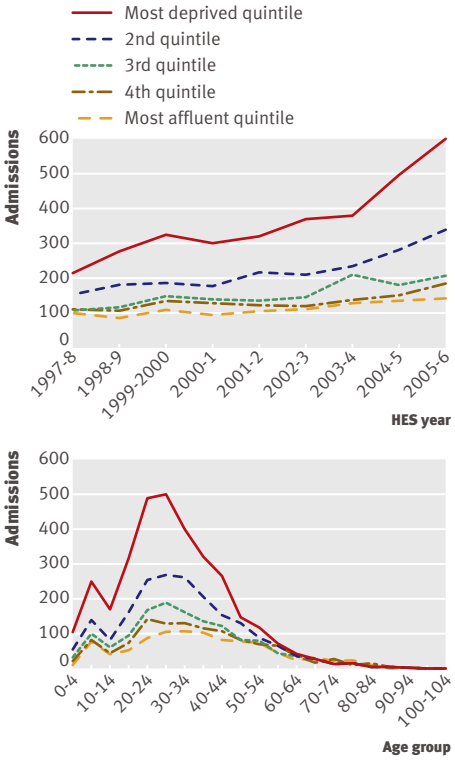
We select the letters for these pages from the rapid responses posted on bmj.com favouring those received within five days of publication of the article to which they refer. Letters are thus an early selection of rapid responses on a particular topic. Readers should consult the website for the full list of responses and any authors' replies, which usually arrive after our selection.

EPIDEMIC OF DENTAL ABSCESSES?

Dental abscesses have increased most among poorer people

Thomas et al analysed aggregate data on drainage of abscess of alveolus of tooth from the hospital episode statistics (HES) website.[1] I analysed the individual episode records for the same procedure (OPCS4.2 code F16.1), using data obtained as an extract from HES from 1 April 1997 to 30 March 2006. Using individual episode data permits a greater degree of resolution, particularly when combined with other relevant details including the relative deprivation of area of residence of admitted patients (using quintiles of the index of multiple deprivation[2]).

Worryingly these data indicate the presence of considerable inequalities. The figure shows the numbers of admissions each year stratified by deprivation quintile. Although the numbers of admissions have risen in all groups, the deprivation gradient is strong, with the greatest increase occurring among people living in the most deprived areas. The number of admissions has increased almost threefold over nine years for people living in the most deprived quintile based on the deprivation index.



Numbers of admissions by year and deprivation quintile (top) and age at admission by deprivation quintile (bottom)

Further analyses indicate that 86.3% of the total 8896 admissions were classified as being an emergency. A socioeconomic gradient occurs, such that people living in more affluent areas are less likely to have been admitted as an emergency (odds ratio per deprivation quintile=0.946 (95% confidence interval 0.906 to 0.988, P=0.013) analysed using a generalised estimating equation approach to account for clustering). Thirty five patients were admitted twice over the nine year period for the same procedure. A stay in intensive care units was required in 34 episodes, and three deaths occurred.

My analyses, much like those of Thomas et al, are unable to ascribe causality, but they do paint a bleak picture of both a worsening situation and increasing socioeconomic inequalities. One of the most important aims of the reformation of NHS dentistry is to ensure the equitable provision of affordable dental services, as indicated in the subheading to Freeman's editorial.[3]

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Competing interests: None declared.

1 Thomas SJ, Atkinson C, Hughes C, Revington P, Ness AR. Is there an epidemic of admissions for surgical treatment of dental abscesses in the UK? *BMJ* 2008;336:1219-20. (31 May.)
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Patients can't see a dentist at short notice

The amount of dental problems general practitioners see seems to have risen over the past 10-15 years, in keeping with the similar decline in NHS dental work.[1] We are not qualified to do dental work and have to preface our treatment with advice to this effect. The (empirical) experience of my patients is that they cannot access a dental practitioner at short notice for almost any problem. "Emergency" appointments are often available some weeks in advance, and the out of hours system seems to be difficult to access (local experience), time limited, and telephone based.

My overall impression is of a system that fails to acknowledge that what a patient calls an urgent problem is an urgent problem for the system. This seems to me to amount to systemic denial, and I wonder why it is that the government has allowed this situation to arise. Imagine pain or infection at another site—backache, pelvic inflammatory disease, cellulitis—to realise that a similar scenario of (seeming) neglect couldn't any longer happen in general practice.

