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	

This pay disparity poses a significant deterrent to those wishing to pursue further training and gain experience providing treatment for patients in a secondary care environment in Northern Ireland. This issue needs to be raised and addressed urgently by the relevant healthcare authorities in NI to ensure equal opportunities for all trainees.

B. McGuckin, Newcastle-upon-Tyne, UK

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Paediatric dentistry

Let it go – Lego!

Sir, we would like to bring an interesting case to the reader's attention of a six-year-old boy that we recently saw in our paediatric dental department.

He presented with his anxious and worried mother, having bitten down onto a piece of Lego which was now firmly lodged onto his lower front tooth. The mother explained to us that her son has a tendency to bite on hard objects due to sensory issues associated with his autism spectrum disorder. Previous similar cases have been noted.^{1,2} However, the added complexity of this patient's behavioural needs proved challenging in our management of this young boy.

Examination revealed a grey, hollow, cylindrical piece of plastic Lego firmly encasing the lower left permanent central incisor (Fig. 1). The tooth exhibited grade 1 mobility. A limited radiographic

examination confirmed this was his permanent tooth with no obvious abnormal radiographic signs.

Attempts to remove the piece by hand and fast handpiece proved futile as the underlying tooth was tender to pressure and his compliance and anxiety were increasing the longer he was in the dental surgery. Therefore, following discussion with his mother, arrangements were made for the boy to return the following day for removal of the Lego under general anaesthetic.

On contacting the parent later that day to confirm details of his admission, we were surprised and relieved to hear that her son had managed to detach the Lego piece from his tooth whilst eating a 'crunchy chocolate bar' snack, which he had received as a treat for being so brave at the dentist! Plans were made for clinical review of the tooth but unfortunately the family were unable to attend. A telephone review has been undertaken and his mother has confirmed that his boy's tooth (and Lego piece) have made a full recovery.

On discussion with our team, one of our dental nurses highlighted that this particular Lego piece (a wheel hub) has a lever to tighten/release its mechanism. Although we have not tested this theory, it may be possible to use this lever to remove the Lego without resorting to a planned general anaesthetic.

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Oral health

Frederick Hiles

Sir, we believe that in these uncertain times inspiration can be drawn from the life of John Frederick Bartram Hiles (1872–1927). Aged eight, after a tram accident, Hiles suffered the traumatic loss of both arms – amputated at the shoulders.^{1,2} Defiantly refusing to be defined by disability and determined to re-make then re-fashion himself with the opportunities available at the turn of that century, by age 16 Hiles taught himself to draw and paint with pencils and brushes held between his teeth. Eighteen years old and with no indication of the manner of his work, Hiles' paintings had won prizes and his rightful place in the National Arts Academy.¹ At twenty-one, a scholarship from the Royal Society of Arts enabled study in Paris with the impressionists: Renoir, Monet and Pissarro.²

With patronage from Queen Victoria, Hiles returned from Europe to paint by mouth the Princess of Wales. By his early thirties, married with a daughter and elected to the Bristol Savages art society, a regular income was assured. Rather than being marginalised, Bartram emerged from catastrophic childhood injuries to fully participate in a society that was ambivalent towards difference, otherness and perceptions of normality.³

However, this period of Bartram's life was tragically brief: periodontal disease robbed him of an ability to make a living; multiple extractions led to him being unable to work. Deprived of his calling and weakened, by July 1927 aged just 55, Bartram Hiles passed on. Neither the restrictions of disability nor Victorian-Edwardian society prevented the expression of Hiles' artistic talent; his end came from the effects of untreated dental disease. While his legacy was overshadowed in the advent, then aftermath of the Second World War, Bartram Hiles is relevant for dentistry today for the following reasons:

1. Adapting to function with restrictions places critical pressure on a patient, a practitioner or a profession's remaining capacity to continue working
2. Catastrophic failures follow from the simplest of unchecked oversights on any system that is stressed beyond its limits
3. Innocuous pathological, psychological or political symptoms may be indicative of deeper underlying ailments and these cannot be overlooked.

Fig. 1 Lego piece lodged on tooth