participants will be conducted to assess the efficacy of the medication.

Even though the medication is not currently being funded, there are numerous sources available to patients to self-fund. Several websites have been set up to provide patients with resources to get medications, but this can lead to an increased black market supply of these medications. In order to combat this problem nationwide, many genitourinary clinics are now offering advice and support on purchasing PrEP in a safe and affordable manner. As dentists and other health professionals have an intimate relationship with patients, patients may disclose facts about risky behaviour to their health provider. Therefore, it is of utmost importance that the general dentist should be able to provide guidance and have some knowledge on where to obtain support for patients involved in high-risk behaviour.

J. S. Chandan, S. Collins, T. Thomas, Birmingham

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DOI: 10.1038/sj.bdj.2017.295

Orthodontics

Falling foul of standards

Sir, I wish to address T. Kilcoyne's letter[1] in which he asked me to apologise for stating that Fastbraces' advertising has been found by anybody to be misleading whilst also he also claimed that Fastbraces' claims follow evidence-based medicine.

I did not reply at the time as I felt it inappropriate to comment in detail on Advertising Standards Association (ASA) findings that were yet to be made public.

As of 8 March 2017, the ASA have published on their website (www.asa.org.uk) their final ruling on two dental practices that copied claims from Fastbraces' promotional literature onto their own practice websites.

The ASA found that this Fastbraces' advertising (which made claims about faster treatment, less painful treatment and less root resorption in comparison to other fixed appliance treatment) was 'misleading'. The ruling stated that these claims should not appear again in UK advertising without 'adequate substantiation' as a 'sufficient body of evidence' does not exist to justify them. There were 'significant methodological flaws' in the evidence that was provided to justify the Fastbraces' claims.

I feel that it is important for *BDJ* readers to realise that repeating the 'alternative facts' within the promotional literature of the Fastbraces company could lead to them falling foul of ASA and GDC standards.

I hope this will put an end to the matter and we can all accept that certain orthodontic systems are not magical and that competent dentists performing high quality orthodontic treatment is something we can all support.

N. Stanford, by email

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DOI: 10.1038/sj.bdj.2017.296

Multidisciplinary management

Botox and Parkinson's

Sir, I work in general practice and came across a 60-year-old female patient who presented as an emergency in pain. I diagnosed acute apical periodontitis associated with the 33. After assessing her treatment options, patient choice was extraction. The interesting point to note was that the patient had significant bilateral jaw tremor (dystonia) secondary to Parkinson's. This was significantly more pronounced than the classic hand tremor associated with Parkinson's. This can often make dental treatment difficult to perform in a general practice not set up for sedation.

The patient reported that lignocaine-based anaesthetics tend to exacerbate her jaw tremor and so we opted for prilocaine. She also reported that her neurologist had obtained funding enabling him to inject botox into the facial muscles. On further questioning, she was adamant that this was a procedure being provided by her neurologist and not the maxillofacial team. C. Pedemonte *et al.* in 2015 reported a reduction in the signs and symptoms associated with oromandibular dystonia (bruxism, muscle pain and involuntary muscle contraction) with the application of botulinum toxin A.[1] This raises the question of the scope of the application of botox and who should be providing it, especially where there is an overlap between our maxillofacial colleagues and neurologists in complex cases such as this. Furthermore, it raises the question of the effects different local anaesthetics have in patients with Parkinson's with dystonia. It seems that some clarity and guidelines are needed.

S. Olaore, M. Laudat, by email

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DOI: 10.1038/sj.bdj.2017.297

Dental trauma

Rare metabolic disorder

Sir, an unusual case of dental trauma presented within the paediatric dental department. A 2-year-old boy was referred by his general dental practitioner regarding management for the avulsion of four incisors (61, 81, 71 and 72) following minor bumps and falls. The patient's parents were concerned regarding the early loss of his teeth. His primary incisors were traumatised on three occasions including falling on his mother's knee, knocking his teeth on the edge of a bouncy castle and a fall at home on a rug. His trauma history was inconsistent with the dental injuries suffered – raising caution to a possible non-accidental injury.

The parents had reported that their child is somewhat unstable with delayed walking and his health visitor has made a referral to a physiotherapist. In light of his trauma history and medical history, hypophosphatasia was suspected. His general medical practitioner had been contacted, blood tests were requested and referral to a to a paediatric endocrinologist made for further investigations.

Since his initial referral, the patient has been formally diagnosed with hypophosphatasia, an inherited metabolic disorder that has variable clinical presentation. The condition is extremely rare and is often linked with premature loss of teeth. This demonstrates the value of taking a good dental and medical history to aid diagnosis, which can significantly improve a child's ability to thrive.

R. Chawla, A. Patel, S. Dunkley, Eastman Dental Hospital

DOI: 10.1038/sj.bdj.2017.298