

Human factors

A wealth of accessible information

Sir, I was pleased to see the launch of Human Factors and Patient Safety in Dentistry publicised in the *BDJ* (2020; 229: 11). Prior to my retirement in December 2019 I was Vice Chair of the Board which developed this resource. Written 'by dental team members for dental teams' it contains a wealth of accessible information. Teams may find it helpful to identify a lead member to promote use of the resource and to ensure the principles are embedded in the team's systems and processes. The resource can be accessed at www.humanfactors.dental and can additionally contribute to individual development and understanding.

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Royal Colleges

Not entirely accurate

Sir, I am writing in response to the recent interview with Dr Shelagh Farrell (*BDJ* 2020; 229: 164) which includes the claim there is no royal college for dentists. I too hold the MGDS qualification and was also part of the Advisory Committee for the inception of the FGDP, and indeed continue to support its evolution to a College. However, to claim there is currently no royal college for dentists is not entirely accurate.

In fact, all four Royal College of Surgeons (Edinburgh, England, Glasgow and Ireland) have dedicated Faculties of Dental Surgery. In particular, that of the Royal College of Surgeons of Edinburgh has been around for over 70 years and represents over 7,000 dentists from all over the world, ranging from general dental practitioners to specialist level. We are continually trying to broaden our reach and to encourage more dental professionals to join, including DCPs, through targeted advertising and stakeholder partnerships.

RCSEd's Faculty of Dental Surgery offers a range of quality assured diplomas, membership and fellowship qualifications, advocates on behalf of the industry and facilitates high levels of education for members to promote excellence in patient care.

In particular, the Faculty has played a crucial role in supporting its members over the last five months, by helping them understand the ever-changing regulations imposed as a result of COVID-19, and lobbying on their behalf on issues such as

clearer guidance on and provision of PPE. As a Faculty, we are committed to working with the rest of the sector to ensure the best possible outcomes for dentists and patients, and I'd like to make it clear that everyone in dentistry is welcome to join.

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Oral health

Hazards of cocaine misuse

Sir, you published a highly insightful article *Cocaine and oral health* in 2008 (*BDJ* 2008; 204: 365–369). We detail a case of this unusual presentation here with a brief literature review. A 48-year-old female presented with both nasal septal and hard palate perforation secondary to cocaine misuse (Fig. 1). Her history consisted of nasal congestion and obstruction which had deteriorated. She also developed facial pain, foul odour and sensation of food debris and fluids in her nasal cavity. Clinical examination demonstrated an obvious saddle nose deformity due to loss of nasal structural support. Intra-oral examination revealed partial anterior hard palate destruction leading to an oro-nasal fistula. On further questioning the patient admitted to a ten-year history of daily nasal cocaine use in addition to alcohol misuse.

Due to raised inflammatory markers and severe facial pain the patient was admitted to the ENT/maxillo-facial inpatient ward. She received a course of IV antibiotics and nasal douching. She was reviewed by the maxillofacial team and fitted with a cover plate to prevent passage through the oro-nasal fistula. The GP was asked to arrange substance misuse support for the patient to help with cocaine/alcohol cessation. The patient failed to engage with rehabilitation services and surgery was not advised due to the high risk of recurrence.



Fig. 1 Oro-nasal fistula showing a defect in the anterior hard palate extending to the nasal septum

Cocaine is one of the most commonly used narcotics and is a central nervous stimulant resulting in a short term increase in dopamine release.^{1,2} Well known for its uses of anaesthetic and pain relief its chemical structure has been altered to produce commonly used preparations such as lidocaine, one of the most frequently used topical and injectable local anaesthetics.

There are three common routes of cocaine administration: intravenous, insufflation and smoke inhalation.³ Prolonged misuse of cocaine can lead to a myriad of complications which can vary based on the route of administration. Nasal septal perforation is an uncommon presentation and is more commonly associated with trauma and previous septal surgery.⁴

Upon presentation of ulcerative lesions of the face, differential diagnoses must be considered including trauma, infection and neoplastic disease. Ulceration secondary to substance misuse is an uncommon occurrence but sadly the trend is on the rise. Orofacial lesions and destructive midline perforation is not exclusive to abusers of cocaine and physicians who are involved in the diagnosis and treatment of these lesions should be aware that a number of agents and pathophysiological causes can be associated with this appearance.

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References

1. Brownlow H A, Pappachan J. Pathophysiology of cocaine abuse. *Eur J Anaesthesiol* 2002; 19: 395.
2. Nestler E J. The neurobiology of cocaine addiction. *Sci Pract Perspect* 2005; 3: 4–10.
3. Jeffcoat A R, Perez-Reyes M, Hill J M, Sadler B M, Cook C E. Cocaine disposition in humans after intravenous injection, nasal insufflation (snorting), or smoking. *Drug Metab Dispos* 1989; 17: 153–159.
4. Metzinger S. Diagnosing and treating nasal septal perforations. *Aesthet Surg J* 2005; 25: 524–529.

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Eco-brushing

Sir, as consumers are becoming environmentally conscious and the toll of greenhouse gases are apparent, people are understandably looking to reduce their carbon footprint. Currently the majority of toothpaste tubes are not recyclable with an estimated 260 million tubes contributing to landfill annually with biodegradation taking 500 years.¹

While Colgate offers a nationwide recycling programme of toothpaste tubes, this is not commonly accepted by local councils.² Therefore, for those keen to reduce waste, alternatives are sought but these often do not contain fluoride, which as we know,