Cosmetic dentistry

An excellent review

Sir, the article in a recent *BDJ* is an excellent review of the dentistry of tooth whitening.[1] With regret those dentists working in the EU are restricted in their use of tooth whitening as described by the EU Cosmetics Directive, which does not allow the use of higher strength material and tooth whitening on the pregnant or under 18s. The BDA produce a very useful Advice Sheet on the subject to assist members.

Work continues by the BDA through the Council of European Dentists to change the position of the under 18s who have specific indications for tooth whitening.

S. Johnston, by email

1. Haywood V B, Sword R J. Tooth bleaching questions answered. *Br Dent J* 2017; **223:** 369–380.

DOI: 10.1038/sj.bdj.2017.937

Anaesthesia and sedation

No such thing

Sir, there is no such thing as dental general anaesthesia (DGA).[1] As someone on the Dental Register who worked with and provided GA for dental care and also assisted with GA for a number of other procedures from 1975 until it was unilaterally banned by a predecessor of yours I can state this with confidence. General anaesthesia is a patient management technique used to provide a surgeon (usually) with a body to work on. It is the surgeon who limits the area of operation; the anaesthetist supplies an entire person.

To promote the concept of dental GA is inaccurate, erroneous and implies that DGA differs from GA. It doesn't.

T. Caen, by email

1. Ramdaw A, Hosey M T, Bernabé E. Factors associated with use of general anaesthesia for dental procedures among British children. *Br Dent J* 2017; **223:** 339–345.

DOI: 10.1038/sj.bdj.2017.938

Oral health

Asthma and oral candidiasis

Sir, I was discussing a new diagnosis of asthma with a patient and found myself struggling to walk the line between patient-centred advice and opportunistic health prevention. The prevalence of asthma in the UK is approximately one in 11 children and one in 12 adults.[1] In 2016, the British Thoracic Society (BTS) and Scottish Intercollegiate Guidelines Network (SIGN) published new guidelines on its management.[2] A key update in the guidance is the emphasis that individuals should no longer be on a short acting beta-2 agonist as a primary form of treatment; instead the early use of inhaled corticosteroids (ICS) has been highlighted. With up to 5.4 million people[2] now potentially requiring ICS, the question on whether asthma patients should be routinely informed about preventing and recognising oral candidiasis becomes more pertinent.

In our experience during training, both in hospital and in primary care, the discussion of the risk of developing oral candidiasis is neglected. A recent study demonstrated that in the 4–11-year age group of ICS users, the incidence of oral candidiasis ranges from 0.8% to 3.2%,[3] which has been corroborated with previous evidence.[4] An adverse event which occurs in 1–10% of patients taking the drug is deemed as a common adverse side effect of the drug,[5] and the General Medical Council recommends that such effects should be discussed with the patient prior to prescription.[6] Treatment of oral candidiasis and its complications requiring treatment bears a cost to the NHS.

Dental professionals on deep examination of the mouth often spot the first signs of candidiasis, and are also responsible for advising treatment. We believe there is scope for targeted opportunistic health promotion in patients taking inhaled corticosteroids for both doctors and dental professionals. During the discussion of past medical history and drug history, where a patient mentions a history of asthma or ICS use, we believe discussion of good oral hygiene practice following the use of ICS as well as a quick examination of the oral cavity would be of benefit to prevent and identify candidiasis.

J. S. Chandan, London

R. S. Randhawa, T. Thomas, Birmingham

1. Asthma UK. Asthma facts and statistics. 2015. Available at: https://www.asthma.org.uk/about/media/facts-and-statistics/ (accessed 19 August 2017).
2. British Thoracic Society. *British Guideline on the Management of Asthma*. KEY TO EVIDENCE STATEMENTS AND GRADES OF RECOMMENDATIONS. pp 11-75. Scottish Intercollegiate Guidelines Network, 2016.
3. Vandewalker M, Hickey L, Small C J. Efficacy and safety of beclomethasone dipropionate breath-actuated or metered-dose inhaler in pediatric patients with asthma. *Allergy Asthma Proc* 2017; **38:** 354–364.
4. Passalacqua G, Albano M, Canonica G W *et al.* Inhaled and nasal corticosteroids: safety aspects. *Allergy* 2000; **55:** 16–33.
5. World Health Organisation. Definitions by WHO. pp. 1–16. 1972.
6. General Medical Council. *Good practice in prescribing and managing medicines and devices.* pp. 1–11. 2013.

DOI: 10.1038/sj.bdj.2017.939

Eclectic patients

Sir, it's that time of year again when we seem to attract an eclectic bunch of patients. Last year we had a high-needs patient whose underlying problem turned out to be burning mouth syndrome (Fig. 1). We had a further patient for whom, despite extensive investigation, we were unable to resolve his atypical facial pain (Fig. 2).

Do other colleagues have this problem at the end of October?

N. Mallon, by email

Editor's note: After further enquiry, Dr Mallon revealed that the pumpkins illustrating this letter were actually carved as part of an annual dental practice 'carve off' competition: 'The burning mouth syndrome patient was carved using a peeler to break the surface then a wax knife to create form, then finished with a Mitchell's trimmer and Molt #9 periosteal elevator. It was actually designed with 15 different dental issues for a DF1 training day on Pain Management – including roots, over eruption, pericoronitis, cracked teeth, lost fillings and OAF. This became a bit of a nightmare as the family dog got to it the morning it was due to be used! The atypical facial pain patient was carved in a similar fashion with the addition of a courgette.'

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Fig. 1 High-needs patient with burning mouth syndrome

Fig. 2 Patient with unresolved atypical facial pain

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