advocate for dental practices to register their AED at <https://www.thecircuit.uk/>.² This initiative by the British Heart Foundation has the aim of connecting the location of AEDs around the country to ambulance services. As a result, this allows quicker access to AEDs, thereby helping save more lives from out-of-hospital cardiac arrest (OHCA).

Signing up is quick and easy; I urge all dental practices to register their defibrillator and potentially save a life.

N. Mistry, Liverpool, UK

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<https://doi.org/10.1038/s41415-021-3626-3>

Water fluoridation

Fee for fluorosis

Sir, we welcome the 'Statement on water fluoridation' from the UK Chief Medical Officers (CMOs), particularly in light of the proposed changes to legislation in this area.^{1,2}

In order to gain public confidence in water fluoridation, we believe the risks must not be understated and the benefits must not be overstated. With this in mind, we were surprised to read in the statement that 'dental mottling is a small risk'. An authoritative systematic review estimated the risk of dental fluorosis of aesthetic concern to be in the order of 12.5% (where the level of fluoride was at 1.0 ppm), which we regard as substantial and many parents might regard as a high level of risk.³ It is our experience that the current generation of children are highly image-conscious and we see no sign of a reversal in this trend; we postulate that even the minor types of fluorosis might be of aesthetic concern to this future cohort.

The CMOs went on to state 'the cost of hospital admissions for tooth extractions among those aged 0 to 19 years in England was estimated to be £54.6 million, the majority due to preventable tooth decay'. In fact, the report they were quoting states that this figure was £33 million.⁴

We were also disappointed that the statement did not discuss the implications for dental practices of high numbers

of children exhibiting fluorosis. We are convinced there will be an increase in the number of parents seeking advice and treatment for the condition. We would like to see the Department of Health offer training to practitioners in the diagnosis and treatment of fluorosis, particularly to those dentists and therapists currently operating outside of those areas that have fluoridated water supplies. Many of these practitioners will not have been trained in the minimally invasive techniques that are currently recommended to treat the condition.

Finally, we were pleased the CMOs noted the impact water fluoridation is likely to have in reducing dental health inequalities and we partly agree with this. However, without additional financial support, will NHS dental practices be able to offer treatment for dental fluorosis of aesthetic concern? We envisage a potential widening of dental health inequality where those parents who can afford to will pay privately for the treatment of this condition, and for those that cannot, their children will be sadly left untreated.

R. I. Bland, G. M. Bland, Wrea Green, UK

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OMFS

Filler failure

Sir, I write with reference to the letter (*Br Dent J* 2021; **231**: 205) regarding the increase in dermal filler-related complications presenting in the Accident and Emergency department, as an oral and maxillofacial dental core trainee working in South West UK.

In addition to vascular occlusion-related complications, other complications may present and I would like to highlight a few management options for colleagues faced with similar problems:^{1,2,3}

1. **Bruising/ecchymosis:** This can be easily treated with the use of cold compresses, arnica, bromelain, aloe vera or vitamin K creams. Medications which can affect anticoagulation (eg vitamin/herbal supplements, NSAIDs and antiplatelets) should be paused for 7–10 days
2. **Swelling/oedema:** Prophylaxis of this should include the use of anti-inflammatory enzymes, arnica/gelsenium/bromelain and cold compresses. Management of this complication can include the use of NSAIDs, short-term steroids and streptokinase/streptodornase in addition to prophylactic measures
3. **Erythema:** The use of antihistamines, oral tetracycline or isotretinoin may be effective. Short-term use of topical medium-strength steroids can be helpful, with the aid of vitamin K cream
4. **Infection:** This can be managed using co-amoxiclav or ciprofloxacin antibiotics. Second-line antibiotics such as cloxacillin, azithromycin, minocycline and flucloxacillin can also be used. Any abscesses should be drained and a microbiological culture is recommended
5. **Herpes activation:** Patients with a history of cold sores should have anti-herpes medication prescribed prophylactically. In this instance, valaciclovir or aciclovir 1–2 days before and three days after the procedure is recommended
6. **Dysaesthesia/paraesthesia/anaesthesia:** In the event of Bell's palsy, a short course of high-dose oral steroids may be beneficial
7. **Lumps/bumps:** In the event that a non-inflammatory lump persists, treatment will include needle aspiration or a minimal stab wound incision with evacuation. Post-inflammation management may include hyaluronidase injections and intense pulsed light/laser, photo-protection or depigment cream
8. **Tyndall effect:** Superficial placement of fillers can result in blanching and a bluish discolouration in the injection area. Management of this includes the use of local massage, incision and drainage and hyaluronidase injections

9. Acute hypersensitivity: Antihistamines, NSAIDs, intralesional/systemic steroids, minocycline and hydroxychloroquine can be used to manage this complication. Hyaluronidase injections may also prove useful.

