

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

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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.

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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

Spanish people consume a Mediterranean diet which contains complex carbohydrates, fruits, vegetables, beans, nuts, seafood, olive oil and dairy.² Fridell and colleagues have observed that an increase in fruit consumption is associated with an improvement in periodontal health.³ Lipids like vegetable oils can add hydrophobic characteristics to the tooth surface hampering bacterial colonisation and eventually decreasing caries susceptibility.⁴ Olive oil is rich in oleic acid and other phenolic compounds, is useful for enhancing fluoride inhibition of extracellular polysaccharide (EPS) formation by *Streptococcus mutans* and has a role in preventing biofilm formation.^{5,6} Therefore olive oil, which is rich in oleic acid, may be useful in the prophylaxis of dental caries and periodontitis to promote oral health.

M. V. Math, Y. R. Kattimani, S. R. Gawali, Navi
Mumbai, India

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- <https://doi.org/10.1038/s41415-020-1944-5>

NHS dentistry

Shocked and disappointed

Sir, I sent a letter, as suggested by the BDA, to my local MP, Alex Cunningham Labour MP for Stockton North. This is the astonishing response I received...

'Thanks for getting in touch. I will do everything possible to support dental practices which provide NHS services to the people I represent. Others who have abandoned the NHS for the private sector have made their choice and can't expect taxpayers to ride to their rescue. Best wishes.'

It appears that the government and the opposition only want to support government funded dental clinics. I'm quite shocked and disappointed.

W. Carter, Billingham, UK

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Mouth cancer

SCC from a dentigerous cyst

Sir, during routine dental examination a radiolucency with a cyst-like appearance was detected surrounding the crown of a completely impacted right lower third molar (Fig. 1). There was no lesion in the oral mucosa. Although the patient was 75 years old and completely asymptomatic, the GDP was mindful and referred the patient to an oral surgeon, who performed an incisional biopsy. The results revealed carcinoma of undetermined origin. At this stage, the patient was referred to the Department of Oral and Maxillofacial Surgery at the University of Texas Health Science Center in Houston. We reviewed the histopathology and confirmed this rare entity with additional pathology consultations. The patient underwent staging and work up to demonstrate no regional or distant disease. The patient underwent a right hemimandibulectomy with reconstruction with a vascularised fibula osteocutaneous graft. The final specimen revealed SCC arising from a dentigerous cyst.

Although rare, primary intraosseous squamous cell carcinoma (PIOSCC) originating from an odontogenic cyst was first described in 1957.¹ Their estimated incidence is less than 2% of all oral carcinoma,² with 60% originating from a residual or radicular cyst and 16% from dentigerous cyst.³ SCC originating from dentigerous cysts have been reported

amongst children;⁴ however, they are often detected later in life (47% from the sixth decade), more often encountered amongst men (70%) and with a higher incidence for the mandible (87%).⁵ The higher occurrence amongst men is most likely a reflection of the overall higher incidence of both radicular and dentigerous cyst amongst men.⁶

Due to their location within the bone, SCC arising from a dentigerous cyst is staged as a T4 cancer.^{7,8} Hence, enucleation will not be sufficient as most cases need to undergo resection in order to ensure negative margins and adjuvant radiation or chemoradiotherapy depending on age and nodal status.

M. Kharazmi, Västerås, Sweden, J. C. Melville, Houston, USA, A. T. Huang, Houston, USA, A. Kanatas, Leeds, UK, J. Shum, Houston, USA

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Fig. 1 Radiolucency surrounding the crown of the impacted right lower third molar