

Letters to the editor

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Oral health

MDMA and mouth ulcers

Sir, 3,4-methylenedioxyamphetamine (MDMA), otherwise known as ecstasy, is an illicit drug which is consumed for recreational use. In addition to systemic complications, it can also present with a variety of oral side effects. Patients may first present to their primary care practitioners before being referred acutely onwards to an oral and maxillofacial surgery or oral medicine department for further investigations and management, which has been our experience here in a secondary care setting. I would like to raise awareness about these oral manifestations and the management options that can be provided.

Xerostomia can occur which should subside after approximately 48 hours.¹ Patients should be advised to stay hydrated until normal salivary flow returns. Erosion also occurs due to increased consumption of soft drinks and vomiting during the recreational use of MDMA. A fluoride mouthwash and sugar-free chewing gum is recommended to maintain salivary flow and buffering capacity. Sugar-free chewing gum is also recommended for alleviating the symptoms of bruxism which occurs due to partial inhibition of the jaw opening reflex.²

Perhaps one of the most common manifestations for concern is severe, widespread oral ulceration. With these cases, reassurance and a soft diet is advised as these ulcers tend to resolve after 14 days. Management options may include the use of benzydamine, chlorhexidine or corticosteroid mouthwash for symptomatic relief.¹ If there are any concerns for infection, a course of antibiotics could be prescribed.

Y. Lin, Plymouth, UK

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Recreational reluctance

Sir, it seems there is often reluctance within our profession to ask patients about recreational drug use. Whilst undertaking dental core training, it became apparent asking about recreational drug use was the norm, especially in patients undergoing treatment under IV sedation or general anaesthetic (GA).

The oral impacts of cocaine, for example, are well documented and include gingival lesions, palatal perforations and bruxism.¹ More importantly, cocaine blocks nerve conduction similar in action to lidocaine and articaine, therefore enhancing the body's response to epinephrine (often used as a vasoconstrictor in local anaesthetics),² meaning administration of a local anaesthetic after recent cocaine use may induce an acute increase in blood pressure. Cocaine users may also present with an increased risk if undergoing treatment under GA, particularly if ketamine (a reuptake inhibitor of endogenously released norepinephrine) is included in the anaesthetic technique.^{3,4} Cannabis (one of the most commonly abused drugs in the UK) can manifest intraorally (increased caries and oral cancer risk).⁵ Although there are few studies regarding the interaction between cannabis and sedative agents, it has been noted cannabis may compound the effects of anaesthetic agents, thus affecting arterial pressure and heart rate to possibly life-threatening levels. Refraining from using cannabis for 72 hours before treatment under conscious sedation may be advised to

reduce the likelihood of drug interactions.⁶ Additionally, those who use MDMA may complain of ongoing temporomandibular pain due to jaw clenching.⁷

We may find it difficult to discuss drug use with patients, often due to the illegal nature of the subject. However, it is crucial that drug habits are discussed and reviewed such that risk mitigation can be put in place prior to treatment and so patients can be directed to appropriate support groups if required.

O. Mudhar, M. Agarwala, Essex, UK

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Anaesthesia

Inhalation solutions

Sir, I am writing to highlight the benefits of offering inhalation sedation (IHS) to patients, particularly because of the effects of the COVID-19 pandemic on waiting times for general anaesthetic.

In hospital, we are seeing general anaesthetic (GA) waiting lists getting longer, with many patients suffering repeat bouts of pain and infection, and increased treatment with antibiotics. For those old enough, IV sedation can be offered, but for younger children and patients