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.

Denture hygiene

Safety issues with denture care

Sir, we are delighted that the Oral Health Foundation has recently released guidance¹ to promote the importance of good denture hygiene. The guidance rightly identifies that there are many inconsistencies in current advice and practice which can be confusing for denture wearers and carers who support people with mouth care.

The guidance² recommends that dentures are brushed daily, soaked in a denture cleansing solution to disinfect and left out of the mouth overnight.

Whilst this is good advice for those people who are independent, we would like to raise awareness of safety issues for patients with cognitive or visual impairments residing in their own homes, care homes and hospitals.

Manufacturers of denture cleansing products recommend that dentures are meant to be soaked in cleansing solution for a short period of time, but in busy hospital wards and care homes they will often be left in these solutions when not in the mouth, sometimes in glasses or beakers rather than in a denture container. With dehydration common in older patients there is a risk that the denture solution may be accidentally mistaken for a drink.

Older patients in particular may be taking a multitude of pills and the denture tablets could get mistaken for their regular medication, especially effervescent tablets. There are many reported cases³⁻⁵ of people accidentally ingesting denture tablets or cleansing solutions leading to serious damage to their respiratory and digestive tracts and, in a few cases, this has led to death.

When training care staff, the view of the British Society of Gerodontology is that dentures are cleaned on a daily basis with a toothbrush and soap to remove debris and

then rinsed with water. Historically it was common practice to simply leave dentures soaking in a solution without brushing and oral health promoters have worked hard over the years to change this practice.

For some people, for example those with dementia or who are partially sighted, the risk of accidentally swallowing denture cleansers outweighs the benefit of using them.

Denture care including safe storage and denture labelling to help prevent accidental loss is an important part of patient care. We would urge readers to be aware of these potential risks and discuss them with patients and carers.

M. Doshi and V. Jones, by email

1. BDJ. Experts issue guidance on best care for dentures *Br Dent J* 225: 588.
2. Oral Health Foundation. White paper on optimal care and maintenance of full dentures for oral and general health. Available at <https://www.dentalhealth.org/denturecareguidelines> (accessed December 2018).
3. Ochi N, Yamane H, Honda Y, Takigawa N. Accidental aspiration of denture cleanser tablets caused severe mucosal edema in upper airway. *Clin Respir J* 2018; 12: 291–294.
4. Laidlaw S. Accidental Ingestion of Steradent Tablets in a Patient with Cognitive Impairment. *Scot Med J* 2007; 52: 53–53.
5. Boonekamp C, Voruz F, Fehlmann C. Accidental aspiration of a solid tablet of sodium hypochlorite. *BMJ Case Rep* 2018; 2018: bcr2018224213.

DOI: 10.1038/sj.bdj.2019.13

Rules of prescribing

Prescribing cannabinoids – how relaxed are the rules?

Sir, 1 November 2018 marked an important change in the law;¹ rescheduling medical cannabis from schedule 1 to schedule 2.

Schedule 1 drugs are deemed to have no therapeutic value and therefore, cannot be lawfully prescribed, whereas, schedule 2 drugs may be prescribed. This change was heavily covered in the media with newspapers headlining ‘Medical cannabis products available on prescription,’² leading

to a noticeable recent surge in the number of patients asking about the benefit of medical cannabis for treating their dental conditions.

The change in legislation follows the well-publicised cases² of two young boys who suffer with severe, intractable forms of epilepsy and have found a type of cannabis oil to be effective in managing their symptoms, where other medications have failed.

Cannabis is made up of compounds called cannabinoids, the main ones discussed for their therapeutic effect are; tetrahydrocannabinol (THC) which is the psychoactive component of cannabis responsible for recreational ‘highs’ and cannabidiol (CBD), which has no psychoactive effect.³

The recent upheaval in light of these boys’ plights were regarding oils containing both a mixture of THC and CBD which were previously illegal. Medical cannabis products are thought to be of benefit in certain cases of multiple sclerosis spasticity, intractable chemotherapy and severe epilepsy.³ They are therefore, unlikely to be prescribed for other conditions.

It is unsurprising then, that the new legislation restricts the prescribing of medical cannabis to specialists only on the General Medical Council⁴ registry, thus, dentists are excluded.

A letter from the Chief Medical Officer outlining the new shift, highlights that medicinal cannabis may only be prescribed where there is clear evidence of its benefit and where other treatment options have been exhausted. Currently, there are no guidelines, however, NICE are due to produce clinical guidelines on the prescribing of medicinal cannabis products by October 2019.