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Competing interests: None declared.

1 Thomas SJ, Atkinson C, Hughes C, Revington P, Ness AR. Is there an epidemic of admissions for surgical treatment of dental abscesses in the UK? *BMJ* 2008;336:1219-20. (31 May.)

NICE ON LIPID MODIFICATION

NICE has overestimated cardiovascular risk

The National Institute for Health and Clinical Excellence (NICE) recommends that cardiovascular risk be calculated by adding the risks of coronary heart disease and stroke derived from the Framingham study.[1] This is an elementary epidemiological error as the two risks are related. The effect is to overestimate risk.

The Framingham study has its limitations. UK data have been used to produce a UK version, QRISK.[2] This includes much that is missing from Framingham, including family history and deprivation, as well as more accurate estimates of risk relating to diabetes. It represents a large UK population from 1995 onwards not a pre-1991 US population. QRISK seems to give a lower risk than Framingham, which, given the decline in cardiovascular disease over the years, is not surprising. The effect of using Framingham is also therefore to overestimate risk. Given that at a true risk of 20% a patient needs to take a statin for nearly 140-150 years to benefit (annual number needed to treat (NNT) 140-150), any overestimate of risk makes that figure for an individual patient, whose informed consent is needed, look even more absurd.

Why then has the Guideline Development Group recommended the use of added Framingham based risk and rejected QRISK? Prevailing clinical opinion is highly interventionist, and good economic grounds

exist for statins, but for the individual the consent is likely to be misinformed and probably based on the reporting of relative risk not absolute risk reduction. Information should be given to patients in ways they might understand like NNTs or years needed to take (YNTs). Lifestyle changes bring bigger gains across a spectrum of diseases.

Promoting statins risks encouraging a "moral hazard" as patients choose not to live healthier lives because statins will "protect" them. Such behaviour would substantially reduce the real effectiveness of statins.

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Competing interests: None declared.

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NICE's simplified approach to lipids will not work

Although starting all patients on simvastatin 40 mg for secondary prevention is a sound approach for many,[1] a substantial proportion will not achieve the targets of less than 4 mmol/l for total cholesterol and 2 mmol/l for low density lipoprotein (LDL) cholesterol with this therapy.

A meta-analysis by Law et al in 2003 showed that simvastatin 40 mg achieves a reduction in LDL cholesterol of 37%.[2] This implies that as initial therapy, any patient with an LDL measurement higher than 3.1 mmol/l would not be treated to target with simvastatin 40 mg. In the same study, simvastatin 80 mg achieved a 42% reduction in LDL; atorvastatin 40 mg and rosuvastatin 20 mg achieved reductions of 49% and 48%, respectively.

Starting patients with an LDL of greater than 3.1 mmol/l on simvastatin 40 mg seems to mean that their treatment will inevitably have to be escalated at a later date. This will result in additional clinician time, additional blood tests for the patient, and potentially some patients remaining suboptimally treated. Cheshire and Merseyside Cardiac Network advises starting atorvastatin 40 mg in all patients with a total cholesterol concentration higher than 6 mmol/l, and in practice this approach seems effective.[3] It is a shame that a similar tactic was not employed by NICE.

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Competing interests: None declared.

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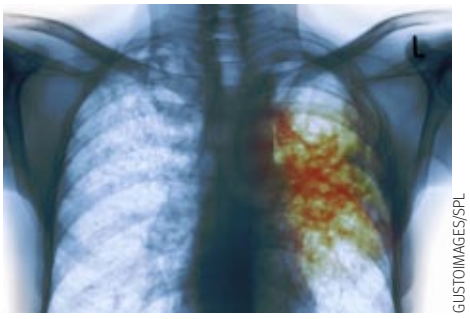
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DRUG RESISTANT TUBERCULOSIS

Service for drug resistant tuberculosis exists in the UK

So far the United Kingdom seems to be keeping clear of most of the international increase in drug resistant tuberculosis, in particular multidrug resistant tuberculosis (MDR-TB).[1 2] But how long can this be maintained?[3]

The problem with drug resistant tuberculosis is that it is still relatively uncommon but gradually increasing. Individual clinicians will have very little experience in managing cases. To help this situation, the MDRTB Service has been established at the Cardiothoracic Centre in Liverpool and has been operational since 1 January 2008. The service has the support of the relevant professional bodies, including the British Thoracic Society, the British Infection Society, and the Health Protection Agency.

