Letters to the Editor

Send your letters to the Editor,
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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.

COLLABORATIVE DEVELOPMENT

Sir, with the problem of limited access to out of hours dental care an increasing number of patients with dental/maxillofacial emergencies are presenting to the emergency department (ED) and this may contribute to up to 4% of the ED workload.[1] Furthermore, most medical professionals do not receive any formal dental training at either undergraduate or postgraduate level. The result is that many dental emergencies may be mismanaged as ED physicians do not feel confident in managing even simple dental emergencies[2] causing significant morbidity and cost for the patient not to mention the medico-legal implications for the clinician.

Not every hospital has access to a 24-hour on call maxillofacial specialist. It is not uncommon for a patient with a dental trauma to wait three hours in the ED before being referred to another unit for definitive treatment. This is not only less than ideal for the patient but may also have a significant impact on the overall prognosis of the tooth.

At present there are few resources which ED physicians can access in order to learn the necessary skills required to manage basic dental/maxillofacial emergencies. As a dually qualified ED clinician I have founded a national course for ED physicians to learn and practise core dental skills. The Advanced Tooth Life Support (ATLS) course uses the stepwise ABC approach favoured by other life support courses (Advanced Life Support) to teach non-dentists how to safely manage common dental emergencies. Recently this course was developed into a national training workshop for ED doctors held at the national Emergency Medicine Trainee Association conference held in July at the Royal Society of Medicine in London. Trainees from around the UK spent the day practising replanting teeth in simulated models, learning how to perform intra-oral blocks and making dental trauma splints.

In order to ensure that patients receive the highest quality of treatment I feel there is a need to support our medical colleagues by collaboratively developing and implementing resources that will enhance their dental knowledge and practical skills. There is great need for such courses as well as further research in this field of emergency (dental) medicine so that every medical practitioner has the basic knowledge and skills to manage dental emergencies competently.

C. R. Trivedy
By email

1. Trivedy C, Jaye P, Parfitt A. *Developing a new classification system for facial injuries in the emergency department.* Abstract presented at the College of Emergency Medicine spring conference, London, May 2007.
2. Trivedy C, Ahmad Z, Parfitt A. *The knowledge base and attitudes of UK emergency physicians in managing maxillofacial emergencies: a pilot study.* Abstract presented at the Fourth Mediterranean Emergency Medicine Congress, Sorrento, Italy (MEMC IV), September 2007.

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UNDER THE SHADOW OF CQC

Sir, my first tentative contact with anything to do with CQC was when I went to one of the newly added Post Office locations to have my CRB form checked. The lady at the counter was charming but had great difficulty with my form because 'they had only been doing it since the first of November and had received no training whatsoever in what to do with the forms'.

Perhaps CQC should get their own house in order before coming to judge us.

C. Zane
London

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A PARALLEL APPROACH

Sir, the drive towards evidence-based dentistry would appear to be creating increasing difficulties owing to the absence of relevant high quality research to support even routine investigations and treatment modalities.

However, there would appear to be a useful parallel approach which could be referred to as indirect evidence-based care and I believe that the taking of pre-treatment radiographs for teeth to be restored with crowns provides an interesting example.

An evidence-based guide to dental radiography providing prescribing advice for minor oral surgery, periodontal and restorative care, has been produced by the Faculty of General Dental Practitioners (UK)[1] with statutory IR(ME)R 2000 regulations at its core. However, despite attempts by the authors to produce a robust evidence-based reference, their efforts were thwarted by a paucity of relevant high quality research evidence. The result is that the evidence for individual radiographic examination treatment modalities ranges from weak to virtually absent.

So, for pre-treatment radiography for crowns, the FGDP advice is that a periapical radiograph should be taken but the 'evidence' for the advice is a recommendation from a specialist dental association which was merely providing an opinion and for which there were no supporting papers or arguments.

Clearly for teeth which give no pulpal response and where the cause is undiagnosed and/or not yet appropriately addressed, then radiographic examination with informed consent remains an appropriate investigation. However, if the tooth is firm, vital and has a good periodontal status based upon

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