improving oral hygiene is unlikely to be detrimental, it has never been more important to uphold scientific rigour in the interpretation and reporting of research findings to help build our collective understanding of the aetiology and prevention of disease.

S. Byrne, Melbourne, Australia

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Emergency dentistry

Surviving on call

Sir, having completed a year as an OMFS DCT in a major trauma unit, I thought it would be useful for fellow colleagues to have some know-how of how to survive an on call:

- If in doubt, ask: senior colleagues will know you haven't done the job before. They have experience of training DCTs and will be more than happy to assist you
- Get to know the paperwork. As laborious as it may be, paperwork is extremely important, and the more you are aware of what needs to be filled in, the smoother the process will be
- Prioritise your jobs. You will have calls coming from multiple different places at the same time, so you need to know which jobs need to be finished urgently, and which jobs can be completed later
- Keep a logbook – preferably electronic but if it is in paper form, make sure there is no patient information which will make them identifiable, and make sure to get it verified by your consultant
- Practise suturing at home. I know it sounds simple, but practising a little can go a long way! You will come across as more confident in front of the patient and will feel less fazed
- Watch videos on how to cannulate – once again, it will be unlikely you will have done many cannulations, so it can be useful to know the exact process of how to place a cannula successfully
- Know the basics about bloods. Having a basic knowledge about what all the blood results mean will be useful when handing information over to senior colleagues, and will help you to know what to look out for
- Get the information – sometimes when you get a bleep from A&E, they may not have completed all the tasks required from them at the time of referral. For example, if there is a mention of head injury, make sure they have assessed and cleared the patient of any head injuries otherwise you will have to sort this out, and it can be daunting
- Know what needs to be on the consent form – you will be admitting and clerking in many patients, so if you know exactly what needs to be on the consent form, it will speed up the process
- When handing over use SBAR – Situation, Background, Assessment, Recommendation. This will make handovers concise and easy to follow
- Make sure to rest properly in your spare time – the job can be demanding so this is vital to stay alert.

And lastly, enjoy this time! You will see extremely interesting cases through to the weird and wonderful; you have an amazing opportunity to learn new things in a supported environment so take advantage of it!

A. Kazmi, Liverpool, UK

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Dental regulation

Keeping up the fight

Sir, thank you for publishing Martin Kelleher's article (*BDJ* 2020; **229:** 225-229). Martin has long been highly respected as an excellent teacher and communicator, and a voice of reason in our profession.

The first part is a truly appalling account of just one problem at the GDC. The second is an excellent reminder that we must not let lawyers overrule common sense in the way we practise. The profession needs a regulator (note not plural) with an understanding of what comprises good dental practice. In the meantime we look to the BDA and its esteemed Journal to continue the fight on behalf of our profession.

P. S. Nayler, Brighton, UK

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Pharmaceuticals

Directions for use

Sir, I write further to the letter of Kalsi *et al.*[1] in which they described that the product Alvogyl (Septodont, Cedex, France) used in the management of acute fibrinolytic alveolar osteitis had been superseded by a chemically different product Alveogyl (Septodont) with potentially significant clinical ramifications.

These colleagues make a very valuable and important point in that the formulations of not only pharmaceuticals but also dental materials and biomaterials may be changed by manufacturers surreptitiously. This may be necessary due to product development, regulatory demands and ongoing product safety. Whilst this is both laudable and proper, the clinician should be mindful of potential changes in product formulation as this may have a significant bearing on how the product is mixed and/or handled clinically. It therefore follows that the failure of the dental team to fastidiously use the material as intended may result in inferior clinical performance.

One way of ensuring best practice would be that the directions for use of each new batch of product are read carefully and then stored in a centrally placed file in the clinic, easily accessible to all members of the dental team. A ring binder folder containing punched pockets is ideal and the responsibility of keeping the file contemporaneous should lie with the member of staff responsible for stock management.[2] Furthermore, dissemination of any change in handling protocol etc should also be communicated to all appropriate clinical staff. Such a measure will ensure that all products intended for clinical use are used correctly to ensure the best outcome for the patient.

S. J. Bonsor, Aberdeen, UK

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Dermatology

Skin care doubts

Sir, there is an increasing number of dentists who have started to provide specialist skin care. May I emphasise, I do not mean facial aesthetics courses (botulinum toxin and fillers). This is after they have gone to a

two-day course (with no hands-on training) by a dermatologist, which then enables them to prescribe the medical-grade skin products that are recommended by the course provider. Dentists are then selling the products and giving specialist skin care advice to patients and the public through social media platforms. This is often misguiding for the general public as they appear to be specialist consultants, but as dentists we are not professionally trained dermatologists.

