

Letters to the editor

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Aesthetic dentistry

Is the NHS equipped to manage complications?

Sir, there has been a recent rise in popularity of dermal fillers with the increased use of social media, video calling and conferencing since the start of the pandemic.¹ As personal care premises, such as beauty salons, have been able to re-open following the easing of COVID-19 restrictions, there has been a rise in the number of patients attending Accident and Emergency (A&E) departments, with vascular occlusion following the injection of filler material undertaken in these establishments.

Vascular occlusion is a rare, but severe, complication occurring due to inadvertent intravascular injection of dermal fillers, or external vascular compression. The incidence of a vascular occlusion following soft tissue augmentation with filler is 1 in 100,000.² It is more common in the glabella and nasal area due to the limited collateral blood flow,³ and has the potential to result in skin necrosis and tissue death if left untreated.² The first-line treatment for vascular occlusion is hyaluronidase, which is a prescription-only medication; it can break down hyaluronic acid, the component found in dermal fillers.⁴

Whether undertaken by medical or non-medical practitioners, it is vital that there is a clear protocol in place for the management of such complications before administering dermal filler. Many patients are referred to their local oral and maxillofacial surgery (OMFS) department once a diagnosis of vascular occlusion is made, but it is important to bear in mind that A&E departments and maxillofacial units may not necessarily be able to manage acute complications of facial aesthetic procedures. The maxillofacial dental core trainees receiving the referrals may not have advanced aesthetics knowledge and training.

In addition, the hospital may not have hyaluronidase medication readily available.

As the public continue to seek facial aesthetic treatments, post-operative A&E attendances are also likely to rise. We believe it is important that A&E and OMFS teams are trained to spot these complications and be aware of onward specialist referral pathways, as appropriate, for the patient to receive the optimum level of care that is vital in these situations.

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History of dentistry

Bluetooth

Sir, as a dentist with a penchant for history, I was reading about the Anglo-Saxon King Canute (1016–1035). A Danish Prince, he became King of England, Denmark and Norway at a time when the Vikings were at large in Northwestern Europe and was the grandson of King Harald Bluetooth.¹

My surprise and amusement in learning the name of this latter Viking gentleman, who was obviously in need of root canal treatment, was only surpassed on learning about the contemporary company Bluetooth.² The Bluetooth company website explains that King Harald Bluetooth was known for uniting Denmark and Norway in the year 958. It goes on to explain that in 1996, industry leaders Intel, Ericsson and Nokia met to

standardise the short-range radio technology subsequently coined 'Bluetooth'. Jim Kardac from Intel was quoted as saying 'King Harald Bluetooth was famous for uniting Scandinavia just as we intend to unite the PC and cellular industries with a short-range wireless link'.²

Another interesting fact is that the curious Bluetooth symbol is a unification of the Danish runes for letters H and B – the initials of Harald Bluetooth.^{3,4} Thus, Anglo-Saxon history, dentistry and modern technology are inexorably linked.

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Restorative dentistry

Veneers not crowns

Sir, sadly, the rhetoric from Dr Kelleher and Professor Burke is not surprising, failing to address any of the issues raised in my initial response and adding nothing to the debate.¹ I made no mention of abfraction and I don't subscribe to any occlusionista tribe, whatever that may be. No treatment was undertaken on temporomandibular disorder grounds but to generate a favourable occlusion ensuring long-term success. Much is made of anterior marginal ridge preservation but current studies relate to molar/premolar teeth where occlusal forces are completely different. Simply extrapolating this data to anterior teeth is unsound.