a referral trigger. There is an ongoing debate about how best to manage the dental care of children with carious primary teeth that will remain unresolved until the evidence base is improved through high quality randomised controlled trials.[2]*

*The results of the large screening trial are currently in press and papers report findings at both the population level (*Journal of Dental Research*) and for those children who screened positive (*British Dental Journal*). These papers provide clear evidence for the relative effectiveness of the three models of school dental screening in terms of reducing untreated dental disease in participating children. Like Dr Moore, the authors are keen to ensure that school dental screening is delivered effectively. If it is shown that school dental screening does not benefit the population, or those children who are screened positive, then we have to ask ourselves whether it is ethical to continue with this public health activity.*

1. Kearney-Mitchell P, Milsom K M *et al.* The development of a consensus among primary care dentists of referral criteria for school dental screening. *Br Dent J* 2006; **200:** 509-512.
2. Tickle M. Improving the oral health of young children through an evidence-based approach. *Comm Dent Health* 2006; **23:** 2-4.

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Improve uptake of care

Sir, the recently updated guidelines for the prevention of endocarditis, that were published by the British Society of Antimicrobial Chemotherapy, state that good oral hygiene and access to high quality dental care are important factors in reducing the risk of endocarditis in susceptible patients.[1] A point emphasised in Michael Martin's editorial in a recent issue of the *BDJ*.[2]

In Morriston Hospital, Swansea, when the urgency of surgery makes it impossible for patients to see their general dental practitioner for a dental assessment prior to cardiac valve replacement, they are referred to the Department of Restorative Dentistry by their cardiologist. A thorough clinical and radiographic dental examination is carried out, and any necessary treatment is arranged prior to surgery. Extractions are planned if there is unrestorable caries, evidence of periapical infection or advanced periodontal disease.

An audit of 21 consecutively referred patients was carried out from December 2005. All patients had a history of cardiac valve regurgitation and were due to have an aortic and/or mitral valve replacement within the next few days. The majority were in-patients following emergency admission and two were outpatients. Of the 21 patients examined, restorations were required in 48% and extractions in 57%. Of those requiring extractions, 67% required the extraction of more than four teeth. No patients required scaling in the absence of other treatment but scaling was carried out if required when antibiotic prophylaxis was administered. Only 38% of the 21 patients were registered with a general dental practitioner, their attendance history was not recorded other than 38% of registered patients had seen their GDP within the preceding month. Following our examination 75% of registered patients required treatment. Only 29% of the total 21 patients did not require treatment; half of the group not requiring treatment were edentulous.

These results suggest that the majority of patients who are at risk of endocarditis do not have access to regular dental care or are unaware of the importance of regular attendance with a GDP. Reasons patients gave for not seeing a dentist included being nervous and not being able to find an NHS practitioner. There is a risk that this position may worsen with the introduction of the new contract in the GDS.

These results suggest that there is a need to improve the uptake of dental care by these patients and better patient education as to the importance of oral health is necessary. This could be provided by the cardiologist or GMP. Dentists must also continue to be vigilant and address any potential sources of bacteraemia in patients at risk of endocarditis, whether or not an antibiotic prophylaxis is required for dental treatment according to the revised guidelines. Access to dental care, including sedation where necessary, also needs to be considered and Primary Care Trusts and Local Health Boards should be aware of these issues when planning services. This is especially the case when cardiac services and targets are being negotiated.

P. Virdee

1. Gould F K, Elliot T S J, Foweraker J *et al.* Guidelines for the prevention of endocarditis: report of the Working Party of the British Society for Antimicrobial Chemotherapy. *J Antimicrob Chemo* 2006.
2. Martin M. A victory for science and common sense. The new guidelines on antimicrobial prophylaxis for infective endocarditis. *Br Dent J* 2006; **200:** 471.

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Puzzling options

Sir, the paper by Kearney-Mitchell *et al.*[1] seems at first sight once again to challenge the desirability of a restorative option in the care of the primary dentition. Interestingly, or perhaps tellingly, the authors note that 'restorative care is becoming less of a priority for primary dental care practitioners in the UK'. As ever, we are faced with the puzzle of which came first, a change of heart or a change of priority? Be that as it may, I am much more concerned about the care implications of their colleague's exclusion of 'caries in the deciduous dentition' as a reason for referral than in any question of 'to fill or not to fill'.

Donaldson, in his research summary in the same edition, questions whether 'referral would be appropriate for preventive interventions'. I agree; when a preventive approach is so passionately advocated by some,[2] and promoted by such an august body as the British Society of Paediatric Dentistry[3] it is surely important that children at dental risk are put in the way of such support.

