Letters to the Editor

Send your letters to the Editor, British Dental Journal, 64 Wimpole Street, London, W1G 8YS
Email bdj@bda.org

Priority will be given to letters less than 500 words long. Authors must sign the letter, which may be edited for reasons of space.

Readers may now comment on letters via the *BDJ* website (www.bdj.co.uk). A 'Readers' Comments' section appears at the end of the full text of each letter online.

FUNDAMENTAL MISUNDERSTANDINGS

Sir, the Scottish Health Technologies Group (SHTG) read with concern the 'Opinion' piece authored by Andrew Smith (published on 27 July 2013 [*BDJ* 2013; **215:** 65–67]) that demonstrated fundamental misunderstandings of SHTG processes and methods. The SHTG is an NHS Scotland evidence review group that aims to provide advice on the clinical and cost effectiveness of non-medicine technologies likely to have significant implications for patient care. SHTG agrees that the principles of health technology assessment (HTA) are to be enthusiastically supported. Through Healthcare Improvement Scotland, SHTG is an active member of the International Network of Agencies for Health Technology Assessment (INAHTA) and recently received NICE accreditation for its technology assessment processes.[1] SHTG uses a variety of technology assessment methods, mainly rapid reviews with a full HTA on occasion.

The SHTG publications on wrapping dental instruments and benchtop steam sterilisers were technology scoping reports, which are prepared in the first instance for all topics submitted to SHTG for consideration. The aim of scoping is to ascertain the quantity and quality of the published clinical and cost-effectiveness evidence to answer the question posed in order to assess the feasibility of producing a more comprehensive evidence review. On these dental topics SHTG was concerned with answering questions posed by the Chief Dental Officer for NHS Scotland, which was to ascertain the available evidence on the impact of these technologies on patient health outcomes. As such, measures of biological contamination of dental instruments related to the technical performance of the technologies were not assessed. The literature searches (full details of which, as indicated in the reports, are available on request) yielded mainly guidance and guideline documents, none of which cited research evidence to support their recommendations thus precluding assessment of either the clinical or cost effectiveness of these technologies.

Consequently, the SHTG determined that it was not feasible to progress from scoping to a more comprehensive evidence review. The SHTG Advice Statements indicated that there was insufficient research evidence to support changes in practice and routine use of these technologies, particularly given the significant anticipated resource impact.

The Chief Dental Officer for Scotland and consultees indicated their satisfaction with the SHTG scoping reviews and advice. Shortly after publication of the advice, the British Dental Association (BDA) issued a press release applauding the SHTG for its commonsense approach to decontamination in Scotland.[2] The SHTG undertakes to regularly update its evidence reviews and advice statements. Both the dental wrapping and benchtop steriliser topics are currently being considered for update but early indications suggest that the research evidence has not progressed sufficiently to make this worthwhile.

P. Rutledge, Chair SHTG
S. Myles, Professional Lead SHTG

1. Full details of the standard operating procedure followed in the production of our evidence review and advice products are available on our website at www.healthcareimprovementscotland.org/our_work/technologies_and_medicines/shtg.aspx (accessed September 2013).
2. British Dental Association. BDA applauds commonsense approach to decontamination in Scotland. Available at: www.bda.org/news-centre/press-releases/31407-bda-applauds-common-sense-approach-to-decontamination-in-scotland.aspx (accessed September 2013).

DOI: 10.1038/sj.bdj.2013.883

RULE FOR CANCER DIAGNOSIS

Sir, there is not only evidence for an increase in oral (mouth) cancer in the UK and many other countries, but also an increase in interest in the early diagnosis both from patients, the profession, regulators, charities and the legal profession.[1-5]

There are already a number of lists and tables highlighting warning signs but, in an effort to facilitate learning as in other areas,[6] I suggest the RULE for suspecting oral cancer should be any single mucosal:

- Red and/or white lesion
- Ulcer
- Lump
- Exceeding three weeks duration.

This is not to say that other signs/symptoms may herald cancer, as referenced elsewhere: if in doubt – ask.

C. Scully
By email

1. Siddique I, Mitchell D A. The impact of a community-based health education programme on oral cancer risk factor awareness among a Gujarati community. *Br Dent J* 2013; **215:** E7.
2. Dave B. Why do GDPs fail to recognise oral cancer? The argument for an oral cancer checklist. *Br Dent J* 2013; **214:** 223–225.
3. Hertrampf K, Wenz H J, Koller M, Grund S, Wiltfang J. Early detection of oral cancer: dentists' opinions and practices before and after educational interventions in Northern-Germany. *J Craniomaxillofac Surg* 2013; pii: S1010-5182(13)00034-6. **DOI:** 10.1016/j.jcms.2013.01.019. [Epub ahead of print].

4. Ogden G, Lewthwaite R, Shepherd S D. Early detection of oral cancer: how do I ensure I don't miss a tumour? *Dent Update* 2013; **40:** 462–465.
5. irwinmitchell solicitors. Lawyer welcomes calls for improvements in diagnosis of oral cancer. 3 October 2012. Available at: www.irwinmitchell.com/newsandmedia/2012/october/lawyer-welcomes-calls-for-improvements-in-diagnosis-of-oral-cancer (accessed September 2013).
6. Scully C. Aide memoires in oral diagnosis: mnemonics and acronyms (the Scully system). *J Investig Clin Dent* 2012; **3:** 262–263.

