

As these appointments are made using a national recruitment process, they are placed into a national pool to gain a DFT job then again for DCT 1, 2 and 3. These processes pit applicant against applicant to obtain the positions that they wish, but naturally also have to fit into their lives as maturing adults. This is as opposed to traditional examinations where if a standard is reached the candidate passes, the candidates for these assessments have to out-do one another. This creates increasing peer to peer pressure with a continued ramping up of standards. At DCT 2 and 3, only two/three years post qualification, not only do young colleagues have to sit more situational judgement tests, but they also need to produce a portfolio giving evidence of publications in peer reviewed journals,

presentations at national and regional level, and of 1 and 2 cycle audits with measurable clinical gain, to obtain high assessment marks.<sup>5</sup>

As the Editor-in-Chief correctly points out in his editorial, young dentists are academically endowed and highly impressive, but this continual ranking and re-ranking and expectation of achievement places significant pressure and possibly overload on our recently qualified colleagues.<sup>6</sup> We thus worry about not just the wellbeing of students at dental school, but also of our colleagues in obtaining their post qualification jobs and their subsequent wellbeing as practitioners. Therefore, in our view, stress resilience workshops incorporated into every DFT training programme are an ideal avenue to

address these concerns, as has already been implemented in the HHE Yorkshire and Humber Deanery.

*D. R. Radford, M. Harris. Portsmouth, UK*

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## CASE REPORT

### Emergency dentistry

#### Double rooted lateral?

Sir, a new patient recently presented with a draining sinus between the 12 and 13 apices although they did not report any symptoms and were unaware of its presence. Sensibility testing confirmed a non-vital 12 and a periapical radiograph

revealed what appeared to be two roots, surprising as there was no evidence of abnormal anatomy (Fig. 1). A further periapical was taken using the parallax technique which confirmed this.

The patient was made aware of the guarded prognosis of the tooth, based on the bone loss and unusual root morphology. A CBCT was taken to assess the canal morphology and assess the viability of carrying out root canal treatment (RCT). This revealed one

main root with one central canal with an additional root fused in the apical third, this did not contain any canals or communicate with the central canal. The scan also showed a palatal invagination in the coronal third. Based on these findings the patient was presented with the options of attempting RCT or extraction and they opted for the first.

The tooth was accessed, and one canal was found located centrally in the crown. Pus was found to be draining through the canal; necrotic pulp tissue was removed and copious irrigation with sodium hypochlorite was used throughout. Calcium hydroxide was placed between visits.

On return a few weeks later the patient reported no pain or problems and that the sinus was now gone. On re-access the canal was found to be dry, with no evidence of infection. It was cleaned and shaped to full working length using Wave One Gold rotary files, before a final flush through with EDTA. Elements Obturation Unit and AH plus sealer was used for warm vertical and backfill obturation. The post-obturation radiograph shows a well condensed root filling with flow of GP into the start of a lateral canal and sealer through the apical delta (Fig. 2).



Fig. 1 Pre-op



Fig. 2 Post-obturation

The diagnosis was *dens in dente*, type 3a. *Dens invaginatus* has been defined as an invagination of the cingulum pit, with maxillary lateral incisors being the most common tooth affected. Prevalence has been reported between 0.3-10%.<sup>1</sup> Oehlers classification system is widely used to classify *dens in dente*; type 2 and 3 often are challenging to manage with complex root canal morphology and should be referred to secondary care.

In this case, as we were able to take a CBCT which revealed simple root canal morphology, we were able to successfully treat in primary care. This report highlights the importance of looking out for *dens invaginatus*, prevention and early intervention and acknowledging that some of these cases may be less complex than anticipated, therefore may be able to be managed successfully by GDPs in primary care.

A. Hamid, Leeds, T. Willan, J. Hudson,  
Horbury, UK

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## Undiagnosed diabetes

Sir, a 47-year-old male attended A&E with a left sided facial swelling that had been present for four days. He had a large, firm swelling anterior to his right ear that was discharging. The patient complained it had rapidly enlarged and had now spread and caused his eye to shut. He was also reporting nausea and vomited several times during assessment. An OPT ruled out a dental cause. The patient was fit and well with no medical history of note. During assessment routine bloods and a random blood glucose was carried out and to our surprise the glucose reading was 25.6 mmol/L. The patient was diagnosed as experiencing Diabetic Ketoacidosis (DKA) and care was shared between the Oral and Maxillofacial Department and Endocrinology.

During his hospital stay he underwent three drainage, washout and removal of necrotic skin procedures under general

anaesthetic. The facial infection was severe and exacerbated/caused by undiagnosed and uncontrolled diabetes. The patient is now discharged from hospital and stable on a subcutaneous insulin regime. The removal of necrotic skin overlying the swelling means primary closure may not be achievable; his wound is being reviewed and decisions are being made as to how best to close the area.

I wanted to highlight this case as it shows the impact diabetes can have when uncontrolled. With this patient, the high glucose levels will have contributed to the severity of the infection, as well as the response to treatment (eg antibiotics). The fact the patient is now facing the prospect of a skin graft shows the impact this condition can have.

Diabetes is something that can manifest later in life and symptoms are not always recognised by patients. As dentists, we are in a position where we may be the first to notice changes, eg periodontal status or rapidly spreading/poorly healing oral and maxillofacial infections. We should have a high level of suspicion for conditions such as diabetes, asking patients if they are experiencing symptoms eg polydipsia, polyuria.<sup>1</sup> If concerned, primary care practitioners should refer the patient to their GP for testing or if in secondary care a random blood glucose should be measured and medical input sought if required.

H. Barrow, Leeds, UK

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## Dental pathology

### Hidden truths of benign lesions

Sir, I share with you a recent experience highlighting the importance of referring unknown pathology, despite how benign it may appear.

A referral was received by our oral and maxillofacial surgery (OMFS) unit for a 93-year-old male with an asymptomatic swelling on the labial aspect of his lower lip. A routine dental examination with a new GDP had prompted a referral, highlighting a

soft tissue lesion on the lower lip – query mucocoele.

The patient was duly assessed and reported the swelling was longstanding but causing no discomfort. Following examination, he was reassured the swelling was indeed consistent with a clinical diagnosis of mucocoele. An excision was organised due to concerns of trauma to the lesion whilst eating.

The histological findings however confirmed the lesion instead to be an angioleiomyoma: a very rare benign tumour of smooth muscle (vascular variant).<sup>1</sup>

The patient was subsequently reviewed and informed of the change in diagnosis. The surgical site showed good post-operative healing. He will be for review in six months to ensure no recurrence prior to discharge.

This case demonstrates how easily clinicians can be caught out as these lesions are often disregarded or ignored for their commonality. Whilst the patient reports no concerns, the often symptomless lesions can easily be overlooked at routine examinations under the guise of being monitored.

Given an angioleiomyoma arises from the smooth muscle of blood vessels, it is clear how trauma to such a lesion would have more serious consequences for the patient compared to trauma sustained to a mucocoele. Furthermore, differentials of angioleiomyoma include oral leiomyosarcoma, which as a malignancy is crucial to rule out.<sup>2</sup>

As such we urge our primary care colleagues to remain vigilant towards all abnormal findings in the oral cavity and refer persistent lesions for diagnosis. Also, we urge our secondary care colleagues not to underestimate lesions as was the case with us and this patient.

T. Thind, East Grinstead, UK

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