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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

Rapid advances

Sir,- It is an encouraging move for the *BDJ* to produce a series of articles that are designed to update the dental practitioner on those aspects of general medicine and surgery that are relevant to dentistry.

With so many of our patients on medication or a beneficiary of surgical advances, it is essential that we try to keep up-to-date with those aspects of medical advances that have any effect on our patients' care.

It is then such a pity that the first in the series, on cardiovascular disease, (*BDJ* 2003, **194:** 537) has two glaring omissions in what it covers. Firstly, despite listing hypercholesterolaemia as a risk factor for cardiovascular disease in Table 1, no mention is made of the statin drugs that are the first choice for controlling cholesterol levels, both as a treatment and as a preventative regime for susceptible patients. Surely, with ever increasing prescribing of these drugs, supported by evidence from several international collaborative studies and approved by NICE, an explanation of how they work on lowering cholesterol levels[1] and the additional effects on arterial plaques would have been beneficial, especially when much has been written about the link between periodontal disease and the arterial diseases?

Secondly, there is a real likelihood that in all practices there will be patients attending who have had angiography and/or percutaneous coronary interventional procedures (stent placement, with or without drug coating) or even revasculation[2,3,4]. There is no mention of these procedures, nor of the need or otherwise for special precautions.

With early intervention by cardiologists now the norm and rapid advances in non-surgical techniques, there will be more of our patients who have benefited from these advances attending for dental care. Dentists should be aware of these procedures and be able to inform and reassure patients of their minimal impact on dental procedures. They are, unfortunately, not going to obtain this from their cardiologists! In particular patients who have undergone PCI do not require prophylaxis against endocarditis. They may be taking asprin and clopidogeral but not usually warfarin.

It is a pity that, what is potentially an important series for the dental practitioner, has started without being up-to-date in two of the most important and developing therapeutic areas in cardiovascular disease. Indeed, there is little in the article that could not have been written ten years ago! In a rapidly developing speciality, all but one reference is more than three years old.

Would it be possible to publish a supplement that contains both the details of modern therapeutic interventions, their impact on dental care and the evidence base to support what is included?

For those interested in up-to-date information on statins and angioplasty, the Medscape website (www.medscape.com) regularly provides informative overviews on these and similar subjects.

S. I. Morganstein, P. Mills
London

1. Law MR, Wald NJ, Rudnicka AR. Quantifying effect of statins on low density lipoprotein cholesterol, ischaemic heart disease, and stroke: systemic review and meta-analysis. *BMJ* 2003; **326:** 1423-1429.
2. Roberts HW, Redding SW. Coronary Artery Stents: Review and patient management recommendations. *JADA* 2000; **131:** 797-801.
3. Grech ED. Percutaneous coronary intervention. History and development. *BMJ* 2003; **326:** 1080-1082.
4. Grech ED. Percutaneous coronary intervention. The procedure. *BMJ* 2003; **326:** 1137-1140.

M. Greenwood and J.G. Meechan, authors of the paper respond:– *We thank Dr Morganstein and Dr Mills for their letter. As mentioned in the introductory abstract, this series is limited to discussing those aspects of medicine and surgery which have a direct relevance to dental practitioners.*

With regard to cholesterol lowering agents, we feel that these commonly prescribed drugs, whilst important to be aware of, do not impact directly on the practise of dentistry, sedation or anaesthesia. The intention of the drugs section of this paper was to deal with those therapeutic agents that affect dental management. The Dental Practitioners Formulary/British National Formulary will always provide easily accessible comprehensive advice and information with regard to the vast range of drugs on offer for the treatment of cardiovascular disease.

With regard to angiography and percutaneous coronary interventional procedures the 'minimal impact' they refer to on dental procedures is the main reason that these procedures were not alluded to. Going down this all-inclusive line one could easily cite investigations such as 24 hour tapes, exercise ECGs and echocardiography as well as others, but the line has to be drawn somewhere in a paper such as this.

The paper was intended to give an overall view of the assessment of a patient with cardiovascular disease from the perspective of a dental practitioner. History and examination are fundamental to this and we would suggest that the basics of this have not fundamentally changed in the last ten years.