Essentially it is an electronically linked instant reaction expert group, who can give advice and direct management of cases across the country. It has already done so in some 17 cases from across the UK. By helping clinicians in the management of cases of drug resistant tuberculosis this national service offers our best hope in overcoming the increasing problem of drug resistance until new drugs become available. The Baltic states have operated a similar system for some years with good success in reducing their cases.

The second function of the service is to collect data on all cases of multidrug resistant tuberculosis identified in the UK, with a view to developing a consensus on the most effective methods of treatment. The data collection will also help assess outcomes of patients.

The service can be contacted by email (MDRTBservice@ctc.nhs.uk) or by phone (0151 600 1427).

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Competing interests: None declared.

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PARACETAMOL AND HYPERTENSION

Time to label sodium in drug treatments?

A soluble tablet of 500 mg paracetamol can contain 388 mmol sodium, the equivalent of 1 g salt. Here lies a more likely cause for the association between regular paracetamol use and hypertension.[1] It is hard to find out how much salt is hidden in our patient's polypharmacy. Do medications need to label salt content in a similar way to food labelling? Would it not be possible to manufacture salt-free medications similar to the sugar-free paediatric preparations?

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Competing interests: None declared.

1 Montgomery B. Does paracetamol cause hypertension? *BMJ* 2008;336:1190-1. (24 May.)

LAW ON UNJUSTIFIED HEALTH CLAIMS

Member states must enforce ban on dubious products

There is law and there is the real world. In between lies the implementation of the law.

It is progress to now have a broad-based legal prohibition on all forms of misselling, including false health claims on foods and other products.[1] However, this impressive sounding legislation will have little effect on the real world unless it is enforced proactively and comprehensively.

Misleading health claims in advertising in the UK are now dealt with by the Advertising Standards Authority, an industry self regulatory body with only weak sanctions against transgressors. Misleading health claims on labels are dealt with by local authorities, who have such limited resources for enforcement that many prefer to avoid legal action altogether, lest they be dragged into expensive litigation, where the offenders have deeper pockets than the upholders of the law. This is a generic problem

that hobbles all the torrent of food legislation that has emerged from the EU since 1992, including the specific new rules on nutrition and health claims.

It is good that European officials and legislators are alert to the problems of misrepresentation in our obese and nutritionally aware world. But unless the enforcement of their new rules is strengthened and properly resourced at national level, their good intentions will be thwarted.

The test of intention is action. Or, in plain English, putting your money where your mouth is. Unless member states are willing to enforce this new law, then all their protestations of concern about obesity and other diet-related problems are just more empty rhetoric—a new type of political false claim.

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Competing interests: None declared.

1 Watson R. New law bans selling of products with unjustified health claims. *BMJ* 2008;336:1150. (24 May.)

ADDITIVES AND HYPERACTIVITY

Food dyes should be banned

Considering the numerous studies conducted over the past 30 years, Kemp is right in urging physicians to routinely encourage patients with hyperactivity to avoid food dyes.[1] However, considering the dyes' lack of health benefit and the risk they pose, the proper public health approach is for national governments to ban the use of all food dyes. After all, it is extremely difficult, firstly, for a parent to determine that a child is sensitive to dyes and, secondly, for parents to protect easily tempted children from tasty colourful foods that are served at parties; sold at stores, restaurants, and vending machines; and traded among friends.

The British Food Standards Agency deserves credit for encouraging manufacturers and restaurants to switch to safer, natural colourings. As a result of government pressure, Kellogg, McDonald's, Kraft, Mars, and other multinational companies now market foods without dyes in Britain, but market the same foods with dyes in the United States. The US Food and Drug Administration maintains flatly that well conducted controlled studies have produced no evidence that food additives cause hyperactivity or learning disabilities in children.[2]

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Competing interests: None declared.

