COMMENT

Letters to the editor

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Oral health

OHRQoL in systemic sclerosis

Sir, we read with interest the article by Veale *et al.* (*BDJ* 2016; **221:** 305–310) about the oral and maxilofacial manifestations of systemic sclerosis.[1] Systemic sclerosis is a multisystem disease in which functional impairment and work disability are common. Oral manifestations of systemic sclerosis include caries, xerostomia, microstomia, gingival recession, periodontal disease and bone resorption of the mandible, sometimes leading to fractures.[2]

Instruments have been developed to assess oral health-related quality of life (OHRQoL) that may be diminished specifically by problems resulting from poor oral health.

Studies of oral health in systemic sclerosis have been performed with small samples, often without appropriate controls. Oral health-related quality of life in systemic sclerosis has not been robustly estimated.[3]

Global oral health-related quality of life is significantly impaired in systemic sclerosis. There is some evidence from studies in non-systemic sclerosis subjects that oral health-related quality of life is associated with global health-related quality. Oral health-related quality of life in systemic sclerosis is independently associated with global health-related quality of life. Oral health-related quality of life, however, is not related to physician-assessed disease severity. Systemic sclerosis patients have more missing teeth, more periodontal disease, less saliva production, smaller interincisal distance and poorer oral health-related quality of life than controls subjects.[4,5]

Given the impact of poor oral health on health-related quality of life, healthcare professionals caring for systemic sclerosis patients should pay more attention to oral health, as has been previously suggested, as interventions to improve oral health in systemic sclerosis have the potential to improve overall health-related quality of life.

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2. Vincent C, Agard C, Barbarot S *et al*. [Orofacial manifestations of systemic sclerosis: A study of 30 consecutive patients]. *Rev Stomatol Chir Maxillofac* 2010; **111:** 128–134.
3. Leung W K, Chu C H, Mok M Y *et al.* Periodontal status of adults with systemic sclerosis: case-control study. *J Periodontol* 2011; **82:** 1140–1145.
4. Maddali Bongi S, Del Rosso A *et al*. The Italian version of the Mouth Handicap in Systemic Sclerosis scale (MHISS) is valid, reliable and useful in assessing oral health-related quality of life (OHRQoL) in systemic sclerosis (SSc) patients. *Rheumatol Int* 2012; **32:** 2785–2790.
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Pharmacology

Discontinuation of bisphosphonates

Sir, in May 2007 a 62-year-old female presented with pain and a bad taste from her lower right jaw. Her previous history included the extraction of the 46 some eight months previously. Her medical history included osteoporosis, type 2 diabetes and a smoking habit of 100 rollups a week. Her drug history included alendronic acid since July 2004. Examination revealed suppuration from the site of the previous extraction with non-vital bone present within the wound. Radiographic evidence of sequestra formation supported a diagnosis of osteonecrosis. Treatment included chlorhexidine M/W, surgical debridement, and culture and sensitivity guided antibiotic Rx (metronidazole). The alendronic acid was discontinued in June 2007 (circa 3-year administration). Following removal of a bony sequestrum symptoms continued episodically but were controlled with regular irrigations and C&S guided systemic antibiotics.

A bone mineral density scan was performed in March 2008 and return to medicated skeletal protection was not indicated. In July 2008 the patient presented with increased pain and dysaesthesia affecting the right side of the lower lip. A radiograph (Fig. 1) demonstrated osteolysis approaching the ID canal with osteosclerotic thickening of the lamina dura of 45, 44 and 43 and a widening of the periodontal space – all signs of progression of the disease. Further antibiotics and surgical debridement gave some relief and in September 2008 resolution of the dysaesthesia was reported and the patient announced that she 'felt best for two years'. Placed on long-term review, a radiograph taken in December 2011 (Fig. 2) demonstrated evidence of bone regeneration and reduced osteosclerosis with return of near normal thickness of the lamina dura and periodontal space of previously affected teeth. The patient was still smoking 100

Fig. 1 Radiograph taken in July 2008

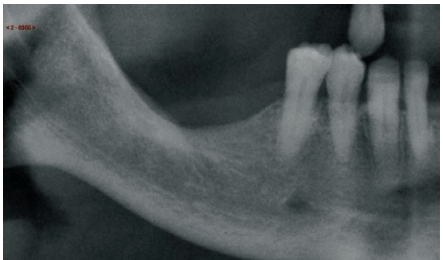

Fig. 2 Radiograph taken in December 2011

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rollups a week. In December 2014 (age 70) a further bone density scan continued to show an improved bone density when compared to the original diagnostic scan taken in 2004 and no further skeletal protection was recommended.

