Letters to the Editor

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TOOTH IN EYE SURGERY

Sir, osteo-odonto keratoprosthesis (OOKP), also known as 'tooth in eye surgery', is a unique form of artificial cornea surgery to restore the vision of patients with the most severe, end-stage forms of corneal blindness that are not amenable to corneal transplantation or other forms of surgery.

OOKP was first described by Professor Benedetto Strampelli of San Camillo Hospital in Rome in 1963. It involves creating a support for an artificial cornea from the patient's own tooth and the surrounding bone.[1] Later Falcinelli modified the technique in a stepwise fashion and the improved technique was reintroduced into Britain in the mid 1990s using a composite bone-tooth lamina to help anchor a polymethyl methacrylate cylinder to the cornea. This is now known as modified osteo-odonto-keratoprosthesis (MOOKP).[2,3] The Falcinelli OOKP (MOOKP), where adequately performed, is now recognised internationally as giving the best, long-term visual and retention results among all keratoprostheses, especially in a dry eye. The MOOKP procedure is carried out in two stages 4-5 months apart. Each stage lasts 6-8 hours and in a few patients multiple surgeries are required.[2,3]

After intraoral examination and radiography, a tooth is selected (usually single rooted) for use depending on the length and width of the root and surrounding alveolar bone. The tooth to be used must have healthy dentine and buccal tissues. The procedure of extracting the tooth along with alveolar bone still remains technically difficult and requires special training.

The creativity of using a tooth as an eye implant should inspire future interprofessional approaches to ophthalmic practice to provide the best care for patients. OOKP is an example of interdisciplinary patient care in which opthalmologist, dentist, anaesthesiologists and other medical professionals work together in a multi-stage procedure.

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3. Falcinelli G, Barogi G, Caselli M, Colliardod P, Taloni M. Personal changes and innovations in Strampelli's osteo-odonto-keratoprosthesis. *An Inst Barraquet (Barc)* 1999; **29:** 47–48.

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OSTEONECROSIS SNAPSHOT

Sir, it is of great interest to read the full results of the national new patient registration of avascular necrosis of the jaws published by the Faculty of General Dental Practitioners (UK) highlighted in a recent *BDJ* (2012; **213:** 594).

The study summarises the results of the two-year National Survey of avascular necrosis of the jaw referred to secondary care units and is the first report to try to obtain a picture of avascular necrosis and bisphosphonte-related osteonecrosis of the jaw (BRONJ) in the UK. Whilst the merits of this ambitious study are without question, I believe that it is important that practitioners read the report in full and accept the figure of 620 new cases reported in the UK annually as at best a 'rough calculation'.

There is clearly a danger in extrapolating a voluntary registration survey to determine an accurate national disease incidence in the UK. This quoted figure is based on extrapolation of the figures from Merseyside and Northern Ireland to the UK as a whole and numerous population assumptions. Indeed, the authors of the report openly highlight the limitations of the study particularly regarding regional under-reporting as well as practical difficulties in online registration. In addition the 'non-exposed' presentation of BRONJ recently described in the literature would not be included in these figures and perhaps reflects our lack of understanding regarding the full spectrum of clinical presentations of this condition.[1]

Nevertheless, the study does highlight some interesting data regarding BRONJ and in particular the fact that the majority of cases were associated with females taking oral bisphosphonates rather than the more potent higher dose intravenous form of the medication. Perhaps this is a reflection of UK prescribing patterns and the high numbers of post-menopausal women taking oral bisphosphonates rather than the risk due to route of administration or dose potency. It is also interesting that half of the patients were also taking corticosteroids and raises the question whether bisphosphonates are the only drug to increase risk of osteonecrosis. This is also in light of osteonecrosis reports in patients taking other anti-resorptive drugs such as the RANKL inhibitor, Denosumab.[2]

Ten years on since the initial description of BRONJ there continues to be much debate as to its disease mechanism and we are only beginning to get a picture of the disease in the UK. Whilst BRONJ appears to be a rare complication of bisphosphonates it is important that we continue to carefully manage our patients taking all forms of bisphosphonates. This report should not be interpreted as a cue to belittle this

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