COMMENT

Letters to the editor

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OMFS

A learning experience in acquired haemophilia

Sir, I read the case report on acquired haemophilia and dental extractions with interest.[1]

In many years of practice, I encountered one patient with acquired haemophilia. Twenty years ago, it was a learning experience in the importance of clear communication with our medical colleagues.

An edentulous patient was referred for care complaining of a very sore mouth. His first words to me were 'I bet you've never heard of the illness I've got'. He had acquired haemophilia and was correct – I had never heard of it! His treatment included high doses of steroids and on examination his entire oral mucosa had a thick coating of thrush. It was not surprising he had a sore mouth.

After advising on local measures, I decided to treat the condition with fluconazole. I telephoned the patient's consultant haematologist to ensure this would be safe and effective. After reassuring him it was not necessary for the patient to attend the hospital unit for this treatment (a round trip of 120 miles), we agreed I would provide care unless the condition worsened or did not respond to treatment.

He agreed that fluconazole was appropriate and outlined the necessary dose/duration. When I came to write the prescription I realised the suggested dose was four times the usual as recommended in the Dental Practitioners Formulary at that time. Thinking I'd made a mistake, I phoned the consultant again to check. Somewhat bemused, he explained it was not uncommon for these patients to receive very large doses of medication and his original advice was correct. He reinforced the need to counsel the patient on possible side effects of fluconazole and treatment commenced. The consultant and I agreed it was a possible near miss with risk of either overdose, or sub-optimal dose which both our teams could use as a learning experience.

After three days, the patient's mouth was more comfortable and after five days the thrush had almost completely resolved. As noted in the article, acquired haemophilia has a high mortality and the patient passed away a few months later.

E. Howells, Caerbryn, UK

References

1. Zhou Z M, Mumtaz S, Jefferies C. Acquired haemophilia and dental extractions – a cautionary tale. *Br Dent J* 2023; **234:** 747.

https://doi.org/10.1038/s41415-023-6164-3

Leadership

Honesty, trust and integrity

Sir, I was interested to read the three contributions on leadership in the latest *BDJ* issue.[1,2,3]

I was somewhat disappointed these authors do not first define leadership in clinical/practice and professional/national settings as they are very different!

While many qualities of leadership were mentioned, there was no mention of those personal qualities that cannot be taught. I was thinking of honesty, trust and integrity – all of which must be prerequisites for any leadership role. Integrity can take years of effort but be lost in seconds!

The strength of having one's own practice with a loyal patient base, gave me the ability in my days to call out unfairness and injustice, even in those that wielded power or were in authority, for the very reason that I was not dependent on them for my pay, promotion or pension!

What about leadership by example? We must beware: our young colleagues are watching (just as our children did). True leaders should be resilient and have the mental and physical stamina to stay the course. They should also be able to put their hands up and accept their mistakes, no matter how uncomfortable.

The primary quality of any leader in any sector at any level, must surely be trust? I am deeply concerned after 50 years in dentistry that trust between colleagues and indeed between the profession and the public/patients is being eroded rapidly. If this continues, it will indeed make it difficult for future generations to regain it.

I rest my case.

R. Ladwa, Ealing, UK

References

1. Pal A. Leadership in dentistry – a personal perspective. *Br Dent J* 2023; **234:** 921.
2. Wong J. Perspectives on leadership. *Br Dent J* 2023; **234:** 920.
3. Gambold S. Leadership in dentistry. *Br Dent J* 2023; **234:** 922.

https://doi.org/10.1038/s41415-023-6163-4

Orthodontics

Expansive advice

Sir, it is news to me that 'it is only within the last few years that some American orthodontists have started to recommend expansion.'[1] I was taught how to expand a dental arch (transverse, anterior and posterior expansion) to correct a malocclusion, when I started as a postgraduate orthodontic trainee in 1991. I continued to use expansion in clinical practice, whenever I considered it appropriate for an individual patient. I was also taught, and regularly treated, young people using functional appliances and without requesting removal of premolars. Although I believed and explained to the young people and their parents that orthodontic treatment could straighten the teeth, improve their smile and improve their social wellbeing, I never claimed that, using these techniques, I could consistently and significantly change their skeletal pattern or cure them of breathing difficulties, temporomandibular

disorders, wetting the bed or a number of other conditions, which it has been suggested malocclusion can cause.

P. Benson, Hathersage, UK

References

1. Mew J, Trenouth M. What does the Dentists Act say about orthodontic treatment choice? *Br Dent J* 2023; **234:** 727–729.

https://doi.org/10.1038/s41415-023-6167-0

RETRACTED ARTICLE: A threat to scientific integrity

On 11 August 2023, the *British Dental Journal* published a letter online and in hardcopy, entitled 'A threat to scientific integrity'. We hereby retract the article because legal concerns were raised to the Publisher. The *British Dental Journal* takes no position with respect to the contents of this letter and this retraction is in agreement with the author of this letter. This letter has been removed from the online version of the *British Dental Journal*.

Oral health

SDF in radiation-induced caries

Sir, following the paper by Goh *et al.*,[1] we would like to suggest that silver diamine fluoride (SDF) application before undergoing radiotherapy can be beneficial in preventing radiation-induced dental caries.

Radiation-induced dental caries is a complex disease, which differs from conventional dental caries because of its capacity to rapidly compromise dentine, its sudden progression and effects on surfaces like tips of the cusps and smooth surfaces that are not usually affected by caries.[2] SDF was found to be more effective in radiation-induced caries because it hinders dentine collagen degradation by forming CaF_2, Ag_3PO_4, and NH_4OH, which interacts with dentine hydroxyapatite, forming fluroapatite and leading to an acid-resistant environment. Studies have reported that SDF will prevent the formation of root caries.[2,3]

Considering the prevalence of head and neck carcinoma and the side effects of radiotherapy, it is advised to prevent the formation of dental caries and in turn improve the quality of life of the patients. SDF application prior to radiotherapy not only prevents the formation of new caries but also arrests the old caries' progression, especially from the interdental and root surfaces where access will be limited to diagnosis and for restorative treatment.

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References

1. Goh E, Beech N, Johnson N *et al.* The dental management of patients irradiated for head and neck cancer. *Br Dent J* 2023; **234:** 800–804.
2. de Souza B M, Silva M S, Braga A S *et al.* Protective effect of titanium tetrafluoride and silver diamine fluoride on radiation-induced dentin caries in vitro. *Sci Rep* 2021; doi: 10.1038/s41598-021-85748-8.
3. Hiraishi N, Sayed M, Takahashi M, Nikaido T, Tagami J. Clinical and primary evidence of silver diamine fluoride on root caries management. *Jpn Dent Sci Rev* 2022; doi: 10.1016/j.jdsr.2021.11.002.

https://doi.org/10.1038/s41415-023-6168-z

Risk literacy

Increasing awareness of risk literacy

Sir, risk literacy refers to 'the ability to accurately interpret and act on information about risk'.[1] A systematic review[2] of clinicians' expectations of benefits and harms of treatments, screening, and tests found 'clinicians more often underestimated rather than overestimated harms and overestimated rather than underestimated benefits'. The importance of risk literacy in medical decision-making[3] has been recognised.

Risk literacy may also be of concern for dentists as seen in the following instance. An expert consensus panel[4] recommended proximal carious lesions confined to enamel did not require restorative intervention. Some dentists[5] determine need for restorations for proximal carious lesions confined to enamel of permanent teeth even in individuals with low caries activity. Risk literacy is one