ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF GLASGOW

CONSULTATION:	Selection Criteria for Dental Radiography
ORIGINATING SOURCE:	Faculty of General Dental Practice (UK)
CONTRIBUTORS:	Members of Dental Council (November 2012 – October 2013)
SUBMITTED:	23rd September 2013

ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF GLASGOW

Our ref: IH/lc

23rd September 2013

Mr D O'Malley
Freelance Editor
Faculty of General Practice (UK)
Royal College of Surgeons of England
35 – 43 Lincoln's Inn Fields
LONDON WC2A 3PE

Dear Mr O'Malley

Thanks you for your invitation to read through the new version of *Selection Criteria for Dental Radiography* and offer some feedback.

I can confirm on behalf of the College that the document does not contradict any advice documents or policies the College has.

Overall the document is an excellent guide to the appropriate use of dental radiography in the management of patients. There are a couple of points that I thought might be worth considering to see if you think they are of any help as you finalise the document.

Section 2 Use of ionizing radiation
In the document the dosage of radiation from various x rays is noted in table 2.1 and in section 2.1.7 makes the comment, "a periapical radiograph may be associated with an effective dose up to three and a half days' background radiation and a panoramic radiograph equivalent to no more than six days' background radiation", is made suggesting 2 periapicals (which are noted as a similar dose or radiation as bitewings in table 2.1) result in a greater exposure to radiation than an OPG. The advice in section 3.4 noted in figure 3.4 seems to suggest that in the late mixed dentition if a single molar has a potential poor prognosis then bite wings should be taken in all quadrants, presumably requiring at least 2 bitewings. If more than one tooth is involved an OPG is advised. If the indication for imaging is primarily to determine the presence of permanent successors it would appear that the dose for a single tooth with a potentially poor prognosis would be greater than for multiple teeth. If an OPG is suitable for assessment when multiple teeth to determine the presence of successional teeth would it not be reasonable to take an OPG rather than bitewings in all quadrants even if only 1 molar has a poor prognosis? My suggestion may be a misunderstanding of the text or a reflection of my lack of expertise in dental radiography, if so please accept my apologies.

Section 6 endodontics
6.4.1 on apex locators indicates "although frequent use of a locator by the dentist improves performance it is still considered necessary, in most cases, to confirm the length radiologically". In section 8 an imaging strategy for the adult patient Section 8.3.4 indicates "reliable electronic apex locators have replaced the need for radiographs to determine working length in many cases."

The two statements about the same issue seem to have a different emphasis on the role of x rays in determining the working length.

6.4.1 also has the statement. In surgical cases, it is desirable to take a radiograph of the periradicular tissues prior to suturing to ensure that an adequate root-end filling has been placed and that debridement of the tissues has been completed, especially if there had been a previous overfill or extrusion of material. We would question whether this is necessary as it should be possible to assess whether an adequate root-end filling has been placed and that debridement of the tissues has been completed by direct vision satisfactorily.

Section 9
It is recommended before taking a radiograph in all cases, seek originals or copies of radiographs taken elsewhere if they are relevant, and indicates this I often possible with PACs systems. Clearly a sensible recommendation. It would equally be sensible to recommend the reverse but unless I have overlooked it this advice is not in the documentation.

I would suggest it would be helpful to recommend in do's and don'ts that if GDP's are referring patients to secondary care for opinions/treatment any existing x rays they have should be sent with the referral. This enable a complete assessment to be made without the secondary care assessor having to either repeat an x ray |(which is clearly not recommended) or arrange a second appointment for the patient and request the x rays for that appointment, thus wasting time and resource for both patient and secondary care services.

In the preface XIII
The guidelines in this publication are based on the best available evidence. However, in a number of areas the level of the evidence is still poor and based on expert opinion. A space is missing between expert and opinion

Yours sincerely

Ian Holland
Secretary of the Dental Faculty
Royal College of Physicians and Surgeons of Glasgow