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.

Editorial decisions

Diminishing credibility

Sir, the cartoonish characterisations of the current covers of the *BDJ* [Volume 223, published July–December 2017] serve to diminish the credibility of the contents of the journal and demean the dental profession. For a serious academic journal, more appropriate cover subject matter might portray some of the history of dentistry's rise from barber-surgeons to the current and future status of the profession as a scientifically-based health discipline. Dentistry should not be portrayed in a discreditable comedic manner, with its reputation already much diminished as a cosmetic calling.

G. Sperber, Canada

The Editor-in-Chief responds: I thank Professor Sperber for his opinion on the cover series. I have always been open to receiving and publishing criticism of the BDJ*'s content as I believe this is the best way to progress debate. The editorial team including our amazing art editor go to great lengths to choose our cover series taking into account visual impact, relevance, originality and a host of other considerations. Previous examples that have had particular impact include the humorous cartoon series to celebrate the 2012 London Olympics and the unique watercolours commemorating the beginning of the First World War. The originals of this latter series having been purchased from the artist and are now on permanent show at the Army Dental Corps Museum.*

As readers will be aware, the series referred to was based on references to oral health, teeth and dentistry as portrayed in literature and have been commissioned by us with detailed briefs to the artist. As such Professor Sperber's comments need to be set in the context that these literary references portray dentistry and oral health as others see them, not as we see ourselves – a crucially important difference. If we are to progress as a profession we need to be objective about our existing, wider image. Professor Sperber's is the only negative comment we have received on the series in comparison to many positive and supportive reactions, especially on social media, where one reaction was 'Fantastic cover art. This makes me so proud of my profession!' It is in this context that I wanted to respond since I strongly believe that the reputation of the BDJ *far from being diminished is in fact enhanced by such embellishments. I am sure that this is part of the reason why the* BDJ *is, by the measure of Altmetrics, the number one most talked about dental journal in the world and from our own statistics read in over 190 countries.*

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Pathetic jokes

Sir, I am writing to you to complain about the content of *BDJ* Volume 223 No. 12, published on 22 December 2017, which contained inaccurate yet plausible content that could mislead and misinform readers of this journal.

The Editorial set the tone for this edition by reporting the use of robots to perform implants in China. This is within the bounds of possibility as was the next item regarding data transmitted from electronic toothbrushes which could lead to a Home Dental Check system that could determine whether a visit to the dentist was required. There were two other 'developments' that bordered on the edge of believable (Uberdent and Airrotor).

Spoof letters and fake news articles regarding various aspects of Christmas and its relevance to CQC, Christmas cards, whisky, cakes and Russian hacking in BDA elections followed. These were all very tongue in cheek (forgive the pun). There followed what I presumed was the serious part of the journal dealing with electronic records, oral and maxillofacial trauma, and burnout in dental students. My problem with the first (flippant) part of the journal is that I now had to ask myself, 'do I believe that there is burnout in dental students with all the attendant suicide problems or is this one of their jokes?'

My feeling, if you have not discerned it so far, is that there is a place for spoof articles and bogus reporting but a serious professional journal is not the forum for such. Anything you read in a professional publication should be true, trusted and believable and not subject to doubt because of some pathetic jokes inserted by the editorial staff. All that was required from the Editor was 'Happy Christmas to all our members and a plague on the GDC'.

A. J. Lawrence, by email

The Editor-in-Chief responds: I am sorry to read of Dr Lawrence's disapproval of the mixed content of our Christmas issue. We made sure that all 'spoof' content was carefully signposted so as not to mislead readers. From the many positive responses that we received the Yuletide content was appreciated and its purpose of spreading a smile or two and injecting some humorous relief at a time when there is much gloom and doom in the world of dentistry

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seems to have been understood. With regard to the 'mixing' point, the BMJ *has taken a similar approach for many years and indeed a 'tongue in cheek' paper in its 2017 Christmas issue was even picked up and enjoyed by the main national media. While we are not seeking to copy the* BMJ *we feel that some dental levity is just as appropriate and were delighted that in our issue, the second of its kind, we published contributions from readers who had been inspired by previous issues. To put this is in another context, the* BDJ *publishes something of the order of 1,000 pages of editorial content a year; the 'spoof' matter takes up less than 0.01%. I am pleased to be able to reassure Dr Lawrence that we will not be marking the Summer Solstice or any other seasonal celebrations in a similar manner so he may read the rest of the 2018 issues with unguarded belief.*

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Oral surgery

A helpful wisdom tooth

Sir, we would like to share a rather amusing case involving an extraction technique on a tooth with its own point of application. A patient was admitted for removal of 38 under local anaesthetic in our outpatient department. The tooth was partly erupted but in a fairly vertical position. When a mucoperiosteal flap was raised we noticed a carious cavity buccally which was not visible on the radiograph. Therefore, without the need of bone removal, a Cryer elevator was applied to the cavity as a point of application and the tooth was elevated in a straightforward manner.

