Pharmaceuticals

Alvogyl or Alveogyl?

Sir, historically general dental practitioners (GDPs) have used Alvogyl in their armamentarium as first line treatment for alveolar osteitis. However, over five years ago following intervention from the Medicines and Healthcare products Regulatory Agency (MHRA), Alvogyl was reformulated as Alveogyl, seemingly unbeknownst to clinicians.

The literature is rich with clinical studies assessing the efficacy and safety of Alvogyl compared to a diverse range of methods in the management of alveolar osteitis.^{1,2} Yet, there is a lack of clinical evidence pertaining to Alveogyl and its new constituents.

Comparison of the ingredients of the two demonstrate a notable difference (Table 1).^{3,4} In particular, the removal of the active ingredients iodoform (antimicrobial) and butamben (anaesthetic) from Alveogyl, and the addition of 'excipients' to Alveogyl.

On further investigation into the reasons for the change, the manufacturer (Septodont) outlined concerns of patient safety due to potential allergic reactions, perhaps due to the introduction of pharmacovigilance reporting. As a result, a reformulation was requested in order to meet MHRA regulations. This raises a number of issues. Firstly, how aware are GDPs of this change? To address this, a survey was developed to assess both the awareness of the change of product used to treat alveolar osteitis and the corresponding change in formulation. The survey was distributed to foundation dentists and educational supervisors in the Yorkshire and Humber region (n = 120). The results revealed that 56%

were unaware of the name change and 91% were unaware of the reformulation. In light of the rapidly evolving field of dental materials, this highlights the need for clinicians to be up to date in their knowledge of current materials used in clinical practice. However, in addition to this, it raises concerns due to the lack of transparency regarding the change in composition from the manufacturers as the new product appears to be almost identical in packaging to the previous one.

Secondly, if clinical guidelines are to be based on current evidence, this change in composition must be reflected in the evidence base and included in primary studies especially as Alvogyl is no longer available in the UK.

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Mouth cancer

GDP referrals

Sir, we would like to highlight our experience of oral cancer referrals in the South West of England and the integral role of the general dental practitioner (GDP) in this pathway. It is well documented that in the UK urgent fast track referrals for suspected head and neck malignancy are on the increase.¹ Our trust is a medium sized District General Hospital with a catchment population of 286,000. We assessed the number and source of our urgent referrals to demonstrate how this and the number of cancer diagnoses has changed over a seven-year period.

A retrospective analysis was undertaken of all patients referred with a suspected cancer to our Head and Neck Clinic from January 2013 – December 2013 versus January 2019 – December 2019. An analysis of the number of patients referred, whether referral was via general medical practitioners (GPs) or GDPs and diagnosis of cancer versus non-cancer, was undertaken.

In 2013 there were 567 referrals with suspected head and neck cancer of which 8.9% were positive (n = 58). Ninety-seven percent of these positive referrals were from GPs, compared to <1% from GDPs and 2% from other referring clinical practitioners. In 2019 there were 1,603 referrals with suspected head and neck cancer of which 4.4% had a positive diagnosis (n = 70). GPs made 69.3% of these positive referrals compared to 30.7% made by GDPs.

Our department experienced a three-fold increase in the number of patients being referred via the urgent cancer pathway, despite minimal changes in catchment population size. The increase in referrals from GDPs coincides with an increased emphasis on oral cancer screening during routine dental examinations and confirms the integral role of the GDP in the early detection and management of head and neck cancer.²

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Foundation training

NI pay disparity

Sir, I am writing in response to an interesting piece of research published in the *BDJ* regarding dental core training.¹ It highlighted an important issue in pay disparity amongst dental core trainee (DCT) jobs in the United Kingdom, particularly in Northern Ireland where the difference is quite significant and could have a detrimental effect on the quality of care provision.

At present, all new graduates who begin dental foundation training (DFT) have a nationalised salary of £32,796.² Following DFT, there are two main pathways taken by trainees: applying for a DCT1 job or securing a contract as an associate dentist in primary care. The salary for DCT1 in Northern Ireland is £28,641, a drop in salary of approximately £4,000. Worryingly, DCTs in Northern Ireland are paid over £8,000 less per annum than their counterparts in England, where the salary is £37,191.¹

Table 1 Alvogyl and Alveogyl Ingredients

Alvogyl	Alveogyl
Butamben*	Eugenol*
Iodoform*	Penghawar Djambi
Eugenol*	Sodium lauryl sulphate
Penghawar Djambi	Calcium carbonate
Sodium lauryl sulphate	Mint flavour
Calcium carbonate	Excipients
Spearmint oil	
Olive oil	
Purified Water	
*active ingredients	