To be a dermatologist requires extensive training: five years at medical school, two years as a foundation doctor, two years of core medical training and then a three-year dermatologist training pathway. Skin care is outside the remit of a dentist and this should not be a service that we provide nor to mislead patients into thinking that they are receiving specialist skin advice and treatment from someone who has been to a two-day course. Would you?

When beauticians were providing tooth whitening, we found this unacceptable and putting patients at risk; what is the difference here with dentists providing skin care? Being a dentist of course involves the facial region, however, this does not mean we can then take on anything that is part of the head and neck. What next? Ear, nose and throat treatment?

S. Jannati, A. Sanalla, London, UK

https://doi.org/ 10.1038/s41415-020-2366-0

Paediatric dentistry

Lego leverage

Sir, I refer to the letter to the *BDJ* published on 28 August 2020 entitled *Let it go – Lego*! (*BDJ* 2020; **229:** 212) regarding the hazards of small pieces of Lego. I am myself familiar with the offending piece of Lego shown in the photograph, having spent many an hour building Lego kits myself. I must stress however, that my lower incisors have thus far been safe from the clutches of such a piece.

I thought readers may find it useful to know of the removal tool to which the authors refer. I believe the instrument in question is the Lego Brick Separator which can be acquired though the Lego shop but which is often included in larger sets of Lego as well.[1]

As can be seen on the Lego website,[1] this tool can act as a lever but also has a small plus shaped fitting as well, mimicking the axel onto which such a wheel hub attachment can be slid. I believe either aspect could have been of assistance in the case detailed last month.

S. Lovel, Sunderland, UK

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https://doi.org/10.1038/s41415-020-2367-z

CASE REPORT

Epidemiology

Oral tuberculosis

Sir, a 39-year-old Caucasian gentleman of Polish origin presented to our department with a non-healing ulcer of the tongue of three months' duration. The area was minimally tender and had not seen significant change in size after the initial growth. His past medical history was significant for 'self-diagnosed' anxiety for which he used diazepam obtained from his friends. He smoked 20–30 cigarettes along with cannabis and consumed 1 litre of vodka every day. He denied any recent foreign travel, fevers or night sweats. He had lost approximately 5 kg of weight in the past three months which he related to not eating well due to a busy job.

On examination, he had no obvious palpable cervical lymphadenopathy. A 3 x 2 cm large indurated ulcer with rolled borders was noted on the right posterolateral aspect of the tongue suspicious for malignancy (Fig. 1). An urgent biopsy revealed ulceration and necrotising granulomatous inflammation with no evidence of dysplasia or malignancy. Magnetic resonance imaging demonstrated a 1 cm diameter enhancing lesion on the right lateral tongue with additional multiple necrotic nodes of ipsilateral level II/III region and contralateral level II region. Computed tomography imaging of the chest showed extensive 'tree in bud' nodularity with calcified granulomas and parenchymal fibrosis (Fig. 2). The patient was referred to the respiratory team for further investigations and management. During the investigative period, the patient developed a productive cough along with dyspnoea. Sputum examination confirmed the diagnosis of tuberculosis (TB).

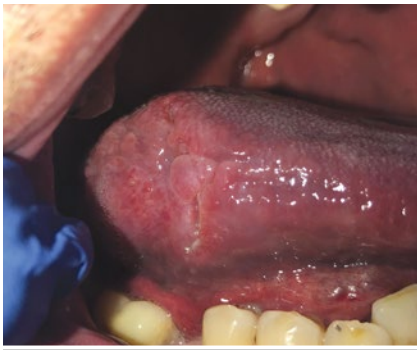

Fig. 1 Large indurated ulcer right posterolateral tongue

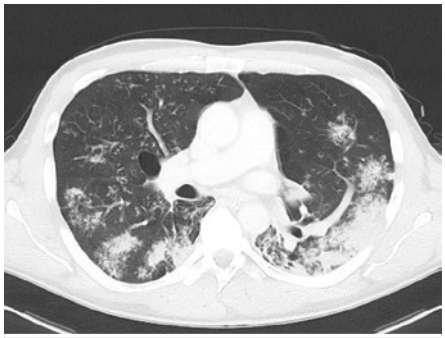

Fig. 2 CT imaging showing 'tree in bud' nodularity

The patient was isolated and treated initially with quadruple therapy (rifampicin/ethambutol/isoniazid/pyrizinamide) with pyridoxine for two months. On review after three months, there was symptomatic improvement and satisfactory healing of the tuberculous ulcer.

It is estimated that 10% of cases of extra-pulmonary TB are found in the head and neck region and 10% of those cases present in the oral cavity.[1,2] Early differentiation together with prompt multidisciplinary management prevents spread of this deadly disease.

S. Mumtaz, R. Pabla, London, UK

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