

Other journals in brief

A selection of abstracts of clinically relevant papers from other journals.

The abstracts on this page have been chosen and edited by John R. Radford.

'SOCIAL ANONYMITY'

The ethics of facial transplantation

Winter GF. *Bulletin* 2016; **98**: 288–292

'...unlikely to make people 'beautiful'; rather '[i]t will make them look normal and forgettable – that is its virtue.'

James Partridge OBE describes his face as 'a patchwork quilt of scars' following reconstructive plastic surgery as a consequence of sustaining 40% burns to his face in a car accident. He is founder and Chief Executive of the charity 'Changing Faces'.

This commentary is grounded on an authoritative document published by the Royal College of Surgeons of England entitled *Facial transplantation: Working party report (2006)*. James Partridge gave oral evidence to the members of this distinguished Working Party and is cited several times in this *Bulletin* paper. It is argued that the case against facial transplantation could be made from the perspective of the recipient, the donor and the community of people with disfigurements.

A RCS Working Party first deliberated on this issue in 2003. Even though this report was published little more than 10 years ago, the working party adopted a somewhat paternalistic approach; 'patient autonomy could not overrule the obligation for patient protection.' There was a shifting of opinion in the 2006 Report, possibly because a partial face transplant from a cadaver donor had been carried out in November 2005 in Amiens, France, and a second partial facial transplant in China.

In this paper, the author gives surgical and medical reasons for not carrying out facial transplantation; there is a mortality rate associated with surgery of 11.5%, life-threatening post-transplant lymphoproliferative disorder of 3.8% and a paucity of studies examining functional and psychological outcomes. But then the author does touch on an ethical dimension by citing the film *Face/Off* (1997). In this multifaceted science fiction film, FBI agent Sean Archer is so determined to get his man he says 'I'd like to take his face... off. Eyes, nose, skin, teeth. It's coming off'. Another illustration of the intimacy between the face and persona is the apocryphal tale of two academics taking an early morning skinny dip, only to be disturbed by a group of students in a punt. One academic asks why he put his towel over his head only to be told 'around here I'm known by my face.' (*Int J Surg* 2004; **2**: 79–81).

Possibly a more persuasive ethical reason against facial transplants, also touched on in this paper, is that from the standpoint of the community. How much richer would be the collective value of the community if it accepted people with disfigurement, as it should with any minority? A mission statement of 'Changing Faces' is 'to change public opinion and combat discrimination, and to help and support those with a visual difference.' There is no contradiction in that James Partridge, in his quest for acceptance on behalf of those with facial disfigurement, read for one week the lunchtime news for Channel 5 but has also stated he has a wish for 'social anonymity'.

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BOTULINUM TOXIN – NEUROPATHIC PAIN

Safety and efficacy of repeated injections of botulinum toxin A in peripheral neuropathic pain (BOTNEP): a randomised, double-blind, placebo-controlled trial

Attal N, de Andrade DC *et al.* *Lancet Neurol* 2016; **15**: 555–565

When treated with botulinum toxin A, those patients with peripheral neuropathic pain and allodynia (triggering of pain from stimuli which do not normally provoke pain) at baseline, would appear to have a better outcome.

As background, the quality of evidence for the efficacy of botulinum toxin for the treatment of peripheral neuropathic pain is low. In this randomised double-blind, placebo-controlled trial, 68 patients (66 completed trial) with peripheral neuropathic pain were allocated to either an intervention group who received two subcutaneous administrations of botulinum toxin A into the painful area of skin, or a placebo group (saline). Those with facial pain were excluded because of the potential for 'unmasking' caused by facial palsy. Botulinum toxin A reduced pain intensity over 24 weeks compared with placebo (adjusted effect estimate/size of the treatment effects was 0.77, 95% CI –0.95 to –0.59; $p < 0.0001$).

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BOTULINUM TOXIN – INTRAORALLY

Intraoral administration of botulinum toxin for trigeminal neuropathic pain

Herrero Babylon A, Kapos FP *et al.* *Oral Surg Oral Med Oral Pathol Oral Radiol* 2016;

121: e148–e153

Intraoral administration was used in addition to the conventional extraoral administration of botulinum toxin.

Patients with refractory orofacial pain of non-dental origin often receive treatment with several different medications such as the sodium channel blocker, carbamazepine. Such patients may also benefit from add-on drugs, such as gabapentin and valproate. Evidence for the efficacy of these adjuncts is weak, and in addition all such medication is associated with side-effects. Acetylcholine is blocked by botulinum toxin that in turn may inhibit the release of local nociceptive neuropeptides. This paper describes the care of two patients, but only the treatment of that patient with persistent dento-alveolar pain disorder (PDAP), will be described. Of note, the patient had received multiple root-canal therapies with no effect. Both conventional systemic medication and topical application delivered by an intraoral appliance did not control symptoms. Yet a combination of both extraoral and intraoral injections with onabotulinum (Botox®) achieved a satisfactory outcome with only minor side-effects. These comprised some intraoral dryness resulting in food retention in the sulcus, and mild muscle asymmetry.

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