ENDODONTIC COUNTERPOINT

Sir, I read the article *Devoid of dentistry* (*BDJ* 2012; **212:** 163-164) and I would like to raise a counterpoint. With regards to endodontic treatment, the author stated that students may never have attempted or completed root canal treatment.

At Peninsula Dental School we are set a quota for a number of different clinical procedures, which we have to fulfil before being allowed to proceed to finals. With specific regards to endodontics, we are required to complete a minimum of six root canal treatments, two of which must be molar teeth, before we can consider finals.

This gives students adequate operative experience of root canal treatment. I don't seriously believe that any dental school would allow a student to graduate without having carried out a minimum number of endodontic treatments.

As for cannulating a forearm for IV sedation, I personally would want to attend further training before sedating a patient. I believe the General Dental Council asks that any dentist providing conscious sedation has undergone 'appropriate training'. In reality this means that they have completed a course covering the numerous aspects of theoretical and practical sedation with supervised sessions. It just isn't feasible to cover this in dental school.

A BDS gives the dental undergraduate the basic foundations to build on. The appropriate level of dental knowledge as detailed in the GDC's *First five years* curriculum covers the key aspects of dentistry for the student. Continual learning is paramount in dentistry and development of techniques and acquisition of new skills continues throughout one's career. Continuing professional development and revalidation are here for a reason.

F. R. Stoops, 4th year dental student

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CUTLERY CONTROL

Sir, the letter *Kitchen standards* (*BDJ* 2012; **212:** 154) highlighted how excessive the present HTM 01-05 regulations are.

It is not something I would wish to dwell on when eating out; I have more pressing matters in trying to find a sensibly priced good wine to accompany the meal; but as I put the fork in my mouth, my mind briefly asks various questions: how many mouths has that fork been in? How many of those mouths had active periodontal disease present with spontaneous bleeding and more importantly was that fork adequately sterilised since the last customer?

It makes me think about the lengths I have to go to to sterilise a mouth mirror.

Surely at the least the fork should be bagged up before being placed on that crisply starched tablecloth or maybe the takeaway has got something going for it! Come to think of it, maybe takeaway dental care might negate the need for HTM 01-05!

P. R. Williams, Lowestoft

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DIRECT REFERRAL

Sir, I recently conducted an audit into basal cell carcinoma (BCC) excisions performed by a maxillofacial surgeon at the hospital unit where I am completing my DF2 year. An example of a BCC is shown in Figure 1.

Of the 247 BCC lesions which were excised within one year, 228 (92%) were removed from the head and neck. Over half of the excisions were removed from areas generally visible to a dentist during an examination and 26% were within the field of the dental light.

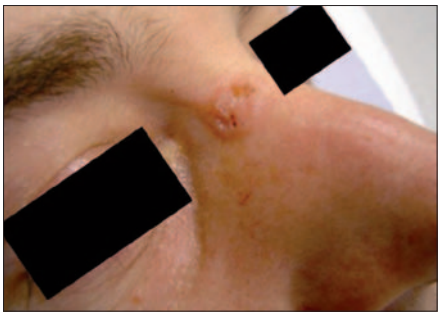

Fig. 1 BCC in a young patient, easily visible in the beam of a dental light

Interestingly, of the 247 cases, not one patient was referred in by their general dental practitioner. It may be possible that none of these patients had needed to see their dentist before they visited their GP, or perhaps the lesion was picked up by the general dentist who referred to the GP as opposed to the specialist directly.

This is a useful reminder that as medical healthcare professionals we can also refer directly to the secondary care specialist and that our extra oral examination can be just as important as the intra-oral one.

S. Patel, Surrey

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BISPHOSPHONATE CONSIDERATIONS

Sir, bisphosphonates are widely used for their undoubted beneficial effects such as protection against bone fractures in osteopenic or osteoporotic people. Bisphosphonate-related osteonecrosis of the jaws (BRONJ) is one possible adverse effect – an avascular area of necrotic bone in the maxillofacial area, with or without exposed bone, that has been evolving for more than eight weeks in patients without a previous history of irradiation in the maxillofacial region and is seen mainly in people receiving intravenous BPs, used largely to treat hypercalcaemia in people with malignant disease.[1-3] There is a huge literature on this aspect of relevance to dentistry. Patients not infrequently seek advice on this medication, and their decisions may be influenced by other drug effects.

As with many new drugs, other adverse effects of bisphosphonates are increasingly being recognised, with atypical bone fractures,[4] atrial fibrillation,[5] cancers (oesophageal and colorectal)[6] and now possibly inflammatory eye effects such as scleritis and uveitis[7] appearing in the ever-lengthening list of potential adverse effects. Potential users may wish to consider these issues when deciding on medication.