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Registration confusion

Sir,- Recently there has been much media coverage of the Brynteg Dental Practice in Carmarthen regarding the availability of dental care. I have observed the situation with interest and concluded that confusion surrounds the issues of registration and treatment need.

Why did the Brynteg practice limit registrations to 300 when demand for registration totalled 600? There are no limits to the number of patients allowed to register with dental practitioners. Clearly, if too many patients with high treatment need register then capacity will be achieved. What criteria has been used to calculate capacity?

Without assessment of treatment need for the 600 in the queue outside the practice, how do the operators in Brynteg know whether the 300 successfully

registered individuals have high or low treatment need? It could be that the 300 registered need no active treatment while the other 300 are experiencing symptoms and have high treatment needs. If national trends are anything to go by, those in the queue will want to be registered but have no great treatment need.

If the treatment need present in the 600 individuals is excessive then this presents a challenge to those responsible for commissioning oral health care. I would have thought it to be appropriate for the Welsh Assembly Government to support organisations, such as Brynteg, so as to expand their services.

We know from the Dental Practice Board that the number of patients registered per dentist varies from less than 1000 to over 4000. It is also known that half the courses of treatment provided by dentists today require no dental intervention. Since 1993 the quantum of patients requiring no dental intervention has increased by ten per cent.

One thing is clear, if social inequality is to be addressed practitioners who are committed to the NHS need to be supported by Government. If the demands made on these practitioners result in high registrations from patients with high treatment need it would be appropriate to facilitate the expansion of their services.

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A fair fee?

Sir,- Since the letters by C. Daniels (*BDJ* 2003, **194:** 466) and J. W. Ferguson (*BDJ* 2003, **195:** 64) were written, the GDC has responded by voting to abolish the Specialist List Retention Fee for 2004 onwards. The matter might therefore seem closed. However, there remain some unanswered questions. From the regulations governing the dental specialties[1] the following points emerge:
a) the fees charged by the GDC can cover the cost of providing the service concerned, together with a reasonable proportion of the overheads but must not include any element of profit
b) the GDC is empowered to charge a fee for issue of a CCST and for entry to a specialist list, but no provision is made for a specialist list retention fee
c) no provision is made for erasure from the lists.

Nevertheless the GDC levied a Specialist List Retention Fee of £200 for the year 2003 and assumed the right to erase non-payers. According to GDC estimates, the specialist lists were only costing about £40 per head to run leaving a cool 400 per cent profit on the deal. Practitioners who take a relaxed view of the regulations are liable to attract the attention of the regulatory authority. Is the boot now on the other foot?

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doi: 10.1038/sj.bdj.4810644

1. Statutory Instrument 1998 No 811. The European Primary and Specialist Qualifications Regulations 1998. HMSO London

Better the devil you know

Sir,- Whilst I appreciate all the work that has gone into *Options for Change*, as the saying goes 'better the devil you know than the one you don't know'. In my opinion the main problem associated with the current GDS schedule is that the fees are wholly unrelated to the cost of providing a quality service. The new 'improved' capitation system is presented as the panacea for the woes of the old one - even though the former's content/delivery mechanism is shrouded in a fog of mystery.

Many practices both here and abroad, successfully provide quality dental treatment on a private fee per item basis. Unlike the GDS, these fees are set according to practice expenses/dentist income expectations.

I believe there is a risk that the proposed capitation system will come to resemble some of the health maintenance organisations (HMOs)/preferred provider organisations (PPOs) found in the USA. Some of our colleagues there have been trapped into caring for a list of patients with ever-dwindling capitation payments. They are actively seeking exit routes from these programmes, which are aimed at cost-containment rather than delivering optimum patient care.

If the 'missing' 50 per cent of the general population were to suddenly start attending our surgeries, how many of us believe that the Government would double its financial commitment to dentistry? Perhaps the BDA should canvass (via a questionnaire?) its members with a number of alternative options - an obvious one that has been bandied about for years being a very limited core service for adults.

If the capitation experiment were later to go pear-shaped, at least the BDA could say 'we told you so'. The BDA has in the past rightly/wrongly been accused of recommending an unpopular mode of public dentistry delivery. It would be a shame if this were to be repeated.

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