In the available literature the drilling of a cavity into a tooth to create an application point during elevation has been described.[1,2] In our case this tooth already had an appropriately sized buccal cavity created by caries subgingivally and hence no drilling was required (Fig. 1). The figure reveals a slight distally curved root and the tooth morphology favoured the path of withdrawal of this tooth in a distal direction. With slight rotation of Cryer elevator within the cavity the tooth eventually 'popped out' distally. This enabled the extraction in an atraumatic manner with no bone removal or tooth sectioning required.

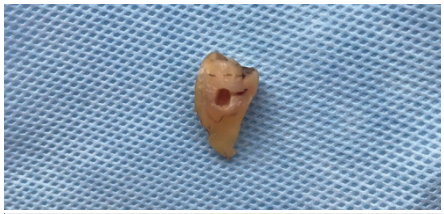

Fig. 1 The 'helpful' tooth which was straightforward to extract

J. Liew, A. Beech, Gloucester

1. Mamoun J. Use of elevator instruments when luxating and extracting teeth in dentistry: clinical techniques. *J Korean Assoc Oral Maxillofac Surg* 2017; **43:** 204–211.
2. Kaminishi R M, Davis W H, Nelson N E. Surgical removal of impacted mandibular third molars. *Dent Clin North Am* 1979; **23:** 413–425.

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Pharmacology

MRONJ risk factor

Sir, medication-related osteonecrosis of the jaw (MRONJ) is a well-documented complication associated with bone modulating therapy from various bisphosphonates and denosumab. In additional anti-angiogenic medication (tyrosine kinase inhibitors and new biologics including monoclonal antibodies) have also been implicated and hence the list of drugs continues to grow. Once patients are 'at risk' of MRONJ, well established risk factors for development of the complication include dental extractions, smoking, trauma, poor dental health and those who are immunocompromised and immunosuppressed. In this latter group certain medications such as corticosteroids, azathioprine, mycophenolate mofetil and methotrexate have been particularly identified.

Leflunomide (Arava) is a disease modifying anti-rheumatic drug (DMARD) that has been used in the treatment of rheumatoid and psoriatic arthritis for many years and can be given in combination with bisphosphonates and methotrexate. *In vitro* studies indicate that leflunomide selectively inhibits RANK-L-induced differentiation of osteoclast, which in turn directly affects bone remodelling as well as inhibiting several tyrosine kinases.[1] These actions are exactly those targeted by the various implicated MRONJ drugs mentioned earlier.

Leflunomide has not been reported as a MRONJ drug. However, we wish to highlight this drug as a possible candidate to be added to the other immunosuppressants that have already been recognised to increase the risk of MRONJ when taken in conjunction with bone modulating and anti-angiogenic therapy. In our dedicated jaw necrosis clinic, 102 patients have been registered with MRONJ of which only two cases are from oral bisphosphonates. In these two cases one patient had bilateral maxillary MRONJ (alendronic acid two years, leflunomide six years) following dental extraction. In addition to this case a further two cases of methotrexate related jaw necrosis are also being managed. Methotrexate jaw necrosis is very rare and often preceded by lymphoproliferative disorder, however, in both our cases this was absent but both on long-term leflunomide.[2] Of these two cases, one failed to heal post extraction while the other case had spontaneous necrosis in a dentate region.

Leflunomide is not a new drug and in the absence of literature reported cases of osteonecrosis of the jaw directly related to it as well as evidence of its impact on bone, it remains reasonable to consider it as a risk factor for MRONJ along with the other already recognised immunosuppressant when taken concomitantly with those drugs that have been implicated in jaw necrosis.

D. Patel, V. Patel, by email

1. Urushibara M, Takayanagi H, Koga T *et al.* The antirheumatic drug leflunomide inhibits osteoclastogenesis by interfering with receptor activator of NF-κB ligand–stimulated induction of nuclear factor of activated T cells c1. *Arthritis Rheum* 2004; **50:** 794–804.
2. Henien M, Carey B, Hullah E, Sproat C, Patel V. Methotrexate-associated osteonecrosis of the jaw: A report of two cases. *Oral Surg Oral Med Oral Pathol Oral Radiol* 2017; **124**: e283–287.

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No studies

Sir, I wish to congratulate Patel and colleagues for their article[1] in which they evaluated medication-related osteonecrosis of the jaw (MRONJ) in early stage breast cancer.[1] The authors stated that oral clodronate and i.v. zoledronic acid appear to be equally effective in reducing breast cancer recurrence and mortality in the adjuvant setting. However, to date, there are no studies comparing efficacy of oral bisphosphonates with i.v. zoledronic acid in terms of reducing clinical outcome when they are used in breast cancer at adjuvant setting. Furthermore, it is expected that intravenous bisphosphonates could be more effective than oral due to their potentially more anti-tumoral activity.[2]

K. Altundag, Ankara, Turkey

1. Patel V, Mansi J, Ghosh S et al. MRONJ risk of adjuvant bisphosphonates in early stage breast cancer. *Br Dent J* 2017; **224:** 74–79.
2. Tonyali O, Arslan C, Altundag K. The role of zoledronic acid in the adjuvant treatment of breast cancer: current perspectives. *Expert Opin Pharmacother* 2010; **11:** 2715–2725.

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