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

non-radiographic periodontal indices, then the clinician faces an NNT (number need to treat) dilemma which arises from research suggesting that for periapical dental radiography there is one death for every 3 million exposures.

Furthermore, the FGDP guidance on taking periapical radiographs did not extend to the same teeth in the event that a plastic restoration was to be placed. Therefore, was the guidance driven by financial concerns, in turn prompted by the need for evidence in the event of a patient complaint to a professional registration body or professional negligence litigation?

I submitted the above arguments in respect of vital teeth requiring laboratory fabricated restorations. The only counter argument put was that radiographs could identify partial necrosis (with apical involvement) in multi-rooted teeth. A search for the incidence of such occurrences found no relevant evidence but there are in turn a number of indirect counter arguments:

- Imaging of the periapical tissues using the LCPA technique could fail to identify a lesion
- The incidence of relevant post treatment pulpal necrosis would appear to be low (PMID: 12473995) where a low trauma technique is used
- The radiographic NNT would appear to be potentially very high to identify each lesion. Therefore both the radiological risk and financial costs are likely to be very high for each identified case
- Where necessary, RCT through the restoration is likely to be successful
- A retrospective study to determine the incidence of such lesions in vital teeth is feasible and potentially less fraught than undertaking an appropriate double blind study to resolve the issue given the potential difficulties from both clinical and ethical perspectives.

Therefore, rather than focusing directly upon comparing outcomes with and without radiographs, I believe that the evidence base dilemma could be substantially addressed by an indirect evidence-based approach. This involves calculating the overall probability of adverse findings additional to those which can be ascertained without using ionising radiation and then assessing the potential value of the additional clinical evidence which the most potentially appropriate radiograph can provide and its associated risks. While this is currently applied implicitly, formal scientific assessments would appear to be indicated.

I understand that these arguments may contribute to a revision of FGDP(UK) guidelines but my PCT and the DPD have accepted them for not taking radiographs for vital teeth which are to be restored with laboratory fabricated restorations.

P. Mc Crory, Radcliffe

1. Pendlebury M E, Horner K, Eaton K A. *Selection criteria for dental radiography*, 2nd ed. UK: Faculty of General Dental Practice (UK), 2004.
2. Personal Communication, Radiation Consultant, 26 July 2010.

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CURRICULUM CRUTCH

Sir, having recently returned to dental school after studying medicine, the importance of the hidden curriculum has never been so obvious.

Before, throughout, and indeed after medical school, during postgraduate training, the hidden curriculum was my crutch. Be it relatives or family friends with their hyperparathyroidism, or Duke's B Colorectal carcinoma, *ER*, *Casualty*, *Sunday Surgery*, glossy magazines, the tabloids, recounting stories with my friends, witnessing signs of disease on public transport and *Panorama*, I was never far away from someone or something that would reinforce my knowledge or inform my clinical practice.

Dentistry is a different kettle of fish. Although it is much easier to appreciate a cavity, restoration, or a gum boil on a friend or family member than perhaps carry out a colonoscopy in the living room, it is not easier to appreciate the finer aspects of dentistry through this method.

ER and *House* are of little help. There is no revision of the properties of elastomeric impression materials in the Sunday papers. I won't come across the morphology of the deciduous teeth on the London Underground. There will be no undercover investigations into oral bullous disease.

In terms of the hidden curriculum, medicine is like being a newsreader with an autocue. Dental students must be aware of this difference, although some of the attidudinal and communication concepts do translate, I will need to look elsewhere for my autocue this time around.

T. W. M. Walker, London

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PRECAUTIONARY PRINCIPLE

Sir, I have been in correspondence with my local MP regarding HTM 01-05 since last year. It has been difficult to make any headway in constructive argument, as there appears to be a policy approach from which the Department of Health will not waver, but I have managed to extract some interesting points.

A letter I received in April 2010 from the Department of Health comments: 'A balance therefore has to be struck between protecting against these risks, the cost of protective measures, and the practical constraints that the design and structure of many dental practices put on the accommodation of new equipment and the adoption of new practices – the so-called precautionary principle.' One wonders where the precautionary principle could start or end?

On pressing further a letter signed from Earl Howe on 25 June 2010 states, 'that best practice may be impossible to implement without relocating some practices.'

After pressing for more information of any audit into the costs and practical implications of so-called 'best practice', I was handed over to 'Customer Services' at the Department of Health. Customer services stated in their letter: 'The Department accept that these standards will have significant implementation costs for some practices with perhaps a small minority only capable of complying by acquiring new practice premises.'

If your practice cannot comply, would it mean your practice would have to close? Sadly I have been made aware of two local dentists who are now filing for bankruptcy.

What would Sir Philip Green have to say about this policy considering he thought the information held about what the Government spent on services was so sketchy that if his business was run in that fashion 'the lights would go out'?

D. Griffiths, Radlett

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