Although these new 'diseases' sound lovely to the ear and would conceivably resonate with both the public and the profession, the terms themselves are gibberish, both factually and etymologically (*ortho* from *orthos* – meaning 'straight'; *dont* from *odontos* – meaning 'tooth'; *-osis* – meaning 'a state of disease' and *-itis* – meaning 'inflammation').

The position paper on these terms (co-written by the same author as the letter mentioned above) is totally bereft of any evidenced rationale for defining these new 'diseases'.² This is especially pertinent when such 'disease' states (which appear to be nothing more than crooked teeth and hyperplastic gingivae) are common in the majority of the population. Were these 'diseases' relevant then I don't doubt that the world would have an overnight epidemic on its hands of biblical proportions.

Isn't it marvellous then that the product that the author coincidentally promotes for monetary gain (Fastbraces) is the only product that can 'cure' this 'disease'.³ Should millions of patients be convinced they have either of these new 'diseases' and then seek remedy from only those trained to provide Fastbrace treatment, how very rewarding this would be for all involved.

This letter is no more worthy of publication that the unrelenting diatribe emerging regarding the debilitating condition of 'craniofacial dystrophy' and the wonders of orthotropics as a panacea for everything from back pain to sinusitis.^{1,4,5} As a frustrated reader of the *BDJ*, I ask that when letters that appear to express a somewhat 'unique' point of view are considered for publication, that an opinion be sought from relevant dentists on the editorial staff that are knowledgeable in the field. In this case, just because an endodontist writes from his position at the Harvard School for Dental Medicine, does not make his opinion regarding orthodontic diagnosis worth publishing.

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CASE REPORTS

Misdiagnosed herpes zoster

Sir, following a recent letter (*BDJ* 2015; **218**: 213) we would like to share a similar case.¹ A 47-year-old male patient presented complaining of an inability to open his mouth and pain in its lower right posterior region. Examination revealed an inflamed pericoronal flap over tooth 48. The area was cleaned with chlorhexidine and analgesics were prescribed for 5 days. Extraction was advised to prevent further recurrence.

The patient returned after 5 days and agreed to the extraction. Although the inflammation had subsided his mouth opening was still restricted and the extraction was postponed to await improvement. After a month the mouth opening was still restricted although improved. During the extraction the patient suffered a few lacerations at the corner of the mouth and lower lip due to the restricted access to the third molar area.

The patient was advised to return after 5 days but did not attend until a month later. He told us that the delay was because he had developed a herpes zoster infection. He reported developing ulcers in the area of the lower right lip and corner of mouth. His family physician had referred him to a dermatologist. His ulcers were limited to the lower right lip area, which suggested that they had occurred due to the extraction trauma. The patient had discussed his dental appointment with the dermatologist, but it appears that the dermatologist did not consider the chances of the lower lip being traumatised during the third molar surgery and misdiagnosed it as herpes zoster infection.

We wish to highlight that traumatic ulceration is a differential diagnosis when considering herpes infection, especially when the patient has had a recent dental appointment.

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Oral vitiligo

Sir, as with the skin, the oral mucosa exhibits pigmentation. The normal mucosal colour is described as coral pink but, as with the gingiva, it exhibits an array of colours ranging from pale pink to coral pink in Caucasians and blue to brown-black in Asians and Africans.¹ Dark skinned individuals are very likely to have dark melanin pigmentation.²

Loss of normal pigmentation from the skin or the oral mucosa is a cause for

Fig. 1 36-year-old male with depigmentation of the lower vermilion

psychological and social problems. One common cause for depigmentation is vitiligo, which is an acquired, non-contagious, auto-immune disorder of the skin. Oral manifestations are far less recognised with occurrence most common in the lip followed by palate, buccal mucosa, gingiva and labial mucosa.³ Although the prevalence of skin vitiligo around the world is 1%, in India it ranges up to 8.8%. The prevalence of oral vitiligo is not known.

Figure 1 shows a 36-year-old male with depigmentation of the lower vermilion as the only manifestation of vitiligo. Most often vitiligo affects the young and is a rarity after age 50. The aetio-pathogenesis is not precisely known but autoimmunity is suggested which results in loss of functional melanocytes from the skin and the mucosa.^{4,5} While there is no effective treatment for this condition, corticosteroid therapy is found to be quite good. Mini pulse therapy using dexamethasone has been utilised to control developing and progressing skin vitiligo effectively.⁶

When initial lesions of vitiligo are encountered in routine dental practice, it is obligatory that patients are informed and management is instituted at the earliest as there are high chances of progression. Further, counselling might be an additional option to avoid psychosocial stigma.

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