

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

References

1. Brand H, Dun S, Nieuw Amerongen A V. Ecstasy (MDMA) and oral health. *Br Dent J* 2008; **204**: 77–81.
2. Brazier W, Dhariwal D, Patton D, Bishop K. Ecstasy related periodontitis and mucosal ulceration – a case report. *Br Dent J* 2003; **194**: 197–199.

<https://doi.org/10.1038/s41415-021-3778-1>

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

References

1. Brand H, Gonggrijp S, Blanksma C. Cocaine and oral health. *Br Dent J* 2008; **204**: 365–369.
2. Yagiela J. Adverse drug interactions in dental practice: interactions associated with vasoconstrictors. *J Am Dent Assoc* 1999; **130**: 701–709.
3. Hill G, Ogunnaike B, Johnson E. General anaesthesia for the cocaine abusing patient. Is it safe? *Br J Anaesth* 2006; **97**: 654–657.
4. Cheng D. The drug addicted patient. *Can J Anaesth* 1997; **44**: R101–R111.
5. Joshi S, Ashley M. Cannabis: A joint problem for patients and the dental profession. *Br Dent J* 2016; **220**: 597–601.
6. Dickerson S J. Cannabis and its effect on anaesthesia. *AANA J* 1980; **48**: 526–528.
7. Brand H, Dun S, Nieuw Amerongen A V. Ecstasy (MDMA) and oral health. *Br Dent J* 2008; **204**: 77–81.

<https://doi.org/10.1038/s41415-021-3781-6>

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

with poor venous access or medical contraindications, this is not a reasonable option.

Our introduction of IHS has allowed us to make good progress in treating these patients and reducing our GA waiting list. SDCEP recommends IHS as the preferred method of conscious sedation.¹ It is a safe technique with quick recovery time, and may help acclimatise patients to treatment and reduce anxiety. It also improves our consent process as it can be offered alongside local anaesthetic and GA. We are currently using this technique in both paediatric and adult cases, and have so far received excellent feedback.

Z. Yasen, Manchester, UK

Reference

1. Scottish Dental Clinical Effectiveness Programme. *Conscious sedation in dentistry*. 3rd edition. 2017. Available at: <http://www.sdcep.org.uk/wp-content/uploads/2018/07/SDCEP-Conscious-Sedation-Guidance.pdf> (accessed December 2021).

<https://doi.org/10.1038/s41415-021-3782-5>

Coronavirus

SOP recovery transition

Sir, I refer to the recent publication C1461 issued by the Chief Dental Officer entitled 'Standard operating procedure: transition to recovery (a phased transition for dental practices towards the resumption of the full range of dental provision)'.¹

The document advises that dichotomous division of all clinic attendees into two pathways, respiratory and non-respiratory, should be conducted prior to their management based on the initial screening for COVID-19. Introducing such additional tiers of screening and further confusion, as well as logistical issues, to an already complex problem, rather than administration of simple point of care (POC) antigen screening, is probably questionable. This is particularly the case when rapid, sensitive POC diagnostic tests for COVID-19 are already available which yield results within 60 seconds (*à la* British Airways).² These could be easily administered by the patient himself/herself prior to clinic attendance, particularly if exhibiting respiratory symptoms.

Another point of contention in the new document is the section on 'Staff at increased risk from COVID-19 and other respiratory infections' (pp 11) which

states that 'staff, including Black, Asian and Minority Ethnic (BAME) staff [...] should be risk assessed so that appropriate measures are put in place to minimise exposure to risk and support safe working'. This is a sweeping statement which is pejorative and unlikely to be evidence-based as far as the UK is concerned. Although emerging evidence suggest that the long-term consequences of COVID-19 may be severe for BAME groups, there are no data, to my knowledge, that such minority groups 'as a whole' are a higher COVID-19 infectious risk to the community than non-BAME groups.³

Perhaps these points should be noted for future editions, although the rapidly evolving dynamics of the disease, as we are currently witnessing, may render them open for further debate.

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References

1. NHS England and NHS Improvement. Dental standard operating procedure: Transition to recovery. Version 6. Updated 25 November 2021. Available at: <https://www.england.nhs.uk/coronavirus/publication/dental-standard-operating-procedure-transition-to-recovery/> (accessed December 2021).
2. Samaranyake L, Kinariwala N. Point-of-Care (POC) diagnostics for coronavirus disease 2019 (COVID-19) and their potential impact on dentistry. *Dent Update* 2021; doi: 10.12968/denu.2021.48.7.585.
3. Nafilyan V, Islam N, Mathur R *et al*. Ethnic differences in COVID-19 mortality during the first two waves of the Coronavirus pandemic: a nationwide cohort study of 29 million adults in England. *Eur J Epidemiol* 2021; **36**: 605–617.

<https://doi.org/10.1038/s41415-021-3783-4>

OMFS

Communicating communication

Sir, the risk of oro-antral communication (OAC) arising from maxillary extraction in dental practice is sufficiently remote that neither the symptoms nor signs of fluid and air passing from mouth to nose can be found in post-operative instructions routinely issued in either primary or secondary NHS dental care. However, the risk is not so vanishingly small that patients with OAC or epithelialisation leading to fistula formation (OAF) continue to be referred to dental school oral surgery departments in significant numbers.¹

Notwithstanding the recognised OAC risks of advanced age, aberrant anatomy and antral proximity of roots, following lockdown, the transitional return to safe

practice carries additional risks for patients of: poor oral hygiene, chronic sinusitis and respiratory-tract infections, coupled with operator risks of skill-fade acquired from inactivity during COVID-19 closure. Undoubtedly, these increase the overall risk for OAC and OAF.

In the absence of post-operative OAC information, a telephone survey requesting post-operative advice from the 18 UK dental school oral surgery departments resulted in:

- Ten departments categorically refusing to give telephone advice (one refusal took 24 hours)
- From such refusals, one department transferred the call to an NHS medical advice line that confidently but incorrectly stated there was no communication risk from extraction
- Eight departments provided advice: four dental nurses (one male) and four female dentists delivered advice that was accurately supportive and reassured: emergency attendance if necessary
- In contrast to ten cold refusals, the sensitive, warm and empathic responses from those dental nurses and dentists taking their time (an average of eight minutes to respond) were incredibly touching, especially given their ages, range of experiences, qualifications and work pressure
- For either refusal or advice, there was no variation across the UK nations or London (with its three dental schools).

While both the significance and seriousness of OAC could engage the materiality in Montgomery, consent according to Mulholland is not an abstract exercise; it is formed within a clinical context.² However, if post-operative instructions fail to document the signs and symptoms of OAC, it may be difficult to prove consent (while actually obtained) was then effectively maintained. From these findings, during the transitional return to NHS dental practice, reliance on communication into the safety net of secondary care cannot be uniformly assured across the UK.

Regrettably, even with such communication failure, there is no regulatory disinclination from the GDC to draw adverse conclusions into the clinical conduct causing communication.