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RUNNING PAIN

Sir, I am writing to draw readers' attention to an interesting phenomenon I have noticed following participation in ultrarunning events. Ultrarunning is a sport of increasing popularity which involves running any distance beyond the marathon which in some cases may be further than 100 miles. I have found that I will predictably have a painful soft palate for about two days following participation in such an event, with a minimum duration of 8-9 hours of running apparently necessary to provoke it. This pain occurs when swallowing only and appears to be related to the period of contact of the posterior tongue with the soft palate. It is intense enough to limit solid food deglutition to two or three cycles before it becomes unbearable, precisely at the time when eating is both necessary and greatly desired! During this two-day period the mucosa in that area seems to have a normal appearance. Fluids thankfully do not pose a problem and the symptom does not last more than 48 hours.

I believe the most likely explanation for this is a prolonged drying effect on the mucosa of the soft palate that may take place during these very long events. However, I do not know any other competitors who have experienced this and cannot find any mention of this symptom in the subject literature. Ultrarunning would therefore seem to be an unusual cause of palatal pain which has apparently not been previously reported.

B. Steel
Hull

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A POOR GRASP

Sir, regarding Mr Mew's latest letter (*Malocclusion challenge*; *BDJ* 2010; **208**: 197) he, yet again, demonstrates that he has not quite grasped the problem that other professionals have with his assertions. It is impossible to prove or test his hypothesis (or any hypothesis) with the

debate that he asks for; what is needed is some form of experiment. Since orthotropics is apparently no different from functional appliance treatment, which has been shown not to grow mandibles beyond normal growth, then it would appear safe to assume neither does orthotropics. For Mr Mew's argument to hold water he needs to demonstrate, firstly, that orthotropics is an altogether different therapy from functional appliance treatment.

The advert that he has in the back of the *BDJ* shows a case that any orthodontist will have had similar success with, without invoking orthotropics. I know I have. With such a case the evidence suggests that success is dependent on normal mandibular growth and not on the brilliance of the therapy. Maybe Mr Mew is unaware that we can all get such a good result in some cases and show similar photos.

A. Pearson
By email

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DEPRIVATION MEASURES

Sir, I very much welcome the publication of *What is the effectiveness of alternative approaches for increasing dental attendance by poor families or families from deprived areas?* (*BDJ* 2010; **208**: 167-171). This important piece of research is essential for the future planning of dental services to meet the needs of the population both now and in the future, when increasingly primary dental disease will be concentrated in the most socially deprived and excluded sections of the population.

I was, however, concerned to see that in the paper it described children as having a high index of multiple deprivation (IMD). This demonstrates a misunderstanding of what the IMD is. The index of multiple deprivation¹ is an area measure of deprivation, not an individual measure of deprivation, such as the Registrar General's index of social class.

It is thus not possible to say that just because an individual lives in an area, where the overall population has a set of characteristics which give it a high deprivation score, that that individual is necessarily from a deprived background.

I trust that the authors of this paper find this observation useful.

D. P. Landes, Durham

1. Noble M, Wright G, Dibben C, Smith G A N et al. *The English indices of deprivation 2004*. London: Office of the Deputy Prime Minister, 2004.

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DENTAL STATUS

Sir, I viewed with considerable interest the short *BDJ* CPD paper *Dental implant failure associated with a residual maxillary cyst* (*BDJ* 2010; **208**: 153-154) and note that it made no reference to the following (probable) findings in the OPG report:

- Periodontal summary: generalised moderate-severe attachment loss
- Query the following at the teeth listed:
 - 17 probable lateral perforation with overfill of the perforation; probable apical radiolucencies, poor mesial fit of crown, under-filled root canals, probable periodontal furcation involvement
 - 15 short posts
 - 14 short posts, probable mesial overhang
 - 13 probable distal caries
 - 11 short post, probable apical radiolucency
 - 23 probable apical ligament widening, probable deep extension of wing/restoration onto root
 - 34 abutment defective margin, no post
 - 26(?27) probable short root treatment - distal canal; query sealer in sinus area, probable periodontal furcation involvement
 - 37 defective restoration, radiolucency mesial root, probable periodontal furcation involvement
 - 36 heavy overhang radiolucencies both roots
 - 34 defective distal restoration
 - 32 apical radiolucency
 - 44 short posts, distal overhang
 - 47 area implant, probable osseointegration failure.

