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Dihydrocodeine to stay on dental practitioners' list

Sir, — As the chairman of the BDA's Dental Formulary Committee I would like to respond to the letters from Matthew and Frame (*BDJ* 1998; 184: 266) and Speechley and Hancock (*BDJ* 1998; 184: 525). Concern was raised about the abuse potential associated with dihydrocodeine and approaches to GDPs by drug users seeking its wrongful acquisition. It was suggested that dihydrocodeine be removed from the dental practitioners' list.

The BDA's Dental Formulary Committee and the Dental Formulary Subcommittee, which includes representatives from the British Medical Association, the Department of Health and the Royal Pharmaceutical Society of Great Britain, have considered the proposal and both committees have agreed that dihydrocodeine should continue to remain on the dental practitioners' list. Dihydrocodeine should be retained in the DPF on the basis that:

- 1 The DPF does not include any fixed dose combination agents.
- 2 Non-opioids, especially paracetamol, may not always provide for sufficient pain relief.
- 3 Paracetamol alone is a less effective analgesic for inflammatory dental pain compared with ibuprofen (which in short courses, up to 7 days, has a similar safety profile).
- 4 For patients unable to take NSAIDs the addition of a non-opioid to paracetamol provides for analgesia the equivalence to that achievable using ibuprofen.

We understand the concerns felt by dentists about pressure to issue prescriptions to drug abusers, but in a recent survey conducted by the BDA it was found that direct physical assault on either dentists or auxiliary staff is rare. We believe that the benefits in respect of dental pain relief afforded by dihydrocodeine for genuine patients outweighs the risks associated with its potential abuse by a small minority.

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Ecstasy related tooth wear

Ecstasy, 3,4-methylenedioxymethamphetamine, is an amphetamine analogue which is increasingly common as a drug of abuse on the dance scene.¹ It is a banned substance under the Misuse of Drugs Act 1971. To date, dental problems associated with ecstasy abuse² have been speculative although reports of its other dangerous side effects are well documented.^{3,4} Possible side effects have been reported as hepatotoxicity, neurotoxicity, psychiatric disorders, palpitations, trismus, bruxism, altered sleep patterns and binge eating on chocolate.



Fig 1



Fig 2

We recently saw a 17-year-old student referred by his general dental practitioner with moderate tooth wear. At presentation, he was largely symptom-free, reporting sensitivity only when he consumed fizzy drinks. He had no history of gastro-intestinal problems, vomiting or regurgitation, factors often contributory to tooth wear. Examination revealed a minimally restored dentition. Marked tooth wear was present and involved all teeth, but especially the premolars and permanent molars (Figs 1 and 2). After discussion regarding possible aetiological factors in tooth wear, the young man was given a diet sheet to complete. Review of the diet sheet revealed a poorly balanced diet with atypical consumption of 500ml carbonated drinks twice daily. Further detailed questioning at this stage revealed the possibility that this was under-reported. The patient admitted to frequently consuming carbonated drinks during 'nights out' in an attempt to counter dehydration. He subsequently admitted to the frequent abuse of ecstasy and has sought professional help

regarding this.

Changes in jaw muscle activity, bruxism and trismus, reported side effects of ecstasy abuse, may be factors in tooth wear. Current health promotion advice to those abusing ecstasy is the frequent consumption of small quantities of 'sports' type or fruit drinks in an attempt to counteract dehydration and avoid ion imbalances. Both of these types of drink are known to have the potential to be erosive to teeth. It is conceivable that the combination of changes in jaw muscle function, appetite and drinking patterns could contribute to, or cause, tooth wear. We consider that the case described provides an example of tooth wear in a young, otherwise healthy man related to the frequent abuse of ecstasy and an associated excessive consumption of fizzy drinks.

With this case we highlight yet another possible cause of tooth wear and means by which a practitioner may identify substance abuse involving ecstasy. As with all cases of marked, active tooth wear, it is suggested that management in cases of the type reported is dependent on the treatment of the underlying cause or combination of aetiological factors, prior to considering the options of monitoring and maintenance or various forms of operative intervention.

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References

- 1 Forsyth AJ. Places and patterns of drug use in the Scottish dance scene. *Addiction* 1996; 91: 511-21.
- 2 Duxbury AJ. Ecstasy - dental implications. *Br Dent J* 1993; 175: 38.
- 3 O'Connor B. Hazards associated with the recreational drug ecstasy. *Br J Hosp Med* 1994; 52: 510-514.
- 4 Schifano F, Magni G. MDMA abuse: psychopathological features and craving for chocolate: a case series. *Biol Psychiatry* 1994; 36: 763-767.

Widespread child behaviour

Sir, — I found the letter 'Potential Bathroom Hazard' (*BDJ* 1998; 185: 58) by Beckett and Robinson of particular interest because I have encountered a number of similar cases myself. Some years ago I called on a colleague, to be greeted at the door by her teenage daughter whose smile was spoiled by the loss of half the crown of one upper central incisor. It turned out that she had long been in the habit of turning the light on and off by gripping the 'acorn' of the pull cord with her teeth. This had caused no damage until she had, presumably, been over enthusiastic in this practice.

Since then I have come across three fur-