cross the placenta and systemic levels after cutaneous injections are extremely low.³ As a caution, BT injected into patients with neuromuscular or neurological disorders (eg myasthenia gravis) can result in severe muscle weakness.

With regards to drug interactions, antibiotics – through their blockade effect at the neuromuscular junction – gentamycin, amikacin, tobramycin and neomycin may result in exaggerated effects of botulinum toxin. Acetylcholinesterase inhibitors, prescribed for patients with myasthenia gravis, act as toxin antagonists and therefore may reduce the effect of botulinum toxin (common medication includes pyridostigmine). Aminoquinoline: these antimalaria medications have a negative effect on acetylcholine and therefore reduce nerve excitation. The result is that it has the potential to magnify the effect of BT. Cyclosporin: through an unknown mechanism, cyclosporin may potentiate the effects of BT.

Side effects can include:

- Keloid scar at injection site
- Ptosis – if an injection is too close to the eyebrow, toxin solution may diffuse to the levator muscles of upper eyelid causing obvious weakness
- Dysphagia – if injection given to major salivary gland or to the sternocleidomastoid muscle. Diffusion of toxin into surrounding muscles can cause this issue⁴
- Respiratory embarrassment – injections into both submandibular glands for excessive hypersalivation may result in toxin solution extruding out of the gland capsule and into surrounding muscles involved with breathing⁴
- Facial weakness – caused by diffusion of toxin to facial nerve branches, in particular when injected into the masseter muscle
- Pain, bleeding, swelling, bruising, infection
- Headache
- Paraesthesia
- Aesthetic disenchantment.

The vast majority of BT injections in this region are safe but a full patient assessment and thorough medical history is essential. Risks must be clearly explained and documented in the medical notes.

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Safeguarding

Continuing vulnerability awareness

Sir, I was assured and saddened to see safeguarding being highlighted once again within the *BDJ*. I would like to thank Mrs Harris for her expert opinion¹ based on the important recent research published by Tuthill *et al.*² into child safeguarding. The role dental teams play in safeguarding is key now, perhaps more than ever.

The National Society for the Prevention of Cruelty to Children published a document regarding child welfare and the pandemic in June 2020.³ Within this document, they conclude that 'the combined impact of increased stressors on caregivers, increased child vulnerability, and reduced safeguards increases the potential for new and recurring cases of abuse in all its forms.' This view was supported by the Children's Commissioner, National Crime Agency and the Children's Society.

Childline subsequently reported record numbers of phone calls,⁴ with the top concerns reported to their helpline being:

- Adult health and behaviour (including worries about parental alcohol and substance misuse, domestic abuse and parental mental health), which increased 42%

- Neglect, which increased 15%
- Physical abuse, which increased 18%
- Emotional abuse, which increased 40%.

As dental services return to a new normal, it is essential that we understand our responsibilities. It may be that we are the first external party, aside from the education sector, to engage with a child or young person since the onset of the pandemic. Principle 8 of the GDC *Standards* document⁵ states we have a responsibility to raise concerns when patients are at risk of abuse and neglect and know how to manage these circumstances.

I would implore and encourage my colleagues to continue to utilise excellent guidance⁶ we have in our possession. Support is available from local safeguarding teams, paediatric dentistry departments, social services and medical colleagues. All of the aforementioned is imperative to protect our paediatric dental patients from harm – particularly as it may be that we are encountering them at their most vulnerable.

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