Secondly, would this exclusion be mirrored elsewhere in the UK? The North West seems to have carried more than its share of being 'questionnaired' to date. Would a similar view be held in other parts of the country? Does the availability of facilities have a bearing here; 'I will recommend what is possible, not necessarily what is ideal'?

However, all this is still of relatively little importance by comparison with the lost opportunity to help to protect a child against neglect and possible further abuse.

'Neglect is the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development, such as failing to provide adequate food, shelter and clothing, or neglect of, or unresponsiveness to, a child's basic emotional needs'.[4]

At the BDA conference in 1997 I asked the question: 'Dental caries in childhood: are neglect and abuse part of the problem?' I argued there that if we define abuse as the repeating of an action which we know to be harmful then both the inappropriate supply of sugars to children, and the failure of a dental professional to act in the presence of the resulting decay could be seen to be abusive. I didn't get very far!

In the USA, the position is much clearer; widespread tooth decay is seen as a clear part of the spectrum of child abuse. I can do no better than to quote:

'Dental neglect, as defined by the American Academy of Pediatric Dentistry, is the "wilful failure of parent or guardian to seek and follow through with treatment necessary to ensure a level of oral health essential for adequate function and freedom from pain and infection.

"Some children who first present for dental care have severe early childhood caries (formerly termed 'baby bottle' or 'nursing' caries); caregivers with adequate knowledge and wilful failure to seek care must be differentiated from caregivers without knowledge or awareness of their child's need for dental care in determining the need to report such cases to child protective services."

'The point at which to consider a parent negligent and to begin intervention occurs after the parent has been properly alerted by a health care professional about the nature and extent of the child's condition, the specific treatment needed, and the mechanism of accessing that treatment.

'Because many families face challenges in their attempts to access dental care or insurance for their children, the clinician should determine whether dental services are readily available and accessible to the child when considering whether negligence has occurred.

'The physician or dentist should be certain that the caregivers understand the explanation of the disease a nd its implications and, when barriers to the needed care exist, attempt to assist the families in finding financial aid, transportation, or public facilities for needed services.

'If, despite these efforts, the parents fail to obtain therapy, the case should be reported to the appropriate child protective services agency'.[5]

Should the UK be very different from this? In the light of these careful statements, are the authors comfortable with their consensus that a 'Child with caries in the deciduous [sic] dentition' should not prompt a referral, or even an 'attempt to assist the families' by the examining dentist?

P. Crawford
Bristol

1. Kearney-Mitchell *et al. Br Dent J* 2006; **200:** 509-512.
2. King D. *Br Dent J* 2006; **200:** 505.
3. Fayle S A, Welbury R R, Roberts J F. British Society of Paediatric Dentistry. BSPD. British Society of Paediatric Dentistry: a policy document on management of caries in the primary dentition. *Int J Paediatr Dent* 2001; **11:** 153-157.
4. What To Do If You're Worried A Child Is Being Abused. Department of Health Publications, PO Box 777, London SE1 6XH.
5. Kellogg N. American Academy of Pediatrics Committee on Child Abuse and Neglect. Oral and dental aspects of child abuse and neglect. *Pediatrics* 2005; **116:** 1565-1568.

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Fear of litigation

Sir, I read with particular interest the CPD article *A dental workforce review for a Midlands Strategic Health Authority* (*BDJ* 2006; **200:** 575-579). It helped, reassuring me that I am not alone in my decision to take early retirement, age 50, from a profession I once enjoyed and was committed to.

My first reason is regulations. I cannot be alone in receiving a very heavy handed letter from the DPB probity department, regarding a patient they implied/accused me of 'mixed' treating. On investigation this turned out to be a minor clerical error, ie my reception staff had claimed for a pinned core on a lower right molar but inadvertently missed claiming the FGC placed over it. Like many busy practitioners I signed the said form.

My second reason is expectations. The general media, but also the dental press, put pressure, directly and indirectly on the practitioner to have expensive, sophisticated equipment. However, most of us will then hear patients complain about the cost of their treatments: 'I was only there 15 minutes and was charged £30', for example, a simple but often heard comment.

Finally, the biggest factor in my decision: the fear of litigation. Every course I attended would drum this issue in. Yes, it is real and needs to be addressed, but the thought of costly, (time rather than money, with dental protection cover held by most of us), stressful interrogations of our professional opinions, mostly given with the best of intentions, finally drove me to seek employment, in a far lower paid environment. It really is about time we do not have to take the blame for everything that causes deterioration in a patient's oral cavity — here I refer especially to the smoking issue and periodontal disease — and put the onus back on the individual to look after him/herself.

I was disappointed to retire from clinical work, but realise how fortunate I am, especially when I now attend courses (yes I am still interested in the profession and keep up my CPD) and see the disillusionment in younger colleagues' attitudes.

S. Edwards
Essex

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