COMMENT

Letters to the editor

Send your letters to the Editor, *British Dental Journal*, 64 Wimpole Street, London, W1G 8YS. Email bdj@bda.org.
Priority will be given to letters less than 500 words long. Authors must sign the letter, which may be edited for reasons of space.

Oral health

Hidden sugars and vaping

Sir, as will be the case for many of us, a significant and increasing number of my patients report that they 'vape' or use an 'e-cig' when I ask them about smoking. Recently, a vaping shop sales assistant attended our practice for a new patient examination. Whilst discussing his sugar intake, he revealed that he tries to avoid 'e-cigarette juices' with a high sugar content, many of which, he claimed, are produced in the USA.

Whilst the literature in this area appears to be sparse, non-clinical *in vitro* studies regarding the cariogenic potential of e-cigarettes have been undertaken.[1] Recent research published in this journal suggested that GDPs did not feel comfortable recommending e-cigarettes to their patients who smoke.[2] Current guidance from NICE encourages healthcare workers in primary care to cautiously present positive information to some patients regarding the use of e-cigarettes in smoking cessation.[3] If the sugars are cariogenic *in vivo*, frequent exposure whilst vaping combined with dietary sugars will put these individuals at high risk of dental disease.

The basis for this letter is anecdotal, but maybe, it is prudent to advise patients under our care who vape to opt for lower sugar concentration 'juices' where possible.

P. J. Radford, Rotherham, UK, by email

References

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2. Ahmed Z, Preshaw P M, Bauld L, Holliday R. Dental professionals' opinions and knowledge of smoking cessation and electronic cigarettes: a cross-sectional survey in the north of England. *Br Dent J* 2018; **225:** 947-952.
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Correction to: Cant in the interpupillary line

The original article can be found online at https://doi.org/10.1038/s41415-019-0954-7.

The above letter, published in the 8 November issue (*Br Dent J* 2019; **227:** 762) gave an incomplete list of authors. The correct list of authors is as follows:

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CASE REPORT

Oral surgery

A difficult diagnosis

Sir, actinomycotic osteomyelitis is rare, however, it is important to retain a high index of suspicion for this infection. Diagnosis can be delayed and difficult due to the atypical presentation of infection, long culture times and difficulty isolating actinomyces. Fewer than 50% of cultures from actinomyces-related infections manage to isolate a species; as a result many diagnoses rely on histopathological visualisation of actinomyces over microbiological isolation.[1]

A fit and healthy 33-year-old male attended our oral surgery unit with a history of tightness in his left jaw and no other symptoms.

Fig. 1 Orthopantomogram (OPG) showing a radiolucent lesion between the left mandibular first (36) and second molar (38), extending from the alveolar crest to the cortex of the lower border of the mandible

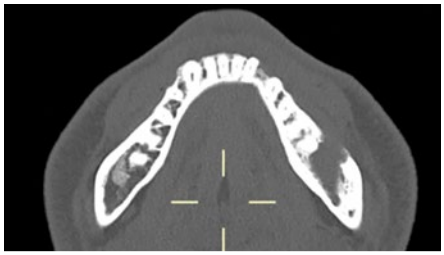

Fig. 2 Dental cone beam computed tomography (CBCT). Axial view of mandible showing radiolucent lesion in the 37 region with erosion of the left buccal cortical plate. The lesion had an intimate association with the inferior dental canal with no intervening bone

On examination there were remnants of a sinus tract in the mandibular left second molar (37) region, with no paraesthesia, drainage or swelling. The 37 had been extracted 20 years previously. An orthopantomogram showed a radiolucent lesion extending from the alveolar ridge of the 37 region to the cortex of the lower border of the mandible (Fig. 1). Cone beam CT revealed there was erosion of the buccal cortical plate and the bone surrounding the inferior dental canal (Fig. 2).

Histopathological analysis of the lesion following curettage and stent placement under local anaesthetic showed large colonies of actinomyces-like bacteria present indicating actinomycotic osteomyelitis. However, initial microbiology