LETTERS TO THE EDITOR

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CASE REPORT

Palatal mucosal necrosis after administration of a palatal infiltration

Sir, I write this letter to raise awareness of a rare complication involving local anaesthetic that presented in our maxillofacial department.

On the 3 October 2014 a 44-year-old female, with a medical history of glaucoma and gastric reflux, attended her regular dental practice to have an extraction of the maxillary second premolar on the right side under local anaesthetic and intravenous sedation in what was believed to be a routine procedure. In total, 0.5 ml of lidocaine 2% with adrenaline 1:80,000 was administered as a palatal infiltration and 1.7 ml of the same anaesthetic injected as a buccal infiltration. The treatment was uneventful and the patient was sent home with post-operative instructions. Later that evening, the patient developed a blister in the region of the palatal infiltration site.

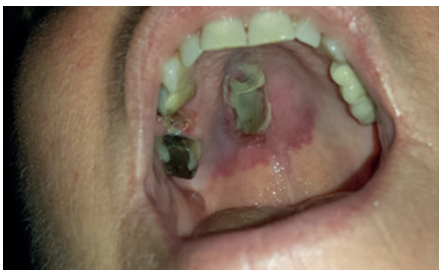

Fig. 1 Palatal mucosal necrosis

The patient visited the dentist for an emergency appointment the following day and was prescribed 500 mg amoxicillin tablets for 5 days and her clinical symptoms were monitored for two weeks. With no improvement, and the blister transitioning into an ulcer-like lesion of approximately 20 mm by 12 mm, the patient was urgently referred to Basildon Hospital's maxillofacial department on the 28 October 2014.

The patient was seen and diagnosed with palatal mucosal necrosis (Fig. 1) which would be managed conservatively with regular review appointments. A further two appointments were arranged for the patient on the 9 December 2014 and 15 January 2015, which highlighted healing of the ulcer and the presence of an erythematous area which was initially 20 mm by 20 mm and decreased to a size that was insignificant. However, the patient was experiencing severe post-traumatic neuralgia which developed at the site of the ulcer during the healing process and was prescribed 10 mg nortriptyline. The patient reported that the whole experience had left her stressed, affecting her personal and social life and has been advised to have counselling to treat this matter.

The palate has a rich blood supply via the greater and lesser palatal arteries which

CONTRACTS

Junior doctors and the NHS

Sir, the proposed new contract for junior doctors is an issue which has implications not just to doctors but also to dentists as well. The contract, which Jeremy Hunt (Secretary of State for Health) is intending to impose from August 2016 will force junior doctors to work anywhere from 7 am – 10 pm Monday to Saturday. This previously stood at 7 am – 7 pm Monday to Friday with time worked outside of these hours paid at a 'banded' rate. The change means the hours classified as 'normal' will increase by 50% and therefore reduce the amount of 'banded' extra pay given for working unsociable hours by up to 30% for doctors (depending upon the speciality). To clarify – the term junior doctor is a loose term. It can be used for anyone fresh from medical school (Foundation Doctor Year 1) to a Senior Speciality Trainee (ST7+), a difference of about 9 years.

An oral & maxillofacial surgery trainee must obtain both a medical and dental degree. Fees are currently at £9,000 a year for university level education and with a minimum of 8 years in university (5 years for dentistry and 3 for medicine or vice versa) the least a student must fund is ≥£47,000 (including available study bursaries – IF awarded).

Furthermore, the second degree does not qualify for a student loan and therefore the fees must be paid for upfront increasing the financial burden. The fees don't stop there, the personal cost of training for compulsory courses and post graduate qualifications is rising and placing further strain.[1] Another area of concern is that of the locum pay cap. The Department of Health wishes to cap what is paid to locums, which is considered to be the financial lifeline of any 'second-degree' student. Pay protection is another matter of concern that is likely to be phased out with the new 'junior doctor' contract.

This allows a trainee who has spent sometimes 2-6 years post primary dental/medical qualification working as a speciality doctor/dentist or otherwise to continue on this level of pay as a foundation doctor, rather than face a massive pay cut of up to 40% and fall to the bottom of the pay pyramid. All of this with annual retention fees causes an immense financial strain on the new crop of oral and maxillofacial trainees.

It is with a heavy heart that, as a third year medical student, I seriously consider my position in a second degree at the mercy of the Department of Health and its decisions. This will push the speciality to the brink and plunge me deeper in debt – which may force me to leave training. Most trainees have their origin in dentistry and with the British Dental Association (BDA). As an organisation the BDA must join the growing body of professional organisations and voice concern over the new contract, as we trainees are facing a questionable and bleak future.

B. E. S. Dawoud
Dentally Qualified
3rd Year Medical Student, by email

1. Giddings C. The effects of rising costs on surgical training. The Associations of Surgeons in Training, 2011. Available online at http://www.asit.org/news/costofsurgicaltraining (accessed December 2015).

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