

We, as part of our micro-educational opportunities,<sup>2</sup> engage with the community by sending our Year 5 dental students and hygiene/therapy students to a variety of community settings together with qualified dental nurses. These include a homeless shelter for young adults, a drug and alcohol detoxification unit, drug and alcohol recovery services, and the Probation Service (community drop in centres). The students talk with the residents and service users disseminating oral health advice, providing oral health screening and free toothbrushes and toothpaste. Patients requiring treatment are then offered an appointment at the Dental Academy where all treatment is provided by students free of charge through our NHS primary care contract.

Although our provision of community service is much less comprehensive than that reported, as it is just one element of what we do at the Dental Academy, it does embed in the students a new dimension to their professional career. Despite reducing budgets, we have continued to provide the services due to their significant positive impact on the patients, as well as broadening the experience of our students. Last, we will point students to this excellent paper to give them greater insight into dental care for the homeless and hard to reach, to enhance their understanding in this important area of dental care provision.

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L. Davda, Portsmouth

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## PERI-IMPLANT DISEASE

### Not the grim reaper?

Sir, I read with interest the article on combating peri-implant disease (*BDJ* 2016; **220**: 48–49). It certainly makes for grim reading and as someone who is actively involved in implant therapy as well as assessing implant cases caught in the net of dento-legal litigation, I am only too aware of the problem.

However, I would caution your readers about the premise upon which much of the periodontal community has drawn its data, since it does not differentiate between aetiologies of peri-implant disease. The need for a classification of aetiology is long overdue since many initiating factors that can lead to peri-implantitis can be avoided and response to treatment can vary widely according to

the initiating or causative factor. Recently my colleagues and I published a classification which aims to dispel much of the myth that surrounds the prevalence data, recognising as it does that true peri-implant disease, defined as being caused by the presence of biofilm, is only one such category.<sup>1</sup>

Few would argue that peri-implantitis caused by the presence of excess cement is the same disease process as a biofilm-induced peri-implantitis in a patient who has a genetic pre-disposition to periodontal disease, especially if they are also a smoker. However, the literature and data upon which the European Workshop on Periodontal Disease relies fails to recognise these differences. The same is true of physiologically or surgically induced peri-implantitis. This occurs when the buccal or labial bone is naturally thin (>0.5 mm) or is rendered too thin by virtue of the osteotomy preparation to be sustainable. Resorption ensues and the surface of the implant becomes exposed to the soft tissue environment. The effects of biofilm then come into play. Had there been adequate bone thickness no such vulnerability to the biofilm would be exposed.

I was also concerned by the suggestion that the work of Addison was either new or in some way indicated in the pathophysiology of peri-implantitis. It has been known for very many years that titanium corrodes in a physiological environment. A quick search on Medline will attest to numerous studies going back as far as the 1960s demonstrating this very effect<sup>2</sup> and many recent studies have demonstrated that titanium particles, which can be found in distant tissues including lymph nodes, lungs etc appear to be very well tolerated with little or no side effects.<sup>3</sup> It is a leap to suggest that such nanoparticles or corrosive by-products of titanium are a causative agent in peri-implantitis, although I await the findings of Professor Addison's five-year NIHR study with interest.

Additionally, numerous studies have identified the threshold of clinical parameters used to measure and define peri-implantitis as being very variable. Depending on the level set for these thresholds the prevalence can vary tremendously, and there remains some considerable debate as to where these thresholds lie. In short peri-implantitis is certainly a problem, but with good planning and execution, and a better understanding of the data included and thresholds set in our evaluation of this disease, we may find that it is not quite the grim reaper we all fear.

M. Norton, by email

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implants in a corrosion-producing environment. *Surgery* 1964; **55**: 714–717.

3. Weingart D, Steinemann S, Schilli W et al. Titanium deposition in regional lymph nodes after insertion of titanium screw implants in maxillofacial region. *Int J Oral Maxillofac Surg* 1994; **23**: 450–452.

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## ORAL CANCER

### Link with early coitus

Sir, a 22-year-old mother presented to us, complaining of a sore area on the left side of her tongue, present for about two weeks. There was no other relevant medical history nor adverse oral habits. She had initially reported to a physician who suspected a local traumatic ulcer arising from an unerupted lower third molar. She was prescribed a topical steroid and chlorhexidine mouthwash. Reviewing the patient one week later with no signs of healing and progressive trismus and dysphagia, she was referred to us for further management.

Extra oral examination revealed a tender, hard, enlarged right jugulodigastric and submandibular lymph nodes. Intraoral examination demonstrated a coated tongue, a tender, indurated erosive endophytic ulcer 2 × 3 cm



Fig. 1 A single non-healing erythematous endophytic ulcer involving the left lateral border of the tongue and floor of the mouth

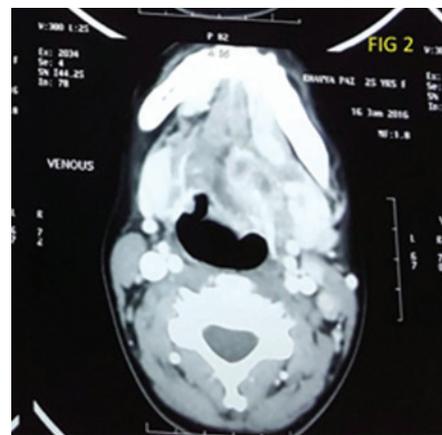


Fig. 2 Axial CECT shows a large left-side tongue base carcinoma. Note the extension approximating the midline and the ipsilateral enlarged jugulodigastric node

on the left lateral border of the tongue and deviation of the tongue to the left side. She complained of intolerance to hot and spicy food and hoarseness in her voice. Clinical diagnosis was confirmed histopathologically as moderately differentiated squamous cell carcinoma of the tongue.

