Letters to the Editor

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Priority will be given to letters less than 500 words long. Authors must sign the letter, which may be edited for reasons of space.

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RADIOTHERAPY INDUCED MALIGNANCIES

Sir, I was interested to read an article regarding *The oral management of patients who have received radiotherapy to the head and neck region* (*BDJ* 2013; **214:** 387–393). Radiotherapy is a common treatment modality for head and neck cancers and it is important for dental professionals to be able to recognise the many side effects of radiotherapy.[1]

Working as a dentist in a head and neck oncology department, I think it is also important that patients and healthcare professionals are not only reminded of the fact that cancer patients are generally at a greater risk of developing secondary primary malignancies, but are also aware of the rare but serious risk of developing a secondary malignancy as a result of radiotherapy treatment, due to the mutagenic effects it may cause.

Head and neck radiotherapy induced malignancies (RIM) tend to have a long latency period and can present as swellings or masses which may be mistaken for dental pathology. Research has shown that radiation-induced head and neck sarcomas tend to be detected quite late resulting in poor long term prognosis. They can then be even more challenging to treat especially as radical surgery is sometimes required in a pre-irradiated site and in close proximity to important structures.[2] This reinforces the importance of cancer screening and early referrals when abnormalities are detected.

The incidence of RIM are only likely to increase due to progressive ageing of the population and the increased survival of head and neck cancer patients due to better treatment regimes.

K. Amin, London

1. Ray-Chaudhuri A, Shah K, Porter R J. The oral management of patients who have received radiotherapy to the head and neck region. *Br Dent J* 2013; **214:** 387–393.
2. Patel S G, See A C, Williamson P A, Archer D J, Evans P H. Radiation induced sarcoma of the head and neck. *Head Neck* 1999; **21:** 346–354.

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LACK OF TMJ KNOWLEDGE

Sir, we have recently conducted a survey on the current status of knowledge of TMJ amongst UK GDPs which illustrates that basic history taking of temporomandibular joint dysfunction is not well understood.

An online survey tool was emailed to 150 newly qualified GDPs to which 142 responded. The survey contained the following questions:

1. Are you comfortable taking TMJ history?
2. Do you know the pre-existing factors that are relevant to TMJ pathology?
3. Are you comfortable in examination of TMJ?
4. Do you make splints for your TMJ patients?
5. What type of splint do you make for your patient if one is fabricated?
6. Do you prescribe jaw exercises for your patients?
7. How long do you treat a patient conservatively prior to referring to secondary care?
8. Have you heard of Wilkes Clinical Score of staging for TMJ pathology?
9. Do you know about the following surgical treatments for TMJ? Highlight Arthroscopic Lysis and Lavage, meniscopexy, eminectomy, discectomy, condylar shave, TMJ replacement (Fig. 1)
10. Do you think you would benefit from additional/refresher TMJ teaching?

Almost half (46.8%) the respondents were not comfortable with taking a TMJ history and over half (56.6%) were not entirely comfortable with examination of the TMJ. There was varied fabrication of different types of splints to treat TMJ symptoms. A recent Cochrane analysis[1] again showed that no one bite splint is superior to others which suggests that more time-consuming repositioning or stabilisation splints should not be used in the first instance, with the simple lower soft splint providing a good

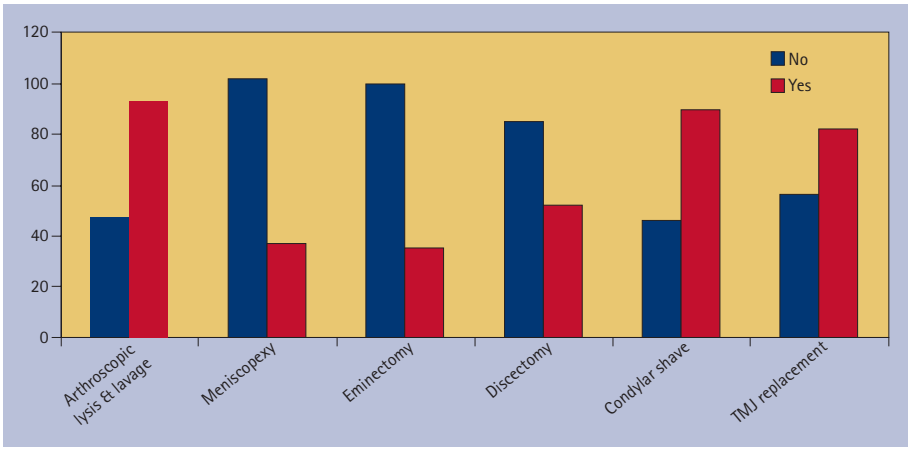

Fig. 1 Do you know about the following surgical treatments for TMJ?

alternative. While 15% of GDPs referred their patients with TMJ problems immediately, 40% referred their patients after 3-6 months, presumably after a period of conservative management which is in line with that which most TMJ surgeons feel is appropriate. The majority of dentists were unclear about the surgical interventions for TMJ dysfunction with nearly half unaware that TMJ replacement existed. Over 90% of GDPs thought that they would benefit from a refresher course.

