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

treatment standards in the UK had failed to keep pace with advances being made elsewhere in the world and were now viewed by our overseas colleagues as being more appropriate for a developing country. It was only with the introduction of the two-year MSc course in orthodontics of the University of London in the same year, masterminded by Professors Mills and Houston, that things began to slowly change, culminating in the introduction of the three-year MOrthRCS and MDO RCPS programmes in 1988. The provisions of these made it clear that the undertaking of a research component was part of specialty training in orthodontics, as it now is throughout the western world, and many of us sat the new diploma examination voluntarily to show our support for this much-needed raising of UK standards. Finally, following the publication of the Mouatt Report in 1995, which supported the introduction of specialist lists in the UK,¹ an Accord was negotiated by Dame Margaret Seward between the General Dental Council, the Royal Colleges and universities.² This recognised the 'key roles that the faculties, the universities and the specialist societies played in the formulation of curricula and syllabi'.³

While the costs of orthodontic specialty training might now be renegotiated, the present standards and responsibilities must not be compromised.

C. D. Stephens OBE, Bristol, UK

References

1. NHS Executive. *Report of the Chief Dental Officer on UK specialist dental training*. London: HMSO, 1995.
2. General Dental Council. *The accord between the General Dental Council and the dental faculties of the Royal Surgical Colleges and other educational bodies*. London: General Dental Council, 1996.
3. Seward M. *Open wide – Memoir of the Dental Dame*. pp 175. Durham: The Memoire Club, 2002.

<https://doi.org/10.1038/s41415-022-3890-x>

Health research

Satisficing and bots

Sir, online recruitment is expanding in health research with sources for possible study volunteers including classified ads, search engine ads, survey panels, crowdsourced online labour markets and social media platforms. Social media recruitment is increasingly popular as most adults use it and rates exceed 60% in practically every sociodemographic category.¹ Secondly, social media sites allow

researchers to tailor adverts to those who are likely to meet study eligibility criteria. Thirdly, the practical and ethical issues of social media recruitment for health research is extensively defined.

However, studies using such recruitment have the same challenges as other online research approaches. Duplicate enrolment, automated enrolment by software applications known as bots, random responses and satisficing all threaten sample validity and data integrity. In a survey, responses can be chosen at random by tapping a random, rather than the appropriate, key. Even a small number of random responses can skew results. Bots (aka automated form fillers) are computer programs that randomly fill up web forms. Satisficing, on the other hand, is a method of reducing cognitive burden by skimming instructions and inquiries. Participants who satisfice choose answers that would seem to fit the question, or respond randomly.

A cross-sectional descriptive study using a web-based survey recruited volunteers via email and Facebook.² Analysis showed that about 60% of completed surveys were fraudulent, underscoring the importance of addressing sample validity and data integrity in social media-based health research.

Open-ended questions are excellent for spotting satisficing, inattention and, most crucially, bots, as is attention to incomprehensible responses or replies made up entirely of random characters. Attention checks are used to assess a participant's comprehension of pre-task instructions. While not confirmation of cheating, failing to read instructions may raise suspicion and prompt a closer look at the participant's data. During the survey, random questions on the survey's objectives may be asked to ensure the participant's comprehension.

Participants finishing a survey in an unusually short period of time may have satisficed or offered random replies, while in a knowledge-based activity, if they have taken longer than expected, they may have studied the answers rather than basing them on their present knowledge. To keep bots out of a study, incorporating a cognitive challenge as a pre-screen condition that must be passed before moving on to the main study may be a good idea. reCAPTCHA is the most widely used way for completing these tasks online.

Combining some of these strategies and techniques may assist to reduce satisficing and random human and bot responses.

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References

1. Pew Research Center. *Social Media Fact Sheet*. Washington: Pew Internet and American Life Project, 2019. Available at: <https://www.pewresearch.org/internet/fact-sheet/social-media/> (accessed June 2021).
2. Dewitt J, Capistrant B, Kohli N *et al*. Addressing participant validity in a small internet health survey (the Restore Study): protocol and recommendations for survey response validation. *JMIR Res Protoc* 2018; doi: 10.2196/resprot.7655.
<https://doi.org/10.1038/s41415-022-3891-9>

Hospital dentistry

Integration with medicine needed

Sir, in 2015, the Brazilian Federal Council of Dentistry first recognised the practice of hospital dentistry as an official qualification.¹ One of the main intentions of this qualification was the provision of regular hospital dental care on an outpatient basis, to systemically compromised patients, including (for example) patients with cancer or haematological disorders. In addition, work in intensive care units (ICUs) is indicated within the qualification's remit, given the widely accepted evidence of a reduction in cases of hospital-acquired pneumonia in patients supported by dental teams in this environment. During the pandemic, the work of dental teams in ICUs has proven essential for the proper holistic management of severe COVID-19 cases, most pertinently those requiring mechanical ventilation.^{2,3}

However, specialties with specific attributes relevant to this qualification are not routinely offered as part of the undergraduate dental curriculum in Brazil. In addition, there is a worrying lack of knowledge amongst most medically trained professionals about the benefits of the work dentists can and should undertake as part of the multidisciplinary hospital team. Combined, the above currently results in low interaction between doctors and dentists,⁴ leading to less favourable outcomes for patients.

In light of this mismatch, urgent measures to modernise the curriculum of undergraduate dentistry courses are required. The inclusion of an appreciation for, and exposure to, specialties such as