

LETTERS TO THE EDITOR

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DENTAL PATIENTS

Tossing for it

Sir, a 70-year-old gentleman was referred by his dentist for an opinion on a grossly decayed unrestorable, albeit symptomless, lower left wisdom tooth (38). I discussed with the patient the options open to him: either surgical removal of the tooth before any symptoms occurred or leaving it until symptoms occurred and then removing it.

I advised the former and invited the gentleman to choose. He calmly took a coin out of his pocket. 'Tails, I leave it; heads, I have the tooth out,' said he. Lo and behold it was tails! I said to myself this is shared decision-making and autonomy at work – the kind I have not come across in my 32+ years of clinical practice. By the way I did not check the coin for possible bias!

S. Appiah-Anane, by email
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Mass in a crypt

Sir, a 42-year-old female attended my surgery for an emergency appointment, complaining of a swelling in her throat. This swelling appeared sporadically, and was most perceptible immediately after eating. Following two visits to her GP, who found nothing on examination, she felt I was her last resort as she was becoming increasingly frustrated by the irritating sensation when swallowing. My examination revealed extremely large but healthy tonsils. Thanks to her patience and lack of pharyngeal reflex, I was able to see a single white mass present in a crypt of her right tonsil. My initial impression, due to its irregular occurrence and soft lumpy appearance was either food debris or perhaps a tonsil stone (although she had no history of tonsillitis).

As a foundation dentist, I have had little experience in this area. Fortunately, I had seen an episode of Channel 4's 'Embarrassing Bodies' where a patient had experienced a similar problem. I removed the mass carefully with a cotton bud. It was indeed food debris, accumulating most likely due to her large tonsils. I advised her to adopt this method in the future, along with salt-water mouth rinses, and I also sent a letter to the GP.

The patient was relieved and extremely grateful to have a solution to this frustrating problem, which she has lived with for a number of years. However, I felt it best not to tell her where I came across the answer!

L. Duffy, by email
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PERIODONTOLOGY

Antibiotics protocol

Sir, recently, dental practitioners have noticed the significant changes in the newest version of the British National Formulary, regarding antibiotics protocol for dental conditions. According to the BNF recommendations¹ the systemic treatment of severe cases of periodontitis, resistant to mechanical debridement, can be based on mono-drug therapy with the use of metronidazole (alternative: doxycycline), the bactericidal agent targeting the gram-negative strict anaerobes from the 'red' and 'orange' Socransky complexes.

Despite the high efficiency of metronidazole against anaerobic bacteria, particularly *P. gingivalis* and *Prevotella intermedia*,² alone it has a limited effect against periopathogen *Aggregatibacter actinomycetemcomitans* (reclassified *Actinobacillus actinomycetemcomitans*), which is a facultative rather than a strict anaerobe and it is considered as the main causative factor in aggressive periodontitis.³⁻⁵ *Actinomyces*, *Streptococcus* and *Capnocytophaga* are also reported to be minimally affected by metronidazole.⁶

Chronic periodontitis is caused by a mixed microbial infection making the selection of targeted antibiotic difficult to justify. No single antibiotic with a relatively narrow spectrum of antibacterial activity can be effective against all periopathogens. Periodontal infections are represented by a broad diversity of periopathogens, including anaerobic, microaerophilic, and aerobic bacteria, both Gram negative and Gram positive. Hence, it is recommended to use more than one antibiotic with different antibacterial spectra.

The combination of metronidazole-amoxicillin and metronidazole plus amoxicillin-clavulanate potassium seems

to be the most effective antimicrobial therapy in the management of advanced periodontitis.^{2,7,8} Amoxicillin reveals broader spectrum decreasing counts of Gram negative anaerobes, including also *Aggregatibacter*. This provides an elimination of bacteria in aggressive periodontitis that had been treated unsuccessfully with mechanical debridement and other, single antibiotics.

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1. British National Formulary. Table 1. Summary of antibacterial therapy for ear, nose, and oropharynx. <https://www.medicinescomplete.com/mc/bnf/current/PHP3268-ear-nose-and-oropharynx.htm>
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ORAL MEDICINE

Off-label cream use

Sir, we write in response to the letter *Erosive lichen planus* (*BDJ* 2014; **216**: 545).