Was the patient fully aware of his dental status, as indicated by the OPG, prior to examination, and if not was he advised of relevant findings by the referral centre?

P. Mc Crory
Radcliffe

Dr Stefano Sivoletta, the leading author of the article, responds: We are very grateful to Dr Mc Crory for his question, which is an indication of his interest in the case we reported. One of the reviewers had raised the same point. In actual fact, as explained in the article (differential diagnosis), 'the general dental condition observed in the panoramic film could suggest a diagnosis of residual inflammatory cyst'. We might add a few comments: 1. The case described in our report was referred to us for the purposes of managing the late implant-related complication, ie the penetration of the implant in a cavity. So, at the time of the treatment, the treatment of the cyst and the removal of the implant took priority. 2. After the treatment at our maxillofacial clinic, the patient's condition was monitored routinely. 3. The patient was warned about his poor state of general dental health and urged to see his own dentist to arrange for the necessary conservative, endodontic and prosthetic treatments.

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DISCONTINUATION CONCERN

Sir, as this issue has already been raised in the *BDJ*, you may wish to publish the letter I received from the European Vice President and General Manager (UK) of Bristol-Myers Squibb Pharmaceuticals Limited (BMS), Frédéric Duchesne. Mr Duchesne has given his permission for this.

This was in response to a letter that Christine Randall and I sent on 7 December 2009 expressing our concerns about the discontinuation of this topical steroid agent.

E. A. Field
Liverpool

Dear Dr Field and Ms Randall, I would like to follow up on the letter I sent you on 22 December 2009 concerning the discontinuation of Adcortyl in Orabase, replying to the letter you have addressed to our Chairman and CEO, James Cornelius. I understand your concerns and disappointment that BMS has made the decision to discontinue the manufacture of Adcortyl in Orabase, and the impact this is having on patients' care. When discontinuing BMS products, we follow a

procedure of informing a number of key stakeholders:

- Our local Regulatory Authorities (MHRA in the UK) - notifications were sent to the MHRA for the 10 g tubes in June 2008 (stock available until February 2009), and in July 2009 for the 5 mg tubes (stock available until September 2009)
- Other key stakeholders (NHS, British National Formulary, MIMS, pharmaceutical journals) were informed of the discontinuation in order to notify their customers - in March 2009 and July 2009 for the 10 g and 5 g tubes respectively
- All doctors, pharmacists and patients who contacted us for information receive a formal response from our Medical Information department, by phone, email or letter.

To address the specific questions that were raised in your letter:

- As this is not a UK only decision but a global decision, we are not considering restarting production, and we will not be able to find any alternative source of supply within BMS
- We have been approached by a few companies which are interested in manufacturing and selling Adcortyl in Orabase. This is being handled by our divestiture team in the US. However, I cannot commit that this will move on positively, and I cannot commit any timing for this to happen. I have requested the divestiture team to keep us up to date on the progress they are making.

We have checked if similar products were still available outside of the UK, and we have found that the company Sigma in Australia/NZ and the company Taro in USA/Canada have products that are similar to Adcortyl in Orabase.

We understand that IDIS may be in a position to supply these similar products on a named patient basis. IDIS contact details are as follows: International Headquarters, Idis, Idis House, Churchfield Road, Weybridge, KT13 8DB.

Again, I understand your concerns, and I hope that this letter is addressing your specific request. Do not hesitate to contact me again if you need further information.

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