COMMENT

Letters to the editor

Send your letters to the Editor, *British Dental Journal,* 64 Wimpole Street, London, W1G 8YS. Email bdj@bda.org.
Priority will be given to letters less than 500 words long. Authors must sign the letter, which may be edited for reasons of space.

Pharmacology

Dangerous interactions

Sir, we read with great interest Professor Pemberton's article regarding the interactions of miconazole gel and warfarin.[1]

Another potentially underappreciated, although rarer, interaction which practitioners should be aware of is that of the antifungal agent fluconazole with those taking a statin. There has been documented evidence regarding the severe potential side-effect of rhabdomyolysis, ie muscle necrosis, in those taking statins who are co-incidentally prescribed fluconazole.[2–4]

Muscle necrosis may lead to myoglobinuria and acute renal failure as a result of impaired clearance of the statin.

We were alerted to this important interaction on reading a colleague's letter which appeared to demonstrate co-administration of fluconazole and atorvastatin[5] without consideration of the side effect of rhabdomyolysis.

SDCEP drug prescribing guidance advises fluconazole not be prescribed to patients on statins.[6] Pharmacy updates advise caution when co-administering fluconazole with atorvastatin, with consideration of reducing the statin dose[7] and monitoring for muscle symptoms.

It is perhaps fortunate in this case that the atorvastatin was not stopped at the same time as administration of fluconazole, as this may have led to a false-positive result with the elimination of the patient's oral ulceration being mistakenly associated with the introduction of the anti-fungal agent. This would have delayed identification of the true cause of the ulceration, ie the statin.

Approximately seven million people in the UK are prescribed a statin[8] making them the most commonly prescribed medication. With so many patients taking this medication, practitioner awareness of this potentially dangerous interaction needs to be raised.

J. E. Tebbutt and R. M. Graham, by email

1. Pemberton M N. Morbidity and mortality associated with the interaction of miconazole oral gel and warfarin. *Br Dent J* 2018; **225**: 129–132.
2. Franz C C, Bruggisser M, Krähenbühl S, Rätz A B. Rhabdomyolysis associated with atorvastatin combined with amiodarone and fluconazole. *Praxis* 2011; **100**: 273–284.
3. Kahri J, Valkonen M, Bäcklund T, Vuoristo M, Kivistö K T. Rhabdomyolysis in a patient receiving atorvastatin and fluconazole. *Eur J Clin Pharmacol* 2005; **60**: 905–907.
4. Hsiao S H, Chang H J, Hsieh T H, Kao S M, Yeh P Y, Wu T J. Rhabdomyolysis caused by the moderate CYP3A4 inhibitor fluconazole in a patient on stable atorvastatin therapy: a case report and literature review. *J Clin Pharm Ther* 2016; **41**: 575–578.
5. Smith D J, Dillon M, Russell J, Kanatas A. Statins and oral ulceration. *Br Dent J* 2016; **220**: 45–46.
6. Scottish Dental Clinical Effectiveness Programme. Drug Prescribing for Dentistry: Dental Clinical Guidance (January 2016).
7. PL Detail-Document, Clinically Significant Statin Drug Interactions. Pharmacist's Letter/Prescriber's Letter. March 2016. Available at https://pharmacist.therapeuticresearch.com/Content/Segments/PRL/2016/Mar/Clinically-Significant-Statin-Drug-Interactions-9486 (accessed 6 November 2018).
8. NHS. NICE publishes new draft guidelines on statins use (17 February, 2014). Available at https://www.nhs.uk/news/medication/nice-publishes-new-draft-guidelines-on-statins-use. (accessed 6 November 2018).

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Dental trauma

Better communication between hospital and primary dental services

Sir, within the UK, patients whom present during 'Out of Hours' to accident and emergency departments are often treated by an on-call dental core trainee (DCT) in oral and maxillofacial surgery (OMFS).

These patients are then advised to seek follow-up treatment with their own general dental practitioner (GDP). A recent project carried out within the OMFS department at Altnagelvin Hospital in Northern Ireland highlighted that these patients were not routinely provided with a follow-up communication aid to outline the treatment they received to their own GDP.

Quite often dental trauma treated within OMFS units is complex. These patients may have had a splint placed which requires timely removal. The follow-up advice provided to these patients is important to allow the traumatised teeth to have the best possible outcome.[1]

A new local guideline has been implemented and a local pro-forma designed within our department for the treatment of traumatic dental injuries, detailing the injury sustained, initial treatment provided and a recommendation for future management.

This not only allows us to better communicate with our GDP colleagues but also fulfil our duty of following the GDC standards,[2] notably Standard 6 : 'Work with colleagues in a way that is in patients' best interests'.

I think it is appropriate to highlight this finding to the wider population of dentists as many DCTs may be faced with a situation in which they are treating patients during Out of Hours and struggle to find a way to appropriately communicate their findings and treatment to the GDP. Perhaps within other OMFS departments, a similar local pro-forma could be implemented allowing for ease of communication between the hospital and primary dental services.

K. McKeague (Dental Core Trainee) and A. Cooper (Staff Grade OMFS), by email

1. Bücher K, Neumann C, Thiering E *et al.* Complications and survival rates of teeth after dental trauma over a 5-year period. *Clin Oral Investig* 2013; **17:** 1311–1318
2. General Dental Council. *Standards for the dental team.* Available at https://www.gdc-uk.org/professionals/standards (accessed 3 October 2018).

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