Letters to the Editor

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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.

DIFFERENTIAL DIAGNOSIS

Sir, following the 'numb chin syndrome' series of articles[1,2] we would like to share our findings of the following case which was recently referred to the Oral Medicine Department at University of Manchester Dental Hospital.

A 37-year-old female patient presented to her general dental practitioner complaining of a numb lower right lip. She had a history of metastatic breast cancer affecting the liver which alerted a prompt referral to the Oral Medicine Department. Recent bone scans performed by the oncologist did not reveal any bony metastases in the pelvis and limbs. However, the bone scan failed to include the head and neck region. Dental radiographic examination (Fig. 1) confirmed the presence of a bony metastasis in the ramus of the mandible affecting the inferior alveolar nerve and lower right third molar. To confirm the radiological findings, she was referred to the maxillofacial department for a biopsy.

Fig. 1 Arrows indicate the presence of a bong metastasis in the ramus of the mandible

The case demonstrates the importance of including metastatic disease in the list of differential diagnosis of a numb lip as failure to recognise such a finding will not only have serious impact on the prognosis of a disease but can lead to medico-legal consequences.

A. Mahdmina, M. Rudralingam, A. Sengupta
Manchester

1. Divya K, Moran N, Atkin P. Numb chin syndrome: a case series and discussion. *Br Dent J* 2010; **208:** 157-160.
2. Ryba F, Rice S, Hutchison I. Numb chin syndrome: an ominous clinical sign. *Br Dent J* 2010; **208:** 283-285.

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THE FULL EXTENT

Sir, we would like to highlight a case of interest that recently presented to our maxillofacial surgery outpatient clinic.

Patient A had originally undergone extraction of a lower third molar tooth as this was grade III mobile. A periapical radiograph had been taken as part of the assessment of this tooth prior to its extraction indicating localised pathology. The tooth was extracted uneventfully in general practice by his GDP.

Six months later, the patient then attended an emergency dental service complaining of pain in the extraction site with a non-healed socket. The patient was then subsequently referred to our clinic for further investigation.

At this visit an orthopantomogram XR revealed an extensive multilocular cystic lesion associated with the extraction socket (Fig. 1). Tissue diagnosis revealed a follicular ameloblastoma.

The patient has since undergone excision and reconstruction with an osteocutaneous fibular free flap. He has made a good post-operative recovery.

This case highlights the possibility that there may be occasions when intraoral periapical radiographs may not adequately define the full extent of any periapical pathology associated with third molar teeth.

In these cases we would recommend that further radiographic imaging should be sought initially in the form of an OPG X-ray. This would enable better visualisation of any pathology, when more detailed CT studies may then be indicated.

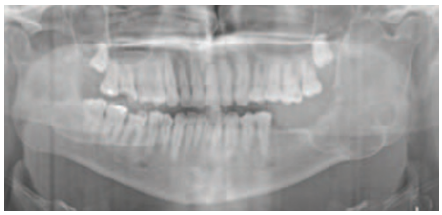

Fig. 1 Extensive multilocular cystic lesion associated with the extraction socket

H. Hassanali, C. Mannion, A. Kanatas
York

1. Cankurtaran C Z, Branstetter B F IV, Chiosea S I, Barnes E L Jr. Best cases from the AFIP: ameloblastoma and dentigerous cyst associated with impacted mandibular third molar tooth. *Radiographics* 2010; **30:** 1415-1420.
2. Kotrashetti V S, Kale A D, Bhalaerao S S, Halliker-emath S R. Histopathologic changes in soft tissue associated with radiographically normal impacted third molars. *Indian J Dent Res* 2010; **21:** 385-390.
3. Flygare L, Ohman A. Preoperative imaging procedures for lower wisdom teeth removal. *Clin Oral Investig* 2008; **12:** 291-302.

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PERSONAL DIATRIBE

Sir, I write regarding *Unethical aspects of homeopathic dentistry* (*BDJ* 2010; **209:** 493-496). We are surprised that such a respected dental research journal with a hard earned impact factor should lend its columns to a personal diatribe of no scientific content. We always considered the *BDJ* to be an academic research and reference platform for original work. Mr Shaw's non-dental article is clearly not of this calibre.

We wish to address some of the fallacious, inappropriate and unsubstantiated remarks made in this article in order to set the record straight.

Dental therapeutics form a very small part of dental treatment and should only be used when a mechanistic approach no

longer suits the clinical situation. The British Dental Formulary reflects this in the small number of medicines available for dental prescription. The NHS Act does not set any limitations upon the number and variety of substances which the dental surgeon may administer to patients in the surgery or may order by private prescription (BNF 2010; **60:** 6).

Homeopathic medicines are a valuable tool in the practitioner tool kit. They are not a cure all and should never be described as such. However, this therapeutic approach may be adopted when everything else has been addressed and found wanting. Very often a homeopathic prescription will assist the healing process when other interventions have not. A distinct though limited body of clinical research evidence supports the effectiveness of classical individualised homeopathy over and above placebo.[1] There is a larger research evidence base to support the use of homotoxicological medicines as used in the EU, ie 106 studies relating to controlled human clinical trials, which have demonstrated that homeopathic medicines are superior to placebo.[2]

Homeopathically trained dentists are no different from any other kind of dentists – they are dentists in the first instance, homeopaths in the second. Homeopathic dental training in the UK is provided by the Faculty of Homeopathy with teaching centres at Glasgow, London and Bristol. A five year modular postgraduate course is available for those dentists wishing to extend their pharmaceutical knowledge.