The aetiology of oral cancer in younger adults remains unclear; however, one needs to ponder on the ubiquitous human papilloma virus (HPV). Oral cancers hidden in cryptic locations of the oral cavity, mimicking symptoms in the initial stages, such as those of pericoronitis and tonsillitis, often confront clinicians with the daunting task of managing them in advanced stages. Thinking outside the box with an early diagnosis and swift referral is key before these tumours progress. In this patient, an early marriage followed by early coitus might have triggered the dormant HPV.<sup>1</sup> HPV-induced oral cancer known for its demographic shift may be an emerging and distinct clinical entity, although future research is necessary.

Sameep S. Shetty, Premalatha Shetty, Mangalore

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## CONTACT DERMATITIS

### Fiddler's neck

Sir, dermatoses in musicians can occur in players of brass, percussion, wind instruments and also players of string instruments.<sup>1</sup> We present a 36-year-old woman (Fig. 1) who plays the violin with an irritant area from contact of the chin rest with the left submandibular neck who came for routine dental examination. Cutaneous examination of the left submandibular neck demonstrated a hyperpigmented, erythematous plaque. A panoramic radiograph showed some calcifications and one of them is an oval calcification with smooth periphery and has the appearance of laminations, giving it a bull's-eye or targetoid appearance in the internal



**Fig. 1** a) Touchpoint of violin on left submandibular area; b) Irritant area from contact of the violin; c) Targetoid shaped oval calcification on panoramic image (white arrow), other small calcifications (white arrowheads)

aspect like phlebolith.

One of the most common types of trauma-induced dermatitis in musicians is fiddler's neck syndrome, induced by violins and violas. There is greater variety of clinical aspects in this syndrome than in the usual irritant contact dermatitis. The lesions can be localised plaques of erythema, sometimes pigmented or lichenified.<sup>2</sup> However, these lesions are generally not considered radiographically and the direct relationship between the violin and phlebolith-like calcification has never before been recorded in medical literature. In some literature violin pressure points have been shown to be among the causes of dystrophic calcification.<sup>3</sup>

We evaluated this calcification seen in the neck as phlebolith from an acquired vascular malformation or a dystrophic calcification. An increase in the number of cases like this would help us to understand this condition more clearly.

G. Geduk, Turkey

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## TMD

### Costen's Syndrome

Sir, it was most interesting to read the short summary 'Revisiting Costen Syndrome' (*BDJ* 2016; **220**: 15).

Costen's Syndrome has been largely ignored over the years since it was first reported in 1934. Research into the embryology of the temporomandibular joint has shown that the middle ear and the joint are closely related. The disco-malleolar ligament, a remnant of the Meckel's cartilage, connects the malleus to the retro-discal tissue of the joint. It should, therefore, not be surprising that aural and joint symptoms are closely linked.

Perhaps it is now time for Costen's early work to be reconsidered and his contribution to multi-disciplinary work recognised.

R. M. Dean, by email

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## PERIODONTOLOGY

### The value of tooth and cocktail picks

Sir, as a registered specialist in periodontology I concur that toothbrushing

is probably the most important and common oral hygiene practice; however, it does not provide adequate interdental hygiene. Originally, dental woodsticks were advocated by the dental profession as 'gum massagers' to be used to massage inflamed gingival tissue in the interdental areas to reduce inflammation and encourage keratinisation of the gingival tissue.<sup>1</sup>

It has been shown that a triangular, pointed woodstick inserted interdentally can maintain a plaque-free region 2-3 mm subgingivally.<sup>2</sup> For open interdental spaces, common among adults, woodsticks seem most appropriate.<sup>3</sup> In periodontitis patients, the woodstick will depress the papilla which may help in recontouring the interdental tissues and consequently preclude the need for periodontal surgery.<sup>4</sup> Woodsticks have the advantage of being easy to use and can be used anywhere.<sup>1</sup>

Round, pointed-end toothpicks or cocktail sticks are an undervalued resource in daily plaque control in the 45% of the population that are susceptible to chronic periodontitis. In the past ten years, I have found them to be effective during the treatment stages and in the maintenance phase in patients diagnosed with moderate/advanced periodontal disease, especially recalcitrant cases. The tip is ideally shaped for access to all root morphologies and most furcations. I have also found them to have the ideal profile for use around the circular emergence profile of dental abutments and dental implants.

In most cases patients have described to me that this was mento-physically less demanding than the other available interdental aids they had previously used. Having seen the success that these toothpicks achieved, I introduced their use in a YouTube video entitled 'Oral hygiene instructions with gum specialist Dr Hafeez Ahmed'. It frees up clinical time and offers the patient a resource for ongoing reminders and training.

So far, there are no high quality prospective studies on the round pointed end tooth pick or the cocktail stick to confirm that they are an effective interdental device in reducing the clinical parameters of plaque and gingival inflammation but I am hopeful that this letter might encourage this.

H. Ahmed, by email

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