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OPIUM PRODUCTION IN AFGHANISTAN

Let's re-examine buying the Afghan poppies that are left

Malloch-Brown claims that the government has repeatedly examined the idea of legal poppy cultivation, such as in the 2001 report by Mansfield.[1 2] But he ignores Mansfield's 2007 report, which says that evidence from the field shows that the growth in the opium poppy economy is the outcome—not the cause—of state and development failure in Afghanistan.[3]

Currently two strategies are being followed to deal with illegal opium: eradication and reconstruction. However, it is difficult to reconstruct a country on the one hand, while at the same time failing to establish secure contracts to buy up the largest sector (poppy production) of that country's most important industry, which is agriculture. As returning soldiers have repeatedly pointed out, the battle to win hearts and minds is not helped by the eradication of livelihoods.

Where Malloch-Brown is right is in emphasising the importance of reducing demand for illegal drugs at home, by increasing and improving prevention and treatment services. The demand from addicts is fundamentally a social and health problem in our society.

We recognise that some provinces are now poppy-free and producing alternative crops, but we want the third policy—of buying up what is left—to be re-examined. If the Afghan poppy production could provide the raw product for quality controlled analgesic production, then for many millions of people around the globe pain relief may become feasible.

The current policy does nothing in humanitarian terms to tackle the enormous suffering through untreated pain world wide. The main beneficiaries at present remain the dealers and traffickers in illegal opium.

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Competing interests: None declared.

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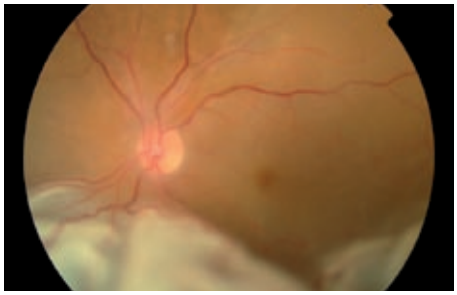

RETINAL DETACHMENT

Anaesthesia for retinal detachment

Nitrous oxide gas (N_2O) rather than volatile anaesthetic agents should be avoided in the management of retinal detachment.[1] Nitrous oxide is highly insoluble in blood and can diffuse and expand into gas filled spaces because it is 40 times more soluble than nitrogen. Volatile anaesthetic agents are liquid at room temperature but evaporate easily for administration by inhalation with the use of a vaporiser. They require the use of a carrier gas such as oxygen, air, or nitrous oxide. Modern examples of volatile anaesthetic agents are sevoflurane and desflurane. A general anaesthetic with nitrous oxide should be avoided for 2-12 weeks after surgery entailing intraocular gas, depending on which gas has been instilled into the eye. Patients should be warned of the potentially catastrophic results of having general anaesthesia with nitrous oxide in this period.[2]

Most doctors and patients are aware that cataract surgery can be carried out under local anaesthesia, but they should also be aware that vitreoretinal surgery does not require general anaesthesia.[3] This trend has been observed in the United States and the United Kingdom.[4] In our institution, an increasing amount of vitreoretinal surgery is carried out with a sub-Tenon's block because of its low complication rate compared with peribular blocks.[5] Most general anaesthesia for retinal detachment surgery (with the exception of cryobuckle surgery) is done because of patients' requests, compliance, or allergy to local anaesthetics rather than surgical need. General anaesthetic options available are total intravenous anaesthesia (used routinely in our institution) or a volatile anaesthetic avoiding nitrous oxide. The airway is usually managed using a flexible laryngeal mask airway unless an endotracheal tube is indicated. Local anaesthesia is a useful adjunct in providing postoperative analgesia.

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Competing interests: None declared.

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CAMPAIGN FOR REAL LECTURES

Using personal experience

Like Greenhalgh,[1] I have an idea of the kind of "real lecture" I prefer to attend. Back in the 1990s Dr D Rowlands from Manchester Royal Infirmary lectured on heart failure at our district general hospital postgraduate medical centre. Instead of blinding us with science, statistics, and PowerPoint, his starting point was to invite members of the audience to volunteer their personal misgivings and uncertainties about any aspect of heart failure that they had always wondered about but had been too afraid to ask.

