Letters to the Editor

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BAD PINT

Sir, plants have been used through the ages to treat illness. For example, chewing willow bark to relieve headaches was prescribed as long ago as 400 BC by Hippocrates. Some plants, such as monkshood (*Aconitum napellus*) and foxglove (*Digitalis lanata*), are extremely toxic, yet at the right dose still have medicinal uses. Irritant plants can lead to dramatic effects if consumed. Stinging nettles (*Urtica dioica*), for example, need to be properly prepared for them to be edible.

Cuckoo pint (*Arum maculatum*) is highly irritating to oral/oesophageal mucosa and, if ingested, can cause swelling of the tongue and throat, leading to difficulty swallowing and breathing. In North Lancashire/South Cumbria, two cases of mistaken identity between the cuckoo pint and wild garlic have led patients to seek medical attention in the last year.

The first case involved a 54-year-old male who, whilst out walking in the countryside in early January, sampled what he thought was 'wild garlic'. Intense burning pain forced him to spit out the stalk immediately and blisters formed on his lips which lasted for some two weeks. Fortunately, this patient had tested it on his lip before attempting to put it into his mouth thus avoiding more severe consequences. Details of this case were shared with colleagues at the local maxillofacial unit so, when a second case occurred a few weeks later, diagnosis was straightforward.

The second patient presented for emergency treatment at Furness General Hospital having eaten a curry made from 'wild garlic'. In this case, severe burning pain in the oesophagus was experienced. It was quickly established that she too had mistaken cuckoo pint for wild garlic.

During January and February, in this part of the country, both cuckoo pint and wild garlic have glossy green foliage which grows on short stalks. By April, the two plants look completely different and the risk of mistaken identity is much reduced. We hope that publication of our letter at this time of year may help colleagues should further patients present with similar symptoms over the next few months.

W. Thompson, by email

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PARENTAL COMPETENCE

Sir, we would like to expand on J. Winston's query about whether there is a the need to give additional warnings of choking hazard during a patient's initial period of adaptation to fixed appliances.[1] It is fortunate that J. Winston's prompt actions managed to clear the Malteser from his daughter's airway. However, he reported that his daughter 'had been sucking a Malteser for comfort and played with it at the back of her mouth to avoid contacting the hypersensitive molars, when it slipped back'. Patients are expected to experience mild discomfort with fixed appliances, especially following an archwire change. This is expected to peak in the first 24 hours with a gradual decrease to negligible levels after three days.[2] This discomfort is usually classified as immediate (following a clinical manipulation of the appliances) and delayed (due to tooth movement).[3] The activity of sucking a Malteser is unlikely to provide adequate oral comfort nor justifiable as a habit to improve patients' experience of pain caused by fixed orthodontic appliances. A study has found that complaints of fixed appliances included altered speech and swallowing[4] and it would be wise to warn patients regarding this. Fixed orthodontic appliances are not known to inhibit the function of the soft tissues during the oral phase of swallowing or the gag reflex. In this case the unusual activity with the Malteser would have put the airway at risk, whether fixed appliances were present or otherwise. In our combined orthodontic experience this is a very unusual case, but serves to highlight the importance of parents being competent in basic first aid.

Further information for patients about fixed appliances can be found at: http://www.bos.org.uk/index/patientinformationleaflets/fixedappliances.

H. Jeremiah, S. Abela, A. Hunter, by email

1. Winston J. Malteser compromise. *Br Dent J* 2012; **213:** 197.
2. Erdinc A M, Dincer B. Perception of pain during orthodontic treatment with fixed appliances. *Eur J Orthod* 2004; **26:** 79-85.
3. Bertl M H, Onodera K, Celar A G. A prospective randomized split-mouth study on pain experience during chairside archwire manipulation in self-ligating and conventional brackets. *Angle Orthod* 24 July 2012 [Epub ahead of print].
4. Sergl H G, Klages U, Zentner A. Functional and social discomfort during orthodontic treatment – effects on compliance and prediction of patients' adaptation by personality variables. *Eur J Orthod* 2000; **22:** 307–315.

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SHARE NOT JUDGE

Sir, this brief report highlights gum erosion as a result of lip piercing. This complication is not uncommon but, to many who perform and wear oral piercings, it is not common knowledge. I hope to use this case to stress an awareness of body piercing and its complications, and ensure we are equipped to advise patients.

This example is of a 30-year-old female with multiple body piercings