Fig. 1 Dental destruction pictured on cigarette pack

Awareness of the link between crack cocaine use and dental disease with these characteristics is not well recognised and with tactful handling such patients may be persuaded to seek advice from a drug counsellor if appropriate.

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NOT AHEAD OF THE GAME

Sir, it is with interest that dental local anaesthetic cartridges, made by the same manufacturers, containing the same agents and other constituents, are labelled differently in the UK compared with Australia and New Zealand.

In Australasia articaine LA cartridges are labelled for infiltration only, whereas lidocaine cartridges are labelled for infiltration and block anaesthesia (Fig. 1). This differentiation does not occur in British labelling of similar local anaesthetics.

Why is this the case? Is it due to the increasing evidence that higher concentration agents are more neurotoxic thus more likely to cause persistent inferior dental block (IDB) related neuropathy?¹⁻⁵

When there is no proven benefit for using higher concentration agents over 2% lidocaine for IDBs, why are dentists still using higher concentration agents for IDBs?⁶⁻⁹

Isn't it about time that dentists woke up to 'SMART' dental local anaesthesia? Infiltration dentistry avoids the use of IDBs, thus preventing LA-related nerve injury, for which there is no cure and which is occurring more frequently than we were taught at dental school (1 in 14,000 blocks causes persistent neuropathy of which 25% are permanent).^{5,10} This requires less skill, less discomfort for the patient during the injection and avoids unnecessary

Fig. 1 Blue printed lidocaine with adrenaline and gold printed articaine with adrenaline local anaesthetic cartridges

lingual anaesthesia after dental treatment. This technique has been well evidenced by Dr John Meechan and his team reporting infiltration LA as more efficacious for providing pulpal anaesthesia in the anterior mandibular dentition compared with IDBs and/or intraligamental injections.¹¹

Many dentists, especially implantologists, already routinely use mandibular infiltration LA to identify when surgery close to the IAN, causing pain, must be ceased to minimise nerve injury. How much more evidence do we need to change practice to this pragmatic technique that heightens patient safety? It appears that other continents are already ahead of the game! Let's catch them up!

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