COMMENT

Letters to the editor

Send your letters to the Editor, *British Dental Journal*, 64 Wimpole Street, London, W1G 8YS. Email bdj@bda.org. Priority will be given to letters less than 500 words long. Authors must sign the letter, which may be edited for reasons of space.

OMFS

Further fillers

Sir, I read with interest the recent correspondence published in the *BDJ* entitled 'Filler failure' by Y. Lin.¹

The duration of onset of complications plays an important role in deciding a patient's management as detailed in expert consensus recommendations as below.² While usually a complication with an early onset, bruising may also present as a persistence of staining. A cosmetically offensive purpura or one which is large in its dimensions may be treated with vascular lasers in order to hasten recovery.

For patients on anticoagulants, if the treatment is well balanced, the risk of discontinuation outweighs that of bleeding. It is also recommended that patients do not undertake strenuous forms of exercise for the first 24 hours after filler insertion in order to reduce the bleeding risk.

Angioedema which typically presents as an early-onset complication may be observed as a late or delayed complication if the episode lasts for more than six weeks. A stepped therapeutic approach is followed in such cases owing to their variable response to treatment, with such cases being regarded as difficult to treat. Oral steroids in their smallest effective dose may be utilised to control oedema. Additional therapeutic choices encompass immunosuppressants and intra-lesional/topical steroids.

Delayed type of hypersensitivity reactions generally present a day after the injection; however, these may be observed even several weeks to many months post-injection. Antihistaminics are ineffective in such situations. Allergen removal is the best approach in such cases. If hyaluronic acid was used, then hyaluronidase treatment is the recommended modality. Other types of fillers may necessitate steroid treatment up

until the resorption of the filler. Extrusion and/or treatment with lasers may also be employed with excision being kept as the last resort for therapy.

Malar oedema is particularly serious, long-lasting and exhibits a poor response to treatment. Therapy encompasses cold compression, elevation of the patient's head, drainage of lymphatics, daily multiple manual compressions and steroids (methylprednisolone). If hyaluronic acid was utilised, then therapy involves treatment with hyaluronidase.

V. Sahni, New Delhi, India

References

1. Lin Y. Filler failure. *Br Dent J* 2021; **231**: 533–534.
2. Urdiales-Gálvez F, Delgado N E, Figueiredo V *et al.* Treatment of soft tissue filler complications: Expert consensus recommendations. *Aesthetic Plast Surg* 2018; **42**: 498–510.

<https://doi.org/10.1038/s41415-022-3884-8>

Emergency dentistry

No automated summary for GDPs?

Sir, I write as a doctor working within emergency medicine with the hope of starting a discussion between dentists and the emergency department (ED). In the scope of my work, I frequently see patients presenting with dental complaints; most commonly, this is pain or swelling. Often, they have self-presented, but may also be referred in by 111 or, occasionally, their own dentist.

With a medical patient, I have easy access to their past medical history, any recent investigations or treatments, and any current medications they are prescribed. I also have a way to communicate my findings and actions back to their GP to enable continuity of this care. With dental patients, I have none of this information. If someone has seen their dentist recently, I am left to rely on the patient's recollection

of the appointment, their understanding of those events or treatments, and names of antibiotics that may already have been prescribed by their dentist.

Whilst there is a limit to the treatments we can provide for dental complaints within the ED, I presume their dentist would want to know about an attendance. If we perform any investigations or prescribe them medications, this is useful information for anyone continuing their care.

We are used to automated discharge summary letters being sent to GPs, but shouldn't there be a way to send information to their dentist? I have never come across a system for doing this, but would be interested to hear from anyone who has received such communication from a hospital, or suggestions on how we can improve this aspect of patient care.

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Orthodontics

Orthodontic standards

Sir, the apparent questioning of the value of an MSc research degree undertaken as part of the UK specialist training in orthodontics ('Back to the future...' *BDJ* 2021; **231**: 599) will be of great concern to colleagues of my generation.

I obtained my diploma in orthodontics by a hospital-based preceptorship in 1968 as was usual for that time. The D.Orth.RCS Eng diploma had remained unchanged since its introduction in 1954 and in which there was no requirement for the successful candidate to show any evidence that he or she had ever treated an orthodontic case effectively. In 1973, I was fortunate to be able to attend the Third International Orthodontic Conference held at London's South Bank Centre, during which it became obvious to me and my contemporaries that orthodontic