The suggestions came thick and fast, and he wrote each one of them down on a flip chart. After consultation with the audience, he then grouped the topics under a few clinically relevant subheadings so as to avoid unnecessary repetition. Using those headings as the basis of his lecture and, without the benefit of notes, slides, transparencies, or PowerPoint, he then delivered the most compelling account of heart failure I have ever heard, using a synthesis of references to the medical literature and his own extensive personal experience so as to reach out to each and every member of that audience. That style of delivery, like an inspirational speech, has enduring value.

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Competing interests: None declared.

1 Greenhalgh T. Campaign for real lectures. *BMJ* 2008;336: 1252. (31 May.)

Chalk and blackboard

The best lecture I had at medical school was given by a retired professor of respiratory medicine at Charing Cross, Stephen Semple, a good 10 years ago. He shuffled down to the front of the lecture hall, took a (semi-) disgusted look at the overhead projector (remember those?) and cranked the antiquated blackboards into life. He then spoke, without notes, for 90 minutes on respiratory physiology, only using a crumbly piece of yellow chalk to illustrate his points.

FELBERT+EICKENBERG/GETTY IMAGES

The diagrams, both cellular and those of gross anatomy, were beautifully clear, and I remember the principles he taught to this day.

He demonstrated that the key to being a good teacher, and a good lecturer, is knowing your stuff—the rest just falls into place.[1]

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1 Greenhalgh T. Campaign for real lectures. *BMJ* 2008;336: 1252. (31 May.)

Beyond bullet points

Of interest may be a book and supporting website called *Beyond Bullet Points* by Cliff Atkinson (www.beyondbullets.com/).[1] He promotes a no-bullet-point approach to presentations and, further, suggests a filmscript type approach to the construction of the message or story to be delivered.[2]

This style is more time consuming to put together, and the greatest hurdle I've had to face is not having the bullet points as a reminder of what I have to say. I have, however, had much better feedback from these presentations than from my "standard" PowerPoint slide sets.

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Competing interests: None declared.

1 Atkinson C. *Beyond bullet points: using Microsoft Office PowerPoint 2007 to create presentations that inform, motivate, and inspire*. Redmond, WA: Microsoft Press, 2007.
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Take the zen approach

Another excellent resource for engaging, image-based presentations[1] is the Presentation Zen blog (www.presentationzen.com) and associated book. As well as denigrating the use of bullet pointed, text heavy slides (which seem often to be designed with automatically generated handouts in mind, rather than as visual aids), its author, Garr Reynolds, urges presenters to focus on the story that their presentation is trying to tell, rather than getting caught up in the minutiae of font sizes and sound effects.

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1 Greenhalgh T. Campaign for real lectures. *BMJ* 2008;336: 1252. (31 May.)

THE WORLD IS ROUND

Salute to the stethoscope

Is Spence really unaware of the pioneering work of the postwar generation of general practitioners who re-established the stethoscope as a valuable aid not to auscultation but to meditation?[1] I can still recall the thrill of discovering that if I placed the business end of my stethoscope over an inert portion of a patient and used the other ends to plug my ears, I could create the perfect ambience for contemplating not just trivial problems such as "What is the matter with this patient?" but more serious ones such as "What is his or her name?", or "What crisp, reassuring, non-discussion provoking phrase will get me out of here in time to watch the football on television?"

The beauty of this clinical manoeuvre is that the very act that enables you to struggle with your own problems gives your patients the impression you are thinking deeply about theirs. As a result, you can make decisions free from the pressure of time. The longer you take, the more your patient is impressed by your thoroughness.

Sophisticates improve this empowering quality by bunging the earpieces with cotton wool to eliminate distracting sounds that may intrude if they inadvertently place the instrument over the heart or other noisy organ. Sound proofed stethoscopes are particularly useful for dealing with talkative patients whom a doctor can halt in full flow by applying the instrument to their chests and telling them to breathe deeply.

Over the years, doctors have found many uses for the stethoscope—as a tourniquet, a paperweight, a hook for retrieving hats that have fallen behind chests of drawers, and an effective binder for boxes with loose lids. I knew a senior doctor who used an old stethoscope to keep his trousers up and a junior one who, when facing a personal credit crunch, would use his stethoscope to siphon petrol from cars left overnight in the hospital car park.

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Competing interests: None declared.

1 Spence D. The world is round. *BMJ* 2008;336: 1134. (17 May.)