Practice marketing

Signs of the times

Sir, there are many ways in which our practices choose to advertise their presence but a recent trip to Cambodia revealed a novel one: an illuminated sign with a pulsating pulp (Fig. 1)! This puts even my own practice's Golden Tooth (Fig. 2) in the shadows. What other quirky signs have your readers discovered around the world?

Fig. 1 The illuminated sign with a pulsating pulp

Fig. 2 The correspondent's Golden Tooth

C. Marks, Southampton, UK

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Alternative therapies

No convincing evidence

Sir, I am concerned about the 27 March 2020 letter to the editor[1] promoting the use of acupuncture for gag reflex and many other conditions. Cochrane reviews have failed to find convincing evidence of the effectiveness of acupuncture for the treatment of any medical condition. The qi and meridians underlying acupuncture have never been found anatomically, nor are they ever likely to be, nor has any plausible causal mechanism been accepted. Of the thousands of medical and dental pathologies, the only conditions for which some trials have found acupuncture beneficial are those with subjective, anecdotal outcomes, ie those particularly susceptible to the placebo effect. This is unlikely to be a coincidence. A placebo effect can still be useful in some circumstances, but our patients deserve care based on high-quality research evidence, not a traditional health system that also promotes the use of rhino horns, tiger penises and shark fins as medicines.

M. Foley, Brisbane, Australia

Reference

1. Kapadia S. Acupuncture in dentistry. *Br Dent J* 2020; **228:** 396.

https://doi.org/10.1038/s41415-020-1939-2

OMFS

Cautionary findings

Sir, we write in response to a case report letter to offer our opinion on the case report, likely aetiology of oral ulceration with bony sequestration (OUBS) for this patient and the recommended follow up in such cases.[1]

We commend the author on a well-written case report with mention of the systematic review of the literature by Palla *et al.*,[2] and highlighting the rarity of OUBS. The author also mentions the appropriate management with adequate oral hygiene, saline and chlorhexidine rinses. OUBS is an area of little representation in the literature and awareness by medical and dental practitioners alike and offers a diagnostic dilemma with regards to aetiology. The author mentioned the probable cause for this case being due to either food trauma or dysphagia, which is highly unlikely.

To note the patient underwent an extensive procedure prior to developing this OUBS with a number of factors to consider. These include a neurosurgical procedure being performed under general anaesthetic meaning endotracheal intubation, the patient more likely being in the prone position and length of the procedure. This will indicate possible direct trauma or pressure necrosis due to endotracheal intubation in the area of the mylohyoid region. This has been identified by Almazrooa *et al.*[3] who described four cases, strongly suggesting that endotracheal tube placement may result in localised osteonecrosis of the mylohyoid ridge of the mandible through a number of potential mechanisms, the most likely being direct trauma or pressure necrosis.

An additional cautionary finding in this case report is the development of a 'recurrent OUBS' – this is an indication for an urgent two-week wait referral.

Dr Burrow's case report highlights the importance of history taking and clinical examination in managing patients with oral ulceration. It also underlines the importance of recognising unusual case presentations which require appropriate and timely referral.

K. Maharaj, A. Majumdar, Bedford, UK

References

1. Burrows R S. Oral ulceration with bony sequestration. *Br Dent J* 2020; **228:** 397-398.
2. Palla B, Burian E, Klecker J R, Fliefel R, Otto S. Systematic review of oral ulceration with bone sequestration. *J Craniomaxillofac Surg* 2016; **44:** 257-264.
3. Almazrooa S A, Chen K, Nascimben L, Woo S B, Treister N. Case report: osteonecrosis of the mandible after laryngoscopy and endotracheal tube placement. *Anesth Analg* 2010; **111:** 437-441.

https://doi.org/10.1038/s41415-020-1940-9

More prevalent than recognised

Sir, in reference to the case report letter *Oral ulceration with bony sequestration* (OUBS), I have seen two similar cases recently.[1] Both were over the left mylohyoid region and they healed uneventfully without any intervention other than saline mouthwashes. Both were men, one in his late fifties and the other in his seventies, with no relevant aetiology, although one of the patients was unsure that he might have burnt that site with a hot pudding. They did not have relevant medical history, especially radiotherapy or medications that cause osteonecrosis of the jaw.

They presented as painful, mobile, thin, whitish sequestrum which exfoliated easily during examination revealing irregular ulcers surrounded by erythematous mucosa and bony base. They healed by full mucosal coverage in 3–4 weeks albeit with loss of localised bone volume. I suspect OUBS could be more prevalent than recognised, as the sequestrum could be easily lost and the examining clinician may diagnose it simply as a traumatic ulcer. I agree with R. S. Burrows that the trauma to the thin lingual mucosa overlying the mylohyoid