foundation dentists, but perhaps the hope of developing as a dental professional to be able to better manage difficult and potentially litigious situations in practice.

Overall, I feel that foundation training in its current structure is good preparation for young dentists whether they decide to stay in practice or enter core training.

C. Heggie, by email

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OMFS

Resection of the calcified ligament

Sir, I write following the excellent chapter on chronic orofacial pain by Professor Tara Renton (*BDJ* 2017; **11:** 826–836).

In the short section on glossopharyngeal neuralgia, she states that management is similar to that for trigeminal neuralgia. However, my experience has been that some with this rare condition show calcification of the stylohyoid ligament on the affected side and that this can be visible on an OPG radiograph, supplemented perhaps by CT. This is known as Eagle's Syndrome. Furthermore, their pain can usually be alleviated by resection of the calcified ligament, in effect now a bone.

This operation is relatively simple to do under GA via an upper neck incision parallel to the anterior border of the sternomastoid muscle. Dissection is straight forward by displacing the muscle posteriorly and bluntly going down the gap (a finger can be helpful here). This takes the operator straight to the 'bone' which is easily palpated. Key neck structures are easily avoided. Upon opening the periosteum, the calcified structure can be resected with bone rongeurs, after which the wound is closed in the normal way. Any OMFS surgeon with experience of parotid gland surgery would be able to do this.

There is also an ENT approach intraorally via the tonsillar fossa with the aid of an operating microscope but it is potentially more hazardous.

Medical management as per trigeminal neuralgia should be tried first in case surgery can be avoided; it may need to be continued for a while post-operatively.

I have done this operation only a handful of times in a career in OMFS over more than 30 years, so it is infrequent.

B. Speculand, Birmingham

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Dentists on film

Ill-informed fish

Sir, I read with interest H. S. Brand's column on *Finding Nemo* (*BDJ* 2018; **224:** 7).

It was the pufferfish and not the boxfish that asked if rubber dam and clamp were installed; they were not despite the starfish's confirmation that they were. Nowadays, even if used, the concern about sensitivity to latex rubber dam means latex-free versions and the generic term 'dental dam' are preferred.

The royal gramma asked what was used for opening the tooth? Not only did the starfish wrongly call the drill Gator Glidden instead of Gates Glidden, this type of drill cannot be used for making initial access. Even for refinement of the access cavity, Gates Glidden drills have largely fallen out of favour, replaced by glide-path instruments. As for whether the hand file used was a Hedstrom or K-Flex, given the current popularity of engine-driven NiTi files, the argument between the pufferfish and the royal gramma is more likely to be whether it it rotary or reciprocating?

The pelican's concern about surplus sealer at the secondary portal terminus is understandable. A combination of heat and hydraulic pressure from Schilder-type obturation technique can lead to a 'Schilder puff' of excess sealer. If it is of any comfort to the pelican, the single-cone technique, but now combined with a bioceramic sealer, which will reduce the risk of surplus sealer, is making a comeback.

Endodontics is a discipline rich in technology. If *Finding Nemo* is ever remade, the script for this film segment will have to be substantially rewritten and updated.

B. S. Chong, London

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Oral health

Sugar tax doubts

Sir, in April 2018 the sugar tax will be introduced. Hailed as one of the biggest UK health initiatives in recent years, it seems a huge step towards curbing increasing rates of childhood obesity and paediatric hospital admissions for extractions. However, can this leap forwards in oral disease prevention and health promotion actually work?

Evidence cited for the potential success includes that of a similar 10% tax introduced by Mexico in 2014, resulting in a 12% decline in sugary drink purchases in year one.[1] Yet, recent data show purchase figures beginning to rise.[2] Denmark's now infamous 'fat tax' was abolished within 15 months and thence plans for a similar sugar tax. A recent paper argued their tax minimally impacted 'unhealthy foods' consumption.[3] Consumers switched to cheaper brands, even going so far as to cross into Sweden and Germany to shop! Effects included increased prices on everyday foods and an increase in inflation. Much tax revenue was eaten up by administration costs. Argued to be 'regressive', hitting the poorest, hardest; a similar argument was cited here in the UK and demonstrated in Mexico with the highest reductions in lower SES households.[1]

California's 2015 soda tax saw only 22% tax value passed onto the customer causing prices to raise less than half the tax amount.[4] Soft drink consumption has been falling across the US regardless, argued to be a 'halo effect' from increased discussion and health awareness surrounding tax proposals. In the UK, manufacturers are already reformulating drinks to below taxable thresholds. A sugar tax may be successful short term, but there are no long-term data as to successes of similar schemes. Marketing strategies including end-of-aisle and till-point locations can increase sales by up to 50%[5] as well as promotional bias towards discounting sugary items. Public Health England suggests 6% of sugar volume sold is preventable[6] and addressing these marketing tactics could go a long way towards reducing sales. We must wait and see what effect the new sugar tax will have.

J. Tebbutt, Manchester

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