

Letters to the Editors should be sent to: Evidence- Based Dentistry, 64 Wimpole Street, London W1M 8AL

From Professor Newell Johnson

Congratulations on the first issue of EBD. I found it very stimulating and rewarding. As a member of the Cochrane Collaboration, and a journal editor myself, I appreciate both the potential value, and the size, of the journey you have embarked upon.

I have a minor criticism — or balancing comment — which you might like to publish. The series of articles by members of the editorial board point the way forward, as does the ‘toolbox’ article. Running through all of these, however, is that the best things are critical reviews — according to Cochrane standards — with exhortations for all of us to read and write them and concentrate our time on journals which publish a lot of them. Lip service is paid to ‘basic research’ and ‘original experiments’, but I feel an unbalanced view emerges. Given that quality and rigour of scientific method are essential in all our endeavours, we must not put down, by implication or explication, the original research — basic or applied — upon which critical reviews are based.

Apart from the obvious fact that you could not approach EBD without the evidence in the first place, we need much more good evidence gathering too. So many issues in dentistry have so little evidence to evaluate. What is/would be the utility of population screening for oral cancer? Can dentists be cost-effective in tobacco habit prevention and cessation? Which drugs make a genuine improvement to the treatment of oral lichen planus? What general health screening tests provide clinical benefit to the patient, and are cost effective, with

dental patients? In the era of triple-drug therapy what oral lesions have predictive value for HIV disease progression? Are there any reliable molecular markers of transformation in oral potentially-malignant lesions and conditions, and of prognosis in oral malignancy? These are just a few with which my colleagues and I are currently engaged.

Please make sure, in your excellent journal, you encourage basic scientists and active researchers, not merely those who take it as their task to criticise (positively or negatively) the former.

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From Dr Tom Marshall

You report on a systematic review which indicates that oral acyclovir started within 72 Hours of the onset of symptoms, reduces the incidence of pain at 6 months by 46%.¹ But this is not the only option. One placebo controlled, double-blind, randomised controlled trial looked at the effect of amitriptyline 25mg a day on post-herpetic neuralgia.² If started at presentation and continued for 90 days, reduced

the incidence of post-herpetic neuralgia at six months by 55%. Consideration of the resource implications may clarify the relative merits of the interventions.

Using an estimate of the incidence of post-herpetic neuralgia (Table 1), we can calculate NNT to prevent post-herpetic neuralgia at different ages (Table 2). This indicates that about 9 patients over 50 will have to be treated with acyclovir. The total drug cost is £1006 (£107.30 × 9) to prevent one episode of post-herpetic neuralgia at six months. The equivalent calculation for amitriptyline is £3 (£0.41 × 8).

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- 1 Jackson J L, Gibbons R, Meyer G, Inouye L. The effect of treating herpes zoster with oral acyclovir in preventing post-herpetic neuralgia. A meta-analysis. *Arch Intern Med* 1997; **157**: 909–9 12
- 2 Bowsher D. The effects of pre-emptive treatment of post-herpetic neuralgia with amitriptyline: a randomised, double-blind, placebo-controlled trial. *J Pain and Symptom Man* 1997; **13**: 327–33 1
- 3 Goh C L, Khoo L. A retrospective study of the clinical presentation and outcome of herpes zoster in a tertiary referral dermatology outpatient referral clinic. *Int J Derm* 1997; **36**: 667–672

Table 1 Incidence of post-herpetic neuralgia — Percentage with pain

Age band	1 month	3 months	6 months	6 months
Age <30	29%	11%	7%	7%
Age 30 to 50	46%	24%	18%	16%
Age >50	62%	39%	23%	20%

Table 2 Numbers needed to treat to prevent pain at 6 months.

	Amitriptyline Absolute Risk Reduction	Acyclovir	Amitriptyline Numbers needed to treat	Acyclovir
Age <30	4%	3%	25	30
Age 30 to 50	10%	8%	10	12
Age >50	13%	11%	8	9

Table 3: Drug cost per episode of postherpetic neuralgia (at 6 months) prevented.

	Amitriptyline	Acyclovir
Age <30	£10	£3,266
Age 30 to 50	£4	£1,302
Age >50	£3	£1,006