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.

N. Kaur, A. Nagpal, Uttar Pradesh

1. Strampelli B. Keratoprosthesis with osteodontal tissue. *Am J Ophthalmol* 1963; **89:** 1029–1039.
2. Falcinelli G, Barogi G, Taloni M. Osteoodontokeratoprosthesis: present experience and future prospects. *Refract Corneal Surg* 1993; **9:** 193–194.
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

condition which although apparently rare can have a significant effect on the quality of life of affected patients.

P. Ryan, London

1. Patel S, Choyee S, Uyanne J *et al.* Non-exposed bisphosphonate-related osteonecrosis of the jaw: a critical assessment of current definition, staging, and treatment guidelines. *Oral Dis* 2012; **18:** 625–632.
2. Pichardo S E, Kuypers S C, van Merkesteyn J P. Denosumab osteonecrosis of the mandible: a new entity? A case report. *J Craniomaxillofac Surg* 2012; pii: S1010-5182(12)00229-6. doi: 10.1016/j.jcms.2012.10.014 [Epub ahead of print].

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BONE CRUSHING HABITS

Sir, we are concerned about tooth wear in patients from African and Afro-Caribbean origin and in particular the prevalence of a bone crushing habit as a risk factor for tooth wear. There is a cultural habit of crushing chicken and fish bones as part of their daily diet.

We prospectively audited 50 successive patients of African and Afro-Caribbean origin aged between 20-50 years who were examined in a general dental practice in southeast London to determine the prevalence and symptoms of bone crushing. We found that 80% of the patients had a score of 2 or more on the Smith and Knight tooth wear index. Sixty-six percent indicated that they crush chicken and fish bones with their teeth. In 26% of the patients other risk factors such as teeth grinding and acid erosion were found. In 64% of the patients tooth wear was not the presenting complaint. In 24% the major presenting complaint was aesthetic concerns (short teeth), followed by 12% with teeth sensitivity. Eighty-two percent were not aware that crushing bones is an important risk factor in tooth wear.

The association between tooth wear and bone crushing in patients from African and Afro-Caribbean origin has been known for years but the prevalence of the habit may have been underestimated. This audit demonstrates the high prevalence of tooth wear related to bone crushing. It is important that dentists educate patients and discourage them from bone crushing habits. Specific questions need to be asked when taking a history from patients about their dietary habits and specifically about bone crushing. One important consequence of this problem is an association with failure of prosthodontic and restorative treatments. Hence these patients tend to attend regularly for repair and replacement of their dental restorations and fractured cusps.

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ORAL MUCOSAL PEELING

Sir, peeling of the oral mucosa is rarely encountered in clinical practice and consequently it can cause diagnostic confusion for unfamiliar practitioners. Therefore, we would like to share an interesting case of oral mucosal peeling that we have recently encountered.

An 80-year-old Caucasian woman presented with a three-month history of asymptomatic peeling of her oral mucosa. The medical history was unremarkable and there was no history of mechanical and chemical trauma, nor any recent changes in her usual oral hygiene practices. Clinical examination showed only grey-white strips of oral epithelium sloughing from the buccal mucosae and dorsal tongue (Fig. 1, arrows). These epithelial layers sloughed spontaneously or could be peeled off easily leaving a normal tissue base with no bleeding or erosions. A clinical diagnosis of oral mucosal peeling (epitheliolysis) was made and the patient reassured and discharged.

Oral epitheliolysis (also known as shedding oral mucosa or oral mucosal peeling) is a rarely described and often unrecognised superficial desquamation of oral mucosa that may be caused by sodium lauryl sulphate (SLS) containing oral hygiene products, though some cases appear idiopathic. The condition has no significant clinical consequences and usually resolves spontaneously or upon discontinuation of any implicated toothpastes or mouthwashes.[1-3]

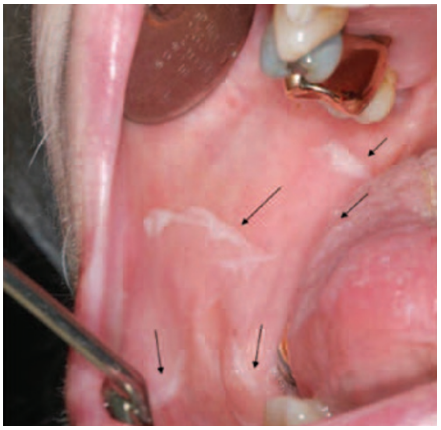

Fig. 1 Grey-white strips of oral epithelium sloughing from the buccal mucosae and dorsal tongue

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1. Zegarelli D J, Silvers D N. Shedding oral mucosa. *Cutis* 1994; **54:** 323–326.
2. Herlofson B B, Barkvoll P. Oral mucosal desquamation caused by two toothpaste detergents in an experimental model. *Eur J Oral Sci* 1996; **104:** 21-26.
3. Plonait D R, Reichart P A. Epitheliolysis of the mouth mucosa (mucosal peeling) as a side effect of toothpaste. *Mund Kiefer Gesichtschir* 1999; **3:** 78–81.

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EVOLUTION OF A CHARITY

Sir, I am pleased to give readers an update to my article in the *BDJ* in 2007 giving an insight into my experiences working for the Northern Cleft Foundation (NCF).[1] The charity has been travelling around India for the last 13 years and has grown in size to include clinicians that normally form part of the cleft multidisciplinary team.

The fundraising for this year's trip took a slight twist on the previous five years. We developed a new website (www.northerncleftfoundation.co.uk) and also created Facebook and Twitter accounts to improve our online profile and to create awareness of the trip. International charities such as SEWA UK (www.sewauk.org) have also rallied to our cause to raise money.

I travelled with my friend and fellow registrar in oral and maxillofacial surgery, Chris Sweet, and we were overwhelmed that the team this year had grown to 48! This included a mix of surgical, anaesthetic, ward and specialist cleft nursing and recovery staff. When we arrived in Nagpur, the local Indian Rotary Club of Nagpur West had worked relentlessly for ten months prior to us arriving distributing leaflets in a radius of 500 km to recruit patients. Ten days of back-to-back operating for approximately 12 hours each day ensued under the supervision of Miss Beale and Misters Penfold, Drake, Van Eeden and Russell.

The aim of the charity has always been to provide quality, safe surgery, and not to operate on large volumes of patients at lower standards. Our final tally included 121 cases successfully treated; the youngest patient was three months of age