C. Scully, Bristol

A. Robinson, Singapore

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DEVALUING THE KUDOS

Sir, on opening my copy of the *BDJ* for 24 March I immediately turned to the *EBD* section. I am actually being serious, as I genuinely believe our credibility as a profession depends on our ability to show that what we do to, and for our patients is based on some sort of evidence. Anyway, I waded through 14 papers which had, presumably, been selected as examples of the sort of evidence on which we should base our practice. Seven of them had little evidence to back them up, and five showed that we don't actually have enough evidence to say which treatment is better. Ah well, at least we are trying. And then I turned to page 265 and read the review of *Yin ain't yang*, which, as far as I can see, openly accepted the 'new evidence' which '*proves* that teeth are joined to vital organs by energy channels ... which can refine the body's chakras'. So there we are then – proof.

The *EBD* section, the result of the academic toiling of committed, questioning dental researchers, has obviously missed the point and got it all wrong. Let us embrace the techniques of Dr Sawicki and utilise 'the meditative exercises using teeth, body and mind' to '...increase bone density, balance hormones, circulate lymph, detoxify organs...' The evidence is obviously there (he says so) and we can avoid the complications of poisoning our patients with bisphosphonates, manage burning mouth syndrome related to hormonal changes, reduce post extraction swelling and cure alcoholic liver disease by the use of simple chewing exercises (okay – I'm simplifying things).

Come on *BDJ*, decide which side of the fence you are sitting on – genuine evidence-based practice or the sort of new age marketing of nonsense books designed to suck in gullible people to invest in the management of their dental, and medical, problems, with treatments designed to line the pockets of charlatans and modern day snake oil purveyors.

EBD is based on the critical appraisal of research, opened up for professional scrutiny. There is no such thing as a perfect research project, and the very presence of doubt or questioning of conclusions is the grit in the pearl which drives forwards advances in understanding, stimulates progress and improves clinical practice, albeit incrementally. The uncritical publicising of books such as *Yin ain't yang* devalues the kudos, and more importantly the credibility, of the *BDJ*. If the journal wishes to maintain its reputation as a world leading scientific journal it would do well to avoid non-critical reviews of books or papers purporting to have 'the answer' to whatever area of dentistry they are addressing.

P. Ramsay-Baggs, Northern Ireland

Editor-in-Chief's note: While I take Dr Ramsay-Baggs' point, the 'News' section is quite obviously different to EBD *in terms of layout, gravitas and evidence-base, and is thus distinguished from other sections and aspects of the journal. We would like to think that readers will add their own judgement to the 'weight' given to the various items of content in our publications and that sometimes 'news' can be an awareness-raising exercise in just what else is out there in terms of public perception.*

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EVERY LITTLE BIT HELPS

Sir, I spoke to delegates about the work of the BDA Benevolent Fund at the British Dental Conference and Exhibition in Manchester last year. We provide financial support to needy dentists and their dependants. This help is not just for BDA members; **any** dentist who is or has been on the UK dental register can apply to the Fund. In many cases the support we offer can mean the difference between remaining in one's home with food on the table and being turned out onto the street.

The causes of dentists' problems are many and varied, sometimes just down to sheer bad luck, but recently the GDC and PCTs have been contributing significantly. This affects GDPs in particular and around 95% of applicants are or were in general practice, with the majority of these being under 50. The effect of sudden cessation of income can be catastrophic for someone with a family to support and financial commitments to meet.

I'm asking for your help in two ways – firstly, please tell your colleagues about the Fund and if you know of anyone who might need help, please encourage them to contact us (in confidence). Secondly, in order to carry on our work, the Fund needs your financial support – the continuing parlous general economic situation means that more dentists than ever are requiring help.

In 2011 the Fund had more applications than in any other year of its 130-year history and this year, so far, has received more than one application per week.

Some LDCs are very generous indeed and the Trustees of the Fund are extremely grateful for this continued confidence in our work with our colleagues. However, many others feel unable or disinclined to help and this is disappointing. If GDPs won't help each other, then who else will?

'Every little bit helps!'

W. Nichols, BDA Benevolent Fund Treasurer

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FIRST TIME EVENTS

Sir, may I draw your readers' attention to the following case. A resident of a nearby nursing home was visited by a local domiciliary dentist. The patient, aged just over 100, requested that his LL7, which was causing him pain, was rectified. To do this root canal treatment was needed, and the patient was re-referred to our practice in Norwich.

I visited him at his nursing home to confirm that he and the tooth were suitable candidates. They were, and the treatment was carried out over two appointments without complication. Rubber dam in conjunction with Reciproc drill and system 'B' were used.

After 37 years in practice I am still surprised by the number of (first time) events that occur in practice on a daily basis. This was one of those events. I am sure that this will be a routine procedure in general practice, if not already.

T. Jones, Norwich

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