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.

CASE REPORT LETTERS

DIY dentistry

Clip-on veneer

Sir, we would like to share a case of DIY dentistry that presented recently to our emergency dental clinic. This lady had purchased a clip-on veneer online from a company offering a 'million dollar smile instantly'. The manufacturers provide a 'Perfect' smile that can be custom fitted to a patient's existing dentition with a home reline material without any form of dental examination or professional support. The new smile was purchased for the princely sum of £10.67. Unfortunately, the home reline became locked onto the patient's teeth. The patient was not registered with a dentist. She had initially sought advice from her GP who could not help before attending an Out of Hours dental service who, again, could not help. She was given advice to attend A&E following which she was directed to the dental hospital and presented in a state of extreme physical and emotional distress.

Needless to say we took the opportunity to fully document the case (Figs 1-4). The remaining material was carefully removed and the patient advised not to consider such options in the future. The image taken following removal of the device demonstrates traumatic ulceration from the prosthesis and unstable oral disease.

It would appear there is a growing market in unregulated home dental kits including whitening, orthodontic and smile make-over procedures. We hope this case helps support dentists to challenge the perceived wisdom patients may have in these fast and significantly less expensive alternatives to traditional dentistry. The cost to the NHS for the patient's four attendances and the concomitant emotional burden to the patient serve to highlight how such quick fixes can easily become false economies.

S. Jadun, L. Monaghan, J. Darcey, by email

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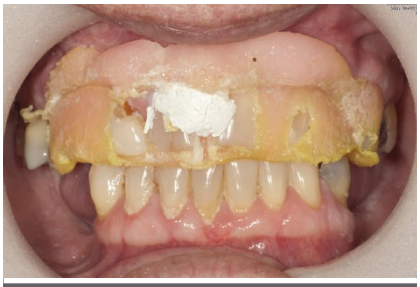

Fig. 1 The low cost clip-on veneer stuck to a patient's teeth

Fig. 3 The 'perfect smile' product purchased online

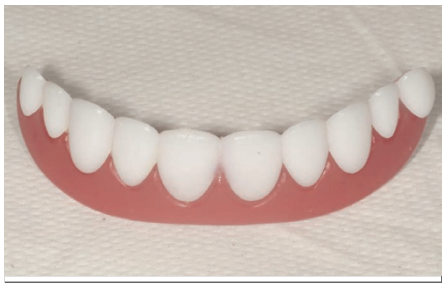

Fig. 2 The clip-on veneer purchased on the Internet

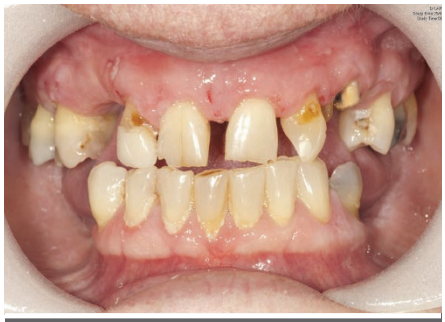

Fig. 4 The patient's dentition after the veneer was removed

OMFS

Sialolith infection

Sir, a 47-year-old female presented with persistent pain and swelling of the right submandibular region of four weeks' duration. There was no history of dental pain or swelling intraorally. She did not complain of any problems eating, drinking, swallowing or breathing. Specifically, she did not complain of any mealtime symptoms of pain and swelling. Due to her symptoms, she visited her general dental practitioner twice thinking it to be a 'dental infection' and was prescribed oral antibiotics on both occasions. She was further advised removal of the lower right first molar tooth after finishing the course of antibiotics.

Medically, she suffered from gastro-oesophageal reflux disease (GORD) and

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hypothyroidism and was on regular levothyroxine and omeprazole. She was afebrile. On examination, she had a tender, fluctuant, localised 7-8 cm swelling of the right submandibular region. Intraorally, her mouth opening was satisfactory with no evidence of any obvious pathology. The floor of the mouth was not tender or raised. The lower right first molar tooth was grossly decayed but no evidence of acute infection was noticed.

An orthopantomograph revealed three radiopaque lesions below the right lower border of the mandible (Fig. 1). The largest of this opacities measured about 1.5 cm in diameter. A diagnosis of right submandibular abscess secondary to multiple sialoliths in the main body of the submandibular salivary gland was made which was further confirmed with an ultrasound scan. The patient underwent aspiration of abscess which revealed about 12 ml of pus and was subsequently booked for formal excision of the submandibular salivary gland. There are many situations where the teeth may not be the cause of facial/neck swellings. We recommend early referral of these patients to secondary care as drainage is necessary to facilitate further spread and prevent further morbidity to the patients.

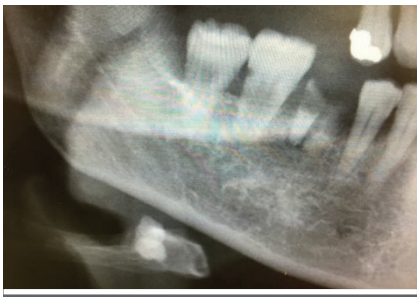

Fig. 1 Orthopantomograph revealing three radiopaque lesions below the right lower border of the mandible

S. Mumtaz, Chelmsford

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Masquerading as periodontal disease

Sir, we write to highlight a difficult to diagnose presentation of early medication-related osteonecrosis (MRONJ) masquerading as periodontal disease.

This 51-year-old female was referred following prolonged pain and infection from suspected periodontal disease distal to lower right second molar (47), which had failed to respond to antibiotic and non-surgical periodontal therapy. Her GDP identified her as high risk of MRONJ and referred to our dedicated clinic for this cohort of patients. Her medical history included recurrent breast cancer with bone metastases managed by hormonal therapy and 30 monthly injections of denosumab.

On presentation, there was tender right submandibular lymphadenopathy. Palpation of the area was limited due to the severity of her pain. Both second and third molars were deemed vital. The interdental papillae between them appeared inflamed and oedematous with profuse bleeding on probing (Fig. 1). The key feature here was loss of attachment, not just to the 47, but on careful examination extending to the alveolar bone. There was no mucosal breach or communication to the bone other than via the periodontium, nor swelling or extensive erythema indicating spreading infection. Intra-oral radiography was not tolerated. A dental panoramic