Perhaps if Mr Shaw (an ethics lecturer not a practising dentist) would like to discuss with us the finer points of the appropriate uses of homeopathic medicine within dentistry, we would like to suggest he does this in person.

S. Farrer

By email

1. Linde K, Melchart D. Randomized controlled trials of individualized homeopathy: a state-of-the-art review. *J Altern Complement Med* 1998; **4:** 371–388.
2. *Homeopathy: the scientific proofs of efficacy.* Milan: Guna S.r.l, 2002.

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SEEK TO UNDERSTAND

Sir, the Society of Homeopaths would like to point out a number of inaccuracies in D. Shaw's opinion article *Unethical aspects of homeopathic dentistry* (*BDJ* 2010; **209:** 493-496).

Most importantly, the article wrongly states that the Society registers dentists. D. Shaw quotes widely from the Society's website, saying that the Society offers no specific information about dentistry which is 'unsurprising as it exists only to register dentists and provide a Code'. In actual fact, although the Society's register of professional homeopaths includes practitioners with backgrounds in law, banking, nursing, science, the armed forces and journalism, it is unsurprising that the website has no information on dentistry in as much as it does not register dentists.

This is only one example of a shocking lack of research on the part of D. Shaw, despite his own sweeping dismissal as flawed 'in one way or another' of all of the research evidence which suggests homeopathic medicine works over and above that of placebo.

The article fails to mention that by the end of 2009, 142 randomised controlled trials comparing homeopathy with placebo or conventional treatment had been published in peer-reviewed journals. In terms of statistically significant results, 74 of these trials were able to draw firm conclusions: 63 were positive for homeopathy and 11 were negative.[1]

D. Shaw further fails to mention that 75% of *in vitro* experiments have found that substances as dilute as homeopathic medicines have specific effects.[2] For example, homeopathically-prepared thyroxine can slow down metamorphosis of tadpoles into frogs.[3] These results were replicated by five separate laboratories in Austria and confirmed by the results of similar experiments carried out by an independent team in Brazil.[4] The homeopathic thyroxine used was so highly diluted that you would not expect any molecules to be present. While more high quality research would be welcomed, it is simply untrue to say that there is no scientific evidence to support the efficacy of homeopathic medicine.

The Society is also concerned that D. Shaw makes serious allegations about practitioners of homeopathy. Firstly, he suggests that 'a routine feature of homeopaths marketing practices is to denigrate mainstream medicine'. He provides no evidence of this apart from the quote of Ben Goldacre, an anti-homeopathy campaigner.

Further, he states that homeopaths are unethical as, for there to be any benefit to homeopathy, patients must be 'deceived'. As already mentioned, there is a growing body of evidence showing the effectiveness of homeopathic medicine, including clinical outcome studies, the largest of which took place at the Bristol Homeopathic Hospital with 6,500 consecutive patients. In this study, carried out over a six-year period, 70% of patients reported an improvement in their health.[5]

Despite the article's claim that it is seeking to provide a summary of the science of homeopathy, it does no such thing. While it is true to say that scientists cannot yet explain the precise mechanism of action of homeopathic remedies, D. Shaw merely jumps on a bandwagon of dismissing homeopathy out of hand. There are many things that science cannot yet explain – surely it is the job of scientists to seek to understand the mysterious, rather than trample it underfoot.

Z. Dymitr

Chairwoman, Society of Homeopaths

1. British Homeopathic Association. The Research Evidence Base for Homeopathy. www.britishhomeopathic.org/export/sites/bha_site/research/evidencesummary.pdf Accessed Dec 2010.
2. Witt C, Keil T, Selim D *et al.* Outcome and costs of homeopathic and conventional treatment strategies: a comparative cohort study in patients with chronic disorders. *Complement Ther Med* 2005; **13:** 79-86.
3. Witt C M, Bluth M, Albrecht H *et al.* The *in vitro* evidence for an effect of high homeopathic potencies - a systematic review of the literature. *Complement Ther Med* 2007; **15:** 128-138.
4. Endler P C, Heckmann C, Lauppert E *et al.* Themetamorphosis of amphibians and information of thyroxine. *In* Schulte J, Endler P C (eds). *Fundamental research in ultra high dilution and homoeopathy.* Dordrecht: Kluwer Academic Publishers, 1998.
5. Spence D, Thompson E, Barron S. Homeopathic treatment for chronic disease: a 6-year, university-hospital outpatient observational study. *J Altern Complement Med* 2005; **5:** 793-798.

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LEARNING LESSONS

Sir, we congratulate Davies and Bridgman (*Br Dent J* 2011; **210:** 59-61) for expressing so clearly that the traditional model of (oral) health education for children lacks evidence. Knowledge alone does not lead to significant behaviour change in adults, adolescents or children. However, this outdated and simplistic model of health education is still the basis for many oral health promotion activities worldwide, including many of