Discontinuation of alendronate in cases of BRONJ can allow recovery of the physiological function of the jaw bone with time while still leaving a positive residual impact on general skeletal protection. Is the higher turnover bone of the jaw showing preferential recovery from the effects of the bisphosphonates?

N. Malden, S. Loh, Edinburgh

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Oral surgery

Mutilation following MDMA

Sir, an 18-year-old female presented to the emergency department with extensive tissue loss from her lower lip. Questioning revealed that she had ingested 3,4-methylenedeoxymethamphetamine (MDMA, 'ecstasy') prior to the events that led to her presentation. An accompanying friend reported that, following consumption of MDMA, the patient exhibited involuntary chewing of her lower lip. Despite the pain, this persisted for several hours which led to gradual tissue loss.

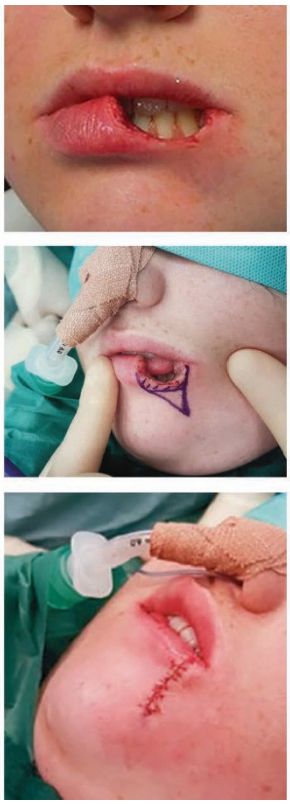

Fig. 1 The 18-year-old patient with extensive tissue loss following MDMA ingestion

Her medical history was unremarkable but she reported regular user of marijuana with monthly use of MDMA.

On examination, there was a 3 cm area of soft tissue loss to the left side of the lower lip. This extended from the midline to near the commissure and was well beyond the vermillion border and into the cutaneous zone. No oral seal was achievable (Fig. 1). Systemic examination, vitals, electrocardiogram and bloods were within normal limits.

The patient was given 5 mg oral diazepam to help reduce the involuntary mastication and was taken to theatre the next day for wedge excision and primary closure. If destruction of the lower lip had been more extensive other complex reconstructive options would need to be employed.

As a department we are seeing an increasing number of cases attending presenting with oro-facial presentations following MDMA use. Despite recent national statistics showing no increase in consumption amongst young adults,[1] a recent survey has reported that purity levels have increased over recent years.[2,3] Whilst the case we present is an extreme example resulting in oral mutilation, bruxism, tooth-wear and oral ulceration remain the most common oral manifestations.[4] Unexplained cases of the aforementioned should prompt a thorough recreational drug history.

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Oral medicine

A waste of paper

Sir, today my practice received through the post six copies of the latest edition of the *BNF*. These books span 1,450 pages and I acknowledge the value of the contents. The price on the back is £49.95. Not unreasonable for such a large book. It then dawned on me that I would imagine that every dental practice must in this day and age have some form of internet access even with a smartphone or laptop if they have so far resisted the relentless drive to computerisation.

I phoned the GDC who informed me that there are approximately 42,000 dentists on the register in the United Kingdom. This equates to a total expenditure of £2,100,000.

There are approximately 240,000 doctors and 45,000 pharmacists also working in the UK. Assuming the NHS is equally as generous this would equate to an extra £14,250,000! This is a total expenditure of £16,350,000. Most of which could be avoided.

Surely the NHS could save this money by encouraging all dentists, doctors, pharmacists etc, to install the BNF app on to their desktops.

R. Raeburn, by email

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Social media

Professionalism

Sir, I would like to comment on Kenny and Johnson's informative paper, *Social media use, attitudes, behaviours and perceptions of online professionalism amongst dental students*.[1] There is little to disagree with in the paper but I was struck by the conclusion that more social media training in professional standards is required, when a significant proportion of their students felt the school already placed too much emphasis on professionalism. One interpretation of the evidence presented is that the majority of students understood what was seen as professional online behaviour, but did not always agree with it. Ninety-seven percent of students saw making negative comments about a person's gender, race or disability as unprofessional and only 1% reported making such comments. This suggests they understood the injunction and agreed with it. In contrast, 92% of students saw publishing photographs of students intoxicated at social events as unprofessional, but 29% of them had actually done so. Perhaps those students simply felt that being intoxicated, at social events, was morally acceptable for a student. Indulging in such activities and then keeping them private may well be prudent, but the real question is whether such activities are permissible. It strikes me that while such behaviour is hardly laudable, it is probably acceptable so long as it does not interfere with their studies or damage their health.

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