DOI: 10.1038/sj.bdj.2013.884

ANTICOAGULANT UPDATE – CORRECTION

The letter *Anticoagulant update* (*BDJ* 2013; **215:** 103-104) was authored by: Professor Mark Griffiths, Professor Crispian Scully, Dr Andrew Robinson; Bristol PCT, WHO Collaborating Centre For Oral Health – General Health and Singapore, and not solely by Professor Scully. This was an editorial error and we apologise for any embarrassment or inconvenience caused.

DOI: 10.1038/sj.bdj.2013.885

BETTER LATE THAN NEVER

Sir, the recent announcement from the Department of Health that, with specific and sensible caveats, dentists with HIV could return to clinical practice including invasive procedures is indeed very welcome (*BDJ* Volume 215 issue 4). The issues and evidence were considered in detail by an international expert group (which included David Croser) at the 6th World Workshop on Oral Health and Disease in AIDS in 2009.[1] This led to the Beijing Declaration[2] with the recommendation worldwide that there was no compelling evidence justifying the continued restrictions on clinical practice in dentistry.

The *BDJ*, BDA and the Medical Protection Society are to be congratulated for their full and sustained support of this evidence-based position. The lifting of restrictions now brings us into line with the USA and many European countries who have already made this decision. Better late than never.

S. Challacombe, London

1. Flint S R, Croser D, Reznik D, Glick M, Naidoo S, Coogan M. HIV transmission in the dental setting and the HIV-infected oral health care professional: workshop 1C. *Adv Dent Res* 2011; **23:** 106–111.
2. Challacombe S J. Beijing Declaration 2009. *Adv Dent Res* 2011; **23:** 6.

DOI: 10.1038/sj.bdj.2013.886

DEATH OF A PASTRY CHEF – CORRECTION

The letter *Death of a pastry chef* published in the *BDJ* on 24 August 2013 (**215:** 155) incorrectly listed the author name. The author's name should have read as follows:

P. Charlier

We apologise for any confusion and inconvenience caused.

DOI: 10.1038/sj.bdj.2013.887

VINE WITHERED DENTISTRY

Sir, all those years ago when I was in general dental practice it was the custom to provide dental care free of charge for one's colleagues and their immediate family. This was a helpful privilege which continued after I retired – albeit without my being able to offer a reciprocal service.

Now, at well over 80 years of age, with the need to find a new 'dentist' following the retirement of our previous practitioner, this supportive role of my colleagues seems to have disappeared.

Indeed we were unable to find treatment under the National Health Service provisions when it was needed urgently and eventually sought care under a private contact without the benefit of any, previously unneeded, dental health insurance!

There was no offer of even a discount for a fellow dentist!

This situation prompts me to ask if the unwritten ethic of free care for one's colleagues and indeed for local medical practitioners has withered on the vine of the need for commercial success.

An echo, perhaps, of the self-glorification displayed by some of the dental surgeons in advertisements today – promoted on the grounds of bringing services to the attention of the public – which makes me feel so nauseous.

Or am I just an out of date old fogie with a conflated, rosy picture of what being a professional man meant way back then?

G. J. Doughty

DOI: 10.1038/sj.bdj.2013.888

RADIOGRAPHIC NECESSITY

Sir, we would like to draw your attention to the issue of necessity of the radiographic examination at trauma units of paediatric hospitals.

We describe the case of a nine-year-old girl presented for examination at the oral surgery department of the Medical University of Warsaw. She was referred from the paediatric department of the University Hospital in Warsaw where she sought help because of extensive bleeding from her nose.

The patient's anamnesis revealed trauma suffered seven years earlier (at the age of two years) when she fell and hit her face against the floor while jumping. She was taken to the trauma unit at the City Paediatric Hospital and examined only by the paediatrician. At that time, the examination revealed avulsion of the primary upper left central incisor and lower lip laceration (that was sutured under local anaesthesia); however, no radiological evaluation was performed since there were no symptoms of brain concussion. The patient's parents were also not advised to receive any dental follow-up.

Only seven years later due to the post-trauma complications (bleeding caused by disruption of mucosa) a detailed examination (including lateral cephalometric and Waters' projection radiograph) (Fig. 1) and accurate diagnosis were performed at the Medical University Hospital. It revealed the root of the tooth extending into the left nasal vestibule. The cone beam

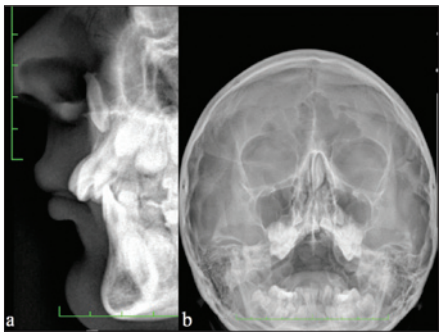

Fig. 1 Lateral cephalometric and Waters' projection radiograph

computed tomography (performed only to plan the surgery) enabled a precise assessment of the position of the tooth at the anterior wall of the left maxillae. The crown was located within the alveolar process left to the anterior nasal spine and the root above the lower edge of the piriforme aperture extending outside of the bone.