

We would point UK dental professionals to the well-considered public health guidance which basically concludes that, for the best chances of quitting smoking, one should use support and pharmacotherapy and that e-cigarettes can be part of that package. Several recent reviews on this topic are available^{4,5,6} which provide references to guidance documents.

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Dental radiography

The dangers of toy magnets

Sir, a four-year-old child recently attended with their mother regarding the loss of a tooth after a fall from a balance bike a few days previously. The child's mother was worried that the tooth could not be found. On examination, the upper right primary central incisor (51) was missing, the socket was healing and the child was not in any pain.

A periapical radiograph confirmed loss of 51 but showed an unusual radiopacity (Fig. 1). I later recalled receiving from my children's primary school a warning to parents about the risks of swallowing small 'ball magnets'. An anterior occlusal radiograph confirmed that the radiopacity remained *in situ*, and therefore must be a foreign body and not artefactual. I referred the child to hospital, including both radiographic images. They were seen in the Paediatric A&E Department at Royal Manchester Children's Hospital where the foreign bodies were removed in A&E with the help of a head light, crocodile forceps and an angled soft-ended ball probe while the child was held by his mother in an upright position. Resistance was felt while pulling at the foreign bodies, suggesting nasal adhesions or that they were magnetic.

Two ball magnets were retrieved, one from each nostril from either side on the nasal septum. They had been there so long that they had corroded, explaining the irregular appearance of their lateral surfaces on the radiographs. They appeared to have caused a small nasal septal perforation. The child's recovery has been uneventful. Their mother still has no idea when these were inserted into the nose and the child had never displayed any symptoms that might have indicated something was wrong. The mother was grateful for their discovery and removal.

The NHS called for a ban on ball magnets as they have been known to cause severe health problems if ingested. They can pinch intestinal tissues, cutting off the blood supply and tearing tissue. The NHS issued a patient safety alert after around 65 children over a three-year period were admitted for urgent surgery after swallowing magnets.¹ A UK-wide study of 11 major trauma centres found 51% of children admitted following swallowing such magnets required surgery to remove them, with most of these undergoing extensive laparotomies to manage injuries, intestinal perforations and life-threatening bowel twists.²

In our case, the magnets were found fortuitously and might otherwise have been left undetected. It is feasible that, if left, they could have produced a larger septal perforation, or been dislodged and ingested, leading to the severe complications described above.



Fig. 1 A periapical radiograph confirmed loss of 51 but showed an unusual radiopacity

More advice on ball magnet safety can be found at: <http://www.gov.uk/government/news/opss-raises-awareness-on-magnets-safety>.

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Anaesthesia and sedation

Sedation and HIV medication

Sir, as we are aware, many patients are dentally anxious and undergo treatment under intravenous sedation using midazolam. What may be less common knowledge is that numerous drugs used in the management of HIV interact with midazolam.

Curative treatment of HIV with antiretroviral therapy is currently not yet possible; however, drug regimens known as combined antiretroviral therapy aim to reduce morbidity and transmission of disease, whilst increasing survival. A combination of drugs are used, commonly two or three, which are from at least two different drug classes.¹

Classes of drugs used in the management of HIV include:

- Nucleotide reverse transcriptase inhibitors (NRTI)
- Non-nucleotide reverse transcriptase inhibitors (NNRTI)
- Integrase strand transfer inhibitors (INSTI)
- Protease inhibitors (PI)
- Fusion inhibitors (FI)
- Post-attachment inhibitors
- Pharmacokinetic enhancers
- Integrase inhibitors
- CCR5 antagonists.^{1,2}

Saquinavir is a protease inhibitor and a study found that the clearance of intravenous midazolam was reduced by 56% in patients taking this drug. Furthermore, the elimination half-life was increased from 4.1 to 9.5 hours.³ Hence, sedation is

likely to be prolonged. Other medications used in the management of HIV include but are not limited to: ritonavir, atazanavir, fosamprenavir, tipranavir, darunavir, cobicistat, lopinavir and letemovir. These are all listed in the BNF as having severe interactions with midazolam.

It is therefore necessary for both sedationists and referrers to be aware of these interactions in order to be able to accurately advise patients of the safe treatment options available to them. Furthermore, this highlights the importance of checking for drug interactions in the BNF.

Given that these drugs are listed as having severe interactions with midazolam, should we consider referring patients taking them for anaesthetist-led sedation?

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BDJ covers

Questionable cover image

Sir, I was surprised to see an example of destructive and unnecessary dentistry on the front cover of a recent *BDJ* (Volume 232 Issue 10, 27 May 2022). The image showed a colourful scanning electron micrograph of a large coarse-grit diamond bur plunging into an occlusal fissure of what appears to be a relatively sound molar. I am currently in the process of teaching my second year dental students about the principles of minimally invasive dentistry, and how many carious lesions can be remineralised

through reducing risk factors, fluoride therapy and perhaps fissure sealants. Picking up the handpiece is normally only recommended for lesions which are active, cavitated and non-cleansable. This image represents an outdated philosophy, still rife within our profession, which leads to harmful destruction of tooth tissue and perpetuates the 'restorative cycle'. Let's make sure the cover of this prestigious journal is representative of the evidence-based content within.

P. Wilson, Cardiff, UK

The Editor-in-Chief replies: I thank Dr Wilson for his comments on this cover image. As he correctly observes, this is a photograph taken from an SEM. As such, it has been created out of the mouth and so we can reassure readers that no teeth entered the restorative cycle as a result of this image. His point is well-made nonetheless, but the journal has repeatedly promoted MID in recent years including three themed issues which I am sure Dr Wilson will have devoured and to which I hope he will repeatedly refer his students.

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Diversity and inclusion

Not an excuse

Sir, I read with interest the letter from Ms Dewshi¹ in which she relates an incident where a male patient asked her if she is strong enough to remove his tooth. I similarly noted the letter next to it, which referred to the new female BAOMS Council members and reflected on the great progress women have made in dentistry.²

Firstly, I would like to supportively observe to Ms Dewshi that in my nearly 40 years of dental experience, a smallish (albeit memorable) proportion of patients can say very questionable things as they sit down in one's chair. These comments can

range from the crassly inappropriate to the jaw-droppingly aggressive and all shades between.

The dental chair can be a very difficult place to sit for very many people and as a result they can sometimes thoughtlessly and inadvertently show the worst of themselves while they are sitting there; totally scared stiff/not looking forward to paying a large bill/cross because the receptionist has been rude/needing the loo etc. It could be that the macho man who offended Ms Dewshi was simply scared stiff of undergoing an extraction and just too 'male' to admit it. I put that forward as a possible explanation not an excuse.

What would I have done in her position? After some thought, I would have booked him a free short review appointment a week later to check healing and get his feedback on the procedure. Then I would explain why I had found his comment inappropriate, asked him his view and then asked him if he wanted to say anything to give me the confidence to retain him as my patient. No doubt the GDC would have a view on that approach.

Secondly, I would also like to add my observation (garnished with my fervent hope) that more female influence in UK OMFS departments will help dilute the noticeable amounts of toxic arrogance and high clinical self-regard present in too many of these male-dominated arenas. Maybe the high levels of clinical acumen backed up with empathy, sympathy and (dare I say it?) some kindness, brought in by more women will improve the care in OMFS departments up and down the country?

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