If most practising dentists are like me, they will have had a hard time passing the original exams in dental school, using extensive and stressful memorisation. Today, I take continuing education courses regularly and consider myself able to do dentistry and enjoy dentistry better than in my previous 50 years. My ability to do great dentistry and achieve excellent results for my patients is my reward. I only wish I could do dentistry for another 50 years.

G. Belok, Manhattan, USA

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Paediatric dentistry

Analgesia – the colour purple

Sir, we write further to the recent paper on local anaesthetic administration for the paediatric patient.[1] In an era where, as Robson[2] illustrates in his recent letter, children and young people (CYP) are waiting substantial periods of time for hospital dental extractions, this paper illustrates how dental professionals can develop their clinical and behavioural management techniques to minimise pain experienced during injections.[1]

Rather than a blind 'unwillingness' *per se* to carry out extractions in primary care, we feel it is more likely to be a reluctance resulting from lack of confidence, as well as access to sedation, to administer comfortable analgesia. This in turn may result in complete loss of compliance, fostering negative memories resulting in the child or adolescent avoiding all future care in that setting. Students are actively encouraged to gain experience of analgesia administration in CYP, so they become adept and confident in its use.

Patient age should not be a contraindication for local analgesic use, even for mandibular blocks in children, where some clinicians advocate the 'Rule of Ten' should be considered: the primary tooth to be anaesthetised is allocated a number according to position in the arch (central incisor = 1, second molar = 5); this number is then added to the child's age (in years); if 10 or less, an infiltration is most appropriate; if greater than 10, an inferior dental block (IDB) is likely to be more effective.[1,3]

Shorter needles, such as the Ultra Safety Plus 30G Extra Short [Septodont, France] are suitable for infiltrations, IDBs and long buccal anaesthesia in children.[1] These are easily recognisable by their short 10 mm needle and unique purple cap. Despite the paucity of evidence on dental phobia and needle length, it could be hypothesised that needle phobia may increase with needle length, hence, a needle shorter than the average fingernail may help.

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American recommendations

Sir, we (two dentists and two paediatricians) would like to bring to your readers' attention the recent American Academy of Pediatrics (AAP) Section on Oral Health guidance on *Fluoride use in caries prevention in the primary care setting.*[1]

AAP state that 'fluoride varnish application is now considered the standard of care in pediatric primary care'. They recommend paediatricians and dentists in USA apply fluoride varnish, recommend the use of fluoride toothpaste, know how to determine the concentration of fluoride in a child's primary drinking water and determine the need for systemic supplements and advocate for water fluoridation in their local community.

Of course, American healthcare provision is different from that in the UK where paediatricians cannot apply fluoride varnish. But the other recommendations are relevant in a British context. AAP argue that community water fluoridation (CWF) continues to be 'a controversial and highly emotional issue' even though the concerns of those opposed to CWF have been shown to have no reliable scientific basis. Scientifically undertaken opinion polls carried out in the UK for the last 40 years, using samples properly representative of the population, have consistently shown that the majority of the population support CWF. Opponents are good at 'getting their vote out' during formal public consultation on implementing new schemes. Proponents of fluoridation need to be more effective in getting the silent majority to register their support.

In the UK, as a result of the COVID-19 pandemic, access to dental care has become difficult and NHS hospitals are postponing routine operations. The most common routine operation for children is dental extraction due to dental caries.[2] These extractions under GA are being delayed and children are suffering prolonged toothache. Reducing the need for carious teeth to be extracted would not only benefit the children involved but also release capacity for other hospital care.

The UK government was elected on a policy of 'levelling up' the North and South of England. Dental caries prevalence is highest among deprived children in the North. We should be pushing at an open door to implement CWF in these areas. Is it not time that dentists speak out more vociferously on this issue and enlist the support of our paediatrician colleagues? Should we not jointly be stressing that the science is overwhelming, and there is a safe and effective public health intervention? Controversy and emotion are not acceptable excuses for failure to implement CWF to protect the public health of all and especially vulnerable children.

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Geography

Northern Ireland

Sir, as a lifelong member of the BDA living in N. Ireland I was very disappointed and unimpressed to see Ballymena referred to as 'Ballymena in Ireland'.[1] It is not – there is no political country called Ireland. Ballymena is in Northern Ireland and the *BDJ* is the journal of the British Dental Association and should know better. I would have expected this 'error' of the *Irish Dental Journal* (which I also subscribe to) but not the *BDJ*. It matters and shows a distinct lack of understanding of NI.

R. Crutchley, Ballymena, Northern Ireland, UK

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