

OTHER JOURNALS IN BRIEF

A selection of abstracts of clinically relevant papers from other journals. The abstracts on this page have been chosen and edited by John R. Radford.

HEAD AND NECK CANCER

PET-CT surveillance *versus* neck dissection in advanced head and neck cancer

Mehanna H, Wong W-L *et al.* *N Engl J Med* 2016; 1444–1454

Despite less surgery, quality-of-life measurements were not superior in patients who received PET-CT-guided surveillance, compared with that group who received routine neck dissection.

'Chemoradiotherapy has become a mainstay of primary treatment in patients with squamous-cell carcinoma of the head and neck.' But for those patients with advanced nodal disease (stage N2 or N3), there are wide variations in their management. Following chemoradiotherapy, cancerous cells have been reported in up to 40% of the nodes of those patients who undergo neck dissection. This fact and survival data are both reasons for routine neck dissection. But positron-emission tomography-computed tomography (PET-CT)-guided surveillance can identify tumours with a negative predictive value of 95%. The aim of this prospective randomised controlled study was to determine if PET-CT can be used to identify those patients with advanced nodal disease, who have already received chemoradiotherapy, who should go on to receive neck dissection. This trial recruited 564 patients from 37 UK centres (282 patients in the surveillance group and 282 patients in the planned-surgery group). Seventy-five percent of patients were positive for HPV-16 protein. The median time for follow-up was 36 months. The investigators reported, there was no difference in survival for those patients who received PET-CT-guided surveillance compared with those who underwent neck dissection. Of note, the PET-CT-guided surveillance group had fewer operations (54 *vs* 221). However, surprisingly there was no difference in quality of life measurements at 24 months. From a monetary perspective, there was a saving of almost £1.5K per person for the provider, for those that received PET-CT guided surveillance.

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COSMESIS

Guidance for all doctors who offer cosmetic interventions

http://www.gmc-uk.org/guidance/news_consultation/27171.asp

'Most dermal fillers have no more controls than a bottle of floor cleaner.' Independent Report, Review of the Regulation of Cosmetic Interventions, Department of Health (DH) 2013.

In response to this DH report, this GMC guidance is relevant to dentists who carry out nonsurgical facial aesthetics and indeed all those who carry out dental cosmesis (See DH Report 3.9 '... similar concerns with cosmetic dentistry and Ministers may wish to consider a further review in this area.'). Irresponsible advertising and aggressive inducements, including promotional tactics such as procedures being offered as prizes should be avoided. The process of consent must not be delegated to others, and the patient should be given time for reflection. Continuity of care should be provided.

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MOLAR TOOTH PROGNOSIS

Loss of molars in periodontally treated patients: results 10 years and more after active periodontal therapy

Dannewitz B, Zeidler A *et al.* *J Clin Periodontol* 2016; 43: 53–62

The reason for extraction of almost half the teeth was unknown.

The investigators conclude that the molar teeth selected in this retrospective study, despite over half having furcation involvement, could be maintained for more than 10 years (mean survival time for molars with furcation involvement of Grade III through-and-through, was 11.8 years). Both a non-surgical and surgical approach was adopted. It was noted that patients who presented with aggressive periodontitis were less likely to lose their teeth, in contrast to those few patient with diabetes. A possible explanation for these findings could be treatment bias. The investigators used, multilevel Cox-regression analysis to look for associations between a range of different variables and molar tooth extractions in 136 patients (1,015 molar teeth at baseline). In addition, hazard ratios were calculated (instantaneous risk comparing one group and another, whereas relative risk is a cumulative value). The hazard ratio for age was (HR 1.57, *p* = 0.01), for female gender (HR 1.99, *p* = 0.035), for smoking (HR 1.97, *p* = 0.034), and for diabetes mellitus was (HR 5.25, *p* = 0.021).

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ZIKA

Zika fever and congenital Zika syndrome: an unexpected emerging arboviral disease

Chan JFW, Choi GKY *et al.* *J Infect* 2016; 72: 507–524

'...detected in breast milk and saliva of infected women...' although 'further studies are needed to determine the risk of ZIKV transmission by...saliva.'

Zika was discovered in Uganda almost 60 years ago. Then there was a massive epidemic in the Pacific islands between 2007 and 2013. There is now the outbreak in Latin America. This latest occurrence maybe associated with the congenital Zika syndrome. Zika fever is usually low grade fever with a generalised, erythematous, maculopapular rash that spreads downward from the face to the limbs. It usually resolves within 3–7 days. But sometimes the symptoms are severe with digestive tract (including aphthous [-like] ulcers), genito-urinary symptoms and severe neurological complication (Guillain-Barré syndrome). Congenital Zika syndrome may comprise a host of different conditions such as microcephaly and resulting redundant scalp skin, neurological abnormalities, including absence of swallowing, and ophthalmological defects, including cataracts and asymmetrical eye sizes. But there is no large-scale prospective cohort or case control study demonstrating a causal link between the presence of ZIKV in the foetus and congenital anomalies, after exclusion of other infectious conditions such as rubella and herpes simplex (TORCH infections), and possibly even a larvicide.

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