Erosive and ulcerative lesions of oral lichen planus (OLP) can be persistent and painful;¹ therapy is warranted when patients have painful disease that may adversely impact upon quality of life, but effective management of OLP can be challenging.² The letter's authors presented their recent preliminary experience

with betamethasone valerate 0.05% cream (Betnovate), which, they report, seems beneficial in controlling painful symptoms.

This is perhaps not unexpected, as a wide spectrum of corticosteroid formulations including mouthwashes, creams, ointments, sprays and intralesional injections have been reported in the treatment of symptomatic OLP. Nevertheless, there remains a lack of well-designed clinical trials in this field, with a relatively recent systematic review indicating that there is little robust evidence for the efficacy of any single treatment for the management of erosive OLP.³ Although grateful to the authors, we highlight that comprehensive management of OLP can be a significantly more complex matter. For example, the medico-legal responsibility of prescribing, dispensing and administering an agent outwith its licensed indication. It is important that clinicians inform patients of the off-label use of these agents and detail possible side effects.⁴ Patients should be carefully reviewed for such events. OLP management must also encompass its malignant potential and oral cancer development which may be in up to 3.5% of cases^{5,6} with essential long-term monitoring of patients to identify and diagnose early dysplastic and malignant changes.⁷

Any patient with possible OLP should be initially referred to specialists to ensure that the diagnosis is formally confirmed, appropriate treatment is provided and adequate, evidence-based information is given. Simply telling a patient that they are likely to have OLP is often unhelpful and sometimes they can become alarmed after surfing the Internet. Patients' perspective and expectation are also important, as conversations regarding the chronic nature of the disease and associated increased risk of cancer may sometimes become difficult.

S. Porter, V. Mercadante, S. Fedele, London

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INFECTION CONTROL

Ebola aware; beware; healthcare

Sir, Ebola virus disease (EVD) is a lethal viral haemorrhagic fever (VHF) that has been smouldering in Sub-Saharan and West Africa at least since the 1970s and possibly for many decades. We previously sensitised the dental community to the infection which, in earlier days, was mainly in rural West Africa and had a lower mortality.¹ Its current virulence (nearly 70% mortality); epidemic spread in West Africa including in urban conurbations; and sporadic appearances in many geographic locales already including resource-rich areas in North America, Europe and the Antipodes, mainly through infected travellers, raises grave concerns of an impending pandemic.

Recognition of EVD, infection control and containment are the major healthcare concerns. In oral healthcare, oral bleeding (gingival mainly) is a main manifestation usually also with epistaxes and bleeding from other orifices. Oral mucosal lesions

and discomfort are yet to be thoroughly described as most patients are too ill and rapidly decline, and healthcare resources too stretched. Universal infection control is mandatory, especially in the later stages when viral loads are at their maximum.

Host-to-human transmission of EVD is only through direct contact with or consumption of the tissues, blood, secretions, or other bodily fluids, of infected hosts such as non-human primates or fruit bats (in 'bush meat' and environments contaminated with such fluids). These products appear outwith Africa, often transported illegally in personal luggage.

Human-to-human transmission of EVD is only through direct contact with the tissues, blood, secretions, or other bodily fluids, including saliva, of infected hosts, and with environments contaminated with such fluids. There is no evidence of airborne spread. Infections in healthcare settings have been due to healthcare workers treating patients with suspected or confirmed EVD when infection control precautions were not strictly practised. To date there are no reported cases of transmission of EVD in dental settings.

However, the fact that Ebola virus may be transmitted through human secretions, including saliva, that 1–6% of infected individuals are asymptomatic or mildly symptomatic and that the incubation period could last up to 21 days, implies that oral healthcare workers (mainly in the endemic areas) may run the risk of acquiring EVD if meticulous infection control measures are not always routinely adhered to.

If an EVD risk is possible, it would seem logical that elective oral healthcare be deferred 21 days.

C. Scully, L. Samaranayake, S. Petti,
R. G. Nair, by email

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