

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 editor¹ 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

ridge could have resulted in disruption to the local blood supply causing breakdown of the soft tissues and periosteum, and I also agree that clinicians should consider OUBS as a differential diagnosis of mouth ulcers.

A. M. Chandrasekaran, Chester, UK

Reference

1. Burrows R S. Oral ulceration with bony sequestration. *Br Dent J* 2020; **228**: 397-398.

Dr Stephen Burrows responds: Thank you for the opportunity to reply to Messrs Maharaj and Majumdar and Mr Chandrasekaran. I agree that caution should be exercised with any oral ulceration especially when it has a protracted history and shows no signs of healing.

An interesting difference was the asymptomatic and potentially insidious nature of the case I presented when a painful symptom picture would have been expected as in the other outlined cases.

Differential diagnosis is of course an important element in the management of oral ulceration and should include recognition of sinister pathology and the need for urgent referral at the outset.

Whilst the medical history included endotracheal intubation (ETI) during recent surgery, the initial signs were of an idiopathic ulcer with a developing bony sequestrum – most likely due to a traumatic incident.

I agree ETI could indeed have been a probable cause and we can be left to speculate on this. However, management of any ulceration should include review to ensure uneventful healing. Two further reviews at short intervals showed this had occurred.

I agree the presence of a recurrent asymptomatic ulcer without any underlying cause could be a reason to refer but again with reviews there were then no indications.

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Dental materials

Diamine or diammine

Sir, I respect the *BDJ* as a flagship national journal that is impactful internationally and should be error-free. As a chemist who teaches Dental Materials Science at a dental school, I am fully aware of chemical spelling.

I had a chance to read a recent *BDJ* article from Seifo *et al.*¹ about the use of silver 'diamine' fluoride (SDF) in dental practice. The appendix is nice and useful; however,

the word 'diamine' in the whole article is an erroneous absurdity. In fact, Lou *et al.*² mentioned in 2012 that the correct spelling of SDF should be silver 'diammine' fluoride, which indicates the two ammonia ligands chelating to the silver metal complex. I have noticed no evidence about the presence of 'diamine', which is referring to a chemical with two amines according to the organic nomenclature from the International Union of Pure and Applied Chemistry (IUPAC), in SDF.

I believe any normal UK A-Level student who studies chemistry will know the differences between 'diamine' and 'diammine'. It seems to be that a proper nomenclature should be advocated; any wrong convention is not an excuse that should be accepted.

J. Tsoi, Sai Ying Pun, Hong Kong

*Nicola Innes responds on behalf of N. Seifo et al.: We appreciate the author's concern and agree with him that the correct nomenclature for SDF should be 'silver diammine fluoride' rather than 'silver diamine fluoride'. However, the latter is now used so universally that it has become accepted in both marketing as well as within the dental scientific literature. For instance, we recently conducted and published an umbrella review (overview of systematic reviews) concerned with SDF and carious lesions (Seifo et al. Silver diamine fluoride for managing carious lesions: an umbrella review. *BMC Oral Health* 2019; **19**: 145). The search strategy included a comprehensive search of multiple databases such as PubMed, Embase and The Cochrane Library using all possible terminologies and spellings of SDF. However, 12 systematic reviews were included, 11 of which used 'silver diamine fluoride' in their manuscripts.*

Furthermore, due to the word limit constraints, we chose not go into details in the article as we prioritised information relevant to the readership and specific to practitioners using SDF in practice. We thought that clarifying the misnomer in the literature, whilst of course still important in terms of accuracy, was less relevant to practitioners than some of the other material included.

References

1. Seifo N, Robertson M, MacLean J *et al.* The use of silver diamine fluoride (SDF) in dental practice. *Br Dent J* 2020; **228**: 75–81.
2. Lou Y, Botelho M, Darvell B. Erratum to 'Reaction of silver diammine fluoride with hydroxyapatite and protein'. *J Dent* 2012; **40**: 91-93.

<https://doi.org/10.1038/s41415-020-1942-7>

Restorative dentistry

Thirty-year-old amalgams

Sir, I am enclosing two bitewing radiographs with 12 restorations (Figs 1 and 2). I have been seeing this patient for 48 years. All the amalgam restorations in the radiographs are more than 30 years old. Some of the academicians do not believe in restoring teeth and want to prevent tooth decay. Restoring teeth is the best way to prevent further tooth decay.



Fig. 1 Radiograph of a patient with amalgam restorations over 30 years old



Fig. 2 Radiograph of a patient with amalgam restorations over 30 years old

I qualified as a dentist in 1961 and have used amalgam as a filling material for more than 60 years. I find amalgam and gold are the best and the longest lasting filling materials.

L. K. Bandlish, London, UK

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Oral health

Olive oil for dental caries

Sir, we have read the impressive article by Dr Sanchez and colleagues about the improvement in oral health in 17,777 Spanish athletes in which they observed improvements in Spanish athletes' physical activity being favourably associated with some self-reported oral health correlates.¹