As healthcare professionals, our clinical judgements should be evidence-based. There is currently no strong evidence or guidelines to support the use of cannabis-derived medication in dentistry and it has not been added to our dental formulary.

CASE REPORT LETTERS

Paediatric type 1 diabetes mellitus Multidisciplinary approach needed

Sir, an eight-year-old female was referred to the department of paediatric dentistry complaining of swollen, bleeding gums and mobile lower incisors, first noted by her GDP.

On clinical examination, the gingivae surrounding the lower incisors was erythematous (Fig. 1) and there was grade II mobility of 31 with grade I mobility of the 42, 41, 32. Radiographic investigation showed periodontal bone loss between 41 and 31, just greater than half the root lengths. There was crestal bone loss between the other lower incisors and widening of the remaining periodontal ligaments of all four lower incisors periapically (Fig. 2).

The patient also had caries affecting a number of her primary teeth. Blood tests were completed to explore any underlying systemic condition. Results were normal

or negative apart from her random blood glucose which was elevated at 15.9 mmol/L. The patient's general medical practitioner was urgently contacted who reviewed her and sent her to hospital. She was diagnosed with type 1 diabetes mellitus and began an insulin regime.

Once her glycaemic control had improved, following liaison with her paediatrician, dental treatment was completed during early morning appointments following breakfast and insulin injection. This included a programme of prevention, supra and

subgingival scaling of the lower anterior teeth, extractions and restoration of her carious primary teeth under local anaesthetic. Her gingival condition significantly improved (Fig. 3) and the family are now adapting well to the patient's newly diagnosed condition.

We would like to stress that in the paediatric patient, any unexplained gingival swelling, bleeding and/or mobility of the teeth requires further investigation and could be a sign of an undiagnosed systemic condition.

The GDP may be the first clinician in contact with these patients and needs to have an awareness of associated oral manifestations of disease, whilst referring promptly if required. Prior to and following diagnosis of diabetes in paediatric patients, an effective multidisciplinary approach to medical and dental management is required for holistic patient care.

*L. Clarke, T. Bradshaw, M. Pemberton and
S. Barry, by email*

DOI: 10.1038/sj.bdj.2019.16

Fig. 1 Pre-operative photograph

Fig. 2 Periapical radiograph

Fig. 3 Post-operative photograph

Patients may continue to ask about this dramatic new medication, but until there is high quality research, cannabinoids at present will remain a novelty in dentistry.

E. Yonis and I. Hussain, by email

1. Government. The Misuse of Drugs (Amendments) (Cannabis and Licence Fees) (England, Wales and Scotland) Regulations 2018. 2018. Available at <http://www.legislation.gov.uk/ukxi/2018/1055/contents/made> (accessed November 2018).
2. BBC News. Medical cannabis products available on prescription. 2018. Available at <https://www.bbc.co.uk/news/health-46045487> (accessed November 2018).
3. Fraguas-Sánchez A I, Torres-Suárez A I. Medical Use of Cannabinoids. *Drugs* 2018; **78**: 1665–1703.
4. Department of Health & Social Care. Cannabis-based products for medicinal use. 2018. Available at <https://www.england.nhs.uk/wp-content/uploads/2018/10/letter-guidance-on-cannabis-based-products-for-medicinal-use..pdf> (November 2018).

DOI: 10.1038/sj.bdj.2019.14

Brexit

Call for the BDA to support a People's Vote

Sir, the UK is in a political crisis. Next March we will be leaving the EU and our two main political parties are deeply divided on this issue.

At the time of writing there is a very real possibility that the UK could crash out of the EU in a no deal scenario. No deal would mean no withdrawal agreement and no transition period. This would be the worst outcome for the country as a whole, and according to the British Medical Association (BMA), could have potentially catastrophic consequences for the nation's health.¹

The impact of different Brexit scenarios

on health and health services has been analysed in detail by Fahy and colleagues,² and applies equally to dentistry. Among others, Brexit will negatively affect recruitment and retention of EU staff, NHS financing, reciprocal healthcare arrangements, licensing and pricing of medical products, and threaten existing public health protections. As regards research, apart from the impact on governance and loss of funding, any Brexit that ends the free movement of people will stifle cross-country research collaborations.²

Brexit is likely to exacerbate existing skills shortages in UK dentistry, especially in rural areas.³ About 16% of registered dentists in the UK are EEA qualified.⁴