John Bradley, lately Consultant Oral and Maxillofacial Surgeon in Lancashire, describes in his book, *Hot spots and hot seats*,² that while a senior registrar at the Westminster Hospital, he cooperated with Tom Casey, the Senior Medical Officer in Ophthalmic Surgery, in the use of a tooth for reconstructing the cornea, based on Professor Strampelli's work. He also describes the interest this caused at the time in the lay press when he reported this use of teeth in this journal. He also suggested the use of costal cartilage for the patient who had no teeth.

A. Sadler
By email

1. Bradley J C. Insertion of an osteo-odonto-kerato-prosthesis into the human cornea. A preliminary report. *Br Dent J* 1966; **120**: 39–40.
2. Bradley J. *Hot spots and hot seats: an experience of practice of oral and maxillofacial surgery*. lulu.com, 2012.

DOI: 10.1038/sj.bdj.2013.589

SUPERSEDED BY SILICONES

Sir, I was interested in the letter of Kaur and Nagpal (*BDJ* 2013; **214**: 373) who have missed reading my article, *Insertion of an osteo-odonto-keratoprosthesis into the human cornea* published in 1966.¹

Essentially I modified Strampelli's operation. Strampelli secured the small lens into the disc of tooth and bone using 'dental cement'. I thought that this was probably oxyphosphate cement and was not happy using it as it leaches phosphoric acid. Since dentine is elastic, a firm mechanical grip could be attained by carefully engineering the hole in the dentine, initially with burs but later with reamers to get a jamb-fit. Messrs Rayners, the ophthalmic instrument makers, made a set of instruments to do this. There was no problem with dislocation of the artificial lens. In the edentulous patient, a thin piece of costal cartilage acted as the vehicle, a punch being used to cut the appropriate sized hole.

At the time, the article attracted considerable press and media attention with the British Council publicising it worldwide!

The technique, I believe, has been superseded with the advent of silicones.

J. C. Bradley, Wiswell

1. Bradley J C. Insertion of an osteo-odonto-keratoprosthesis into the human cornea. *Br Dent J* 1966; **120**: 39–40.

DOI: 10.1038/sj.bdj.2013.590

BETRAYAL OF OUR ETHICS

Sir, it is rubbing salt into a long existing wound to list at the very top of the new BDA Membership Benefits – Trade Union membership. I was one of a small minority on the BDA Representative Board in 1975 who was utterly opposed to being a member of a trade union. We were told that there was no alternative but obey the Law introduced by Barbara Castle. Being a member of a professional association that is a trade union is an oxymoron and the fact that the BDA seems to be so proud of it is a betrayal of our professional ethics.

N. Knott
By email

Martin Fallowfield, Chair of the BDA Principal Executive Committee replies: As one of only 13 special register bodies, most of which are professional associations, the BDA performs a number of functions – including professional association, scientific society and trade union. Each member leans on these functions to differing extents, a fact that underlines the rationale for the new membership structure we have launched and that is reflected in our strapline for its promotion: Dentists have one thing in common. We are all different.

It neither betrays professional ethics nor rubs salt into any wound for the BDA to acknowledge one of the functions it is obliged by law to hold, and on which many employed members rely. The trade union function of the BDA provides support to colleagues who face workplace issues that interfere with their ability to care for patients; the BDA is proud to stand up for those members. The option to change has been fully considered and rejected by the Representative Body last year.

We are an association, society and union that is a welcoming home for all dentists, and we intend to continue being so.

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INFORMING THE PATIENT

Sir, a 20-year-old presented to A&E with a chief complaint of an itchy rash on her body. She had applied a sun cream following a sunbed treatment and also mentioned that she had had a root

canal treatment the day before. She was treated with steroid and antihistamine and was discharged with oral antihistamines. The following day she reattended via an ambulance with widespread erythematous blotches, swelling and pain. Her airway was patent and no obvious swelling of the tongue was noticed.

On taking a detailed history the patient mentioned that she was allergic to penicillin and that an antibiotic was injected during the root canal treatment. Her dentist stated that this was a mixture of demeclocycline, triamcinolone acetonide and calcium hydroxide (Ledermix). The patient was referred to the maxillofacial unit for opinion and management, as she was not responding to the management of anaphylaxis.

On examination the patient had had root canal treatment with a temporary dressing in 24. It was explained to the patient that urgent extraction of 24 was required. Consent was obtained and 24 removed; the socket was explored and irrigated with saline. Following extraction the symptoms started to settle down. The patient was admitted for observation and a final diagnosis of type-1 anaphylaxis reaction possibly due to tetracycline was made. Subsequent assessment under the care of Immunology indicated a strong allergic reaction to tetracycline, confirming the clinical diagnosis.

This case emphasises the importance of informing patients on the type of treatment they are undergoing and also the different medications used as part of the treatment. In the above instance if the patient had not been informed of the use of an antibiotic during root canal treatment it would have delayed management with potentially life threatening consequences.

Ledermix paste comes with a warning of anaphylaxis, which should not be overlooked, and enquiries regarding allergy to the components of any medication should always be sought. Development of the symptoms of allergy – swelling, wheezing, itching or difficulty with breathing – requires prompt onward referral to emergency medical services.

K. R. Jetty, A. Sidebottom
Nottingham

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