Patients with TMJ problems, often presenting with varied complaints, are encountered by dental practitioners on a daily basis. It is important to have a sound knowledge and understanding to formulate a treatment plan or to refer when appropriate. These results highlight that TMJ examination, knowledge and pathology is not well understood and they suggest that more training in TMJ pathology at an undergraduate level and during vocational training is warranted.

K. Kassam
Senior Oral & Maxillofacial Specialist Trainee

1. Al-Ani M, Gray R M J, Davies S J, Sloan P, Worthington H V. *Anterior repositioning splint for temporomandibular joint disc displacement.* (Protocol for Cochrane Review). Volume 1. The Cochrane Library, 2003.

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HPV AND THROAT CANCER

Sir, a recent news item in your columns about human papillomavirus (HPV) (*BDJ* 2013; **215:** 270) entitled *HPV linked to a third of throat cancer cases* concluded 'These results could have important implications for early diagnosis and risk assessment, as well as the clinical impact of the HPV vaccine, broadening its protective sphere against not only cervical cancer, but oropharyngeal cancers and others, though further research is needed.'

Readers will be interested to learn that there is published a large study conducted on 5,840 sexually active women in Costa Rica (ages 18-25 years) comparing the effects of an HPV vaccine with placebo, in which, after four years, mouthwash samples showed only one woman after vaccine was orally HPV-infected but 15 women after placebo vaccine were infected.[1]

C. Scully
By email

1. Herrero R, Quint W, Hildesheim A *et al.* Reduced prevalence of oral human papillomavirus (HPV) four years after Bivalent HPV Vaccination in a randomized clinical trial in Costa Rica. *PLoS ONE* 2013; **8:** e68329.

DOI: sj.bdj.2013.1052

FINE CRUSTING BLISTERS

Sir, as junior trainees within the hospital dental system we see a concentrated number of cases referred by dental practitioners to maxillofacial departments as emergencies. The majority are usually infections of dental origin, but at times we do see the weird and wonderful or classic presentations of fairly common oral medicine conditions depicted in oral medicine textbooks. We have always found oral medicine an intriguing topic, but have noticed a number of clinicians once they have entered the realms of practice, lose the penchant for it. It is not only us in the dental profession that have trouble with unusual presentations of certain common pathology but we have noticed our medical counterparts are also guilty.

A recent case was a 76-year-old lady referred to the emergency department by her general medical practitioner complaining of pain and an unusual skin sensation over the left side of her face and eye. The case was referred to us as an acute cellulitis of dental cause as she was treated by her dental practitioner three days prior. An acute periradicular periodontitis was the assumed diagnosis as it appeared that attempts were made by the GDP to extract the lone standing 37. The failed extraction resulted in a broken crown. Intraorally this was asymptomatic at presentation (Fig. 1). The area had marked erythema and swelling along the maxillary distribution of the trigeminal nerve. There was increased periorbital swelling, lacrimal excretions, and fine crusting blisters in the left infra orbital region. She was apyrexic with a CRP of 14 with a normal WBC. She was started on co-amoxiclav by the dental SHO who also did not pick up the diagnosis from her presentation and assumed the working diagnosis as a dental infection. Ward rounds the following morning revealed a textbook clinical picture of V2 shingles demarcation with the blisters and erythema pathognomonic of this disease (Fig. 2). Viral swabs were taken and PCR analysis confirmed this diagnosis. It is through seeing cases like this that the diseases become etched in our memories and remind us of the importance of oral medicine. This is why we plead to our professional colleagues to keep current with their oral medicine.

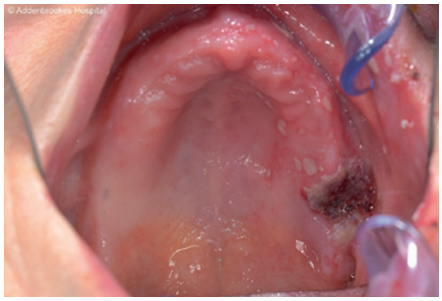

Fig. 1 Intra-oral view

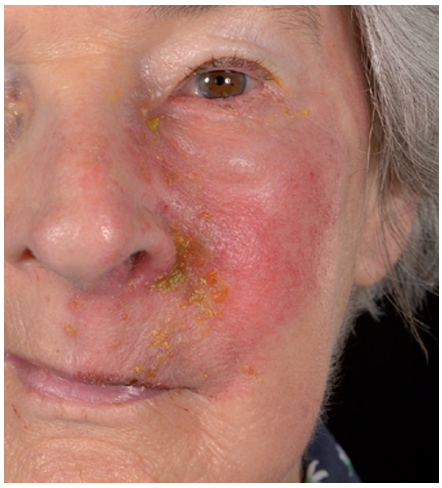

Fig. 2 Patient displayed blisters and erythema

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