In conclusion, I hope that the information above will prove beneficial to dental core trainees working in oral and maxillofacial surgery units when faced with the above complications.

Y. Lin, Plymouth, UK

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Coronavirus

COVID-19 and multidisciplinary dentistry

Sir, we read with great interest the letter 'COVID-19 and consent'.¹ A similar look into patient data in our hospital's oral and maxillofacial surgery department (OMFS) during the COVID-19 pandemic shows a fascinating insight. Being a tertiary centre in a developing country and being in a city of 1.5 million+ people, the department witnessed a tenfold rise in space infection requiring surgical intervention during the first month of national lockdown, when all the dental clinics across the city were closed. This experience highlights the significance of access to oral health and the role of dentists in preventing more adverse space infection arising due to spread of periapical infection. COVID-related mucormycosis cases requiring extensive antifungal therapy and surgical debridement dominated the second wave of COVID-19. Immune dysregulation caused by SARS-CoV-2 and the use of broad-spectrum antibiotics and corticosteroids, particularly in patients with poorly controlled diabetes with ketoacidosis, is likely to have contributed to the rise.² With a prevalence for mucormycosis estimated to be nearly 80 times higher (0.14 per 1,000) in India compared to developed countries, timely

intervention and management was called for, with patients as young as 25 years old presenting to the department requiring surgical debridement.^{3,4}

While the department of OMFS provided emergency services in the first wave and later extensive surgical debridement for patients with mucormycosis, the job is far from over for teams of prosthodontists and maxillofacial prosthetists, as providing a better quality of life to patients who have undergone maxillectomy and other resections remains a top priority. COVID-19 has shown us the importance of primary oral healthcare, as an absence of such services, due to nationwide lockdown, elevated what would have been tooth infection into a more complex facial space infection. It further strengthens the importance of multidisciplinary teamwork in dentistry, as displayed by maxillofacial surgeons providing frontline life-saving services and prosthodontists who can further provide a better quality of life for patients.

N. Kurian, S. Gandhi, A. M. Thomas, Ludhiana, India

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Health and wellbeing

Benevolent running

Sir, I write this letter to you having completed The Virtual London Marathon, a lengthy 26.2-mile race around London. Three other runners and I, all members of the dental community (Dr Robert Chaffe, Dr Helen Reddington and Dr Zayd Rawoot), took on the event to fundraise for the British Dental Association (BDA) Benevolent Fund, raising more than £6,000 for the charity and counting.¹ As sore as my body felt crossing the finish line, I experienced an overwhelming sense of attainment, having been part of the world-famous event.

During the first lockdown, as all of my undergraduate teaching had moved online, I found myself spending roughly six hours

a day in front of a computer screen. I therefore took up running, as a means of staying active and to get out of the house. Now, as dentistry returns to normality, I use the sport as a way to de-stress after a busy day on clinic. Long-distance running is a cathartic experience, that allows time for much-needed self-thought and reflection. To quote a former marathoner, Amby Burfoot, 'if you train your mind for running, everything else will be easy'.

I had always wanted to run the London Marathon, and to have the privilege of running on behalf of the BDA Benevolent Fund made me even more determined. I wanted to give back to those in the dental community that has been hit hard by the COVID-19 pandemic. The BDA Benevolent Fund has seen a 15% increase in grants being given, and now to more younger applicants, seeing the average age of recipients being 31 years old.² The experience has helped me adopt a new passion, whilst also promoting a charity that helps those in our profession. I encourage all those in the dental profession to consider running, either to raise money for charity or as a great way to keep both the mind and body healthy.

R. Lee, London, UK

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Occupational health

Achenbach's – other lesions

Sir, regarding the recent letter by R. Chate and C. Chate,¹ we want to mention that Achenbach's syndrome has been defined as the appearance of bruises in the fingers or palms of the hands; however, within the spectrum are other types of lesions such as ecchymosis and even purple ones. It is important to note that there are no changes concerning the exposure to cold and capillary filling remains normal.²

Regarding gender, it has been shown to be more frequent in women, with a 7:1 ratio compared to men, with a predisposition in people older than 50 years.² Other common symptoms are oedema and pain in the affected area, which are present in approximately 50–60% of cases; paraesthesia