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**.

Anti-resorptive and anti-angiogenic drugs

Oral health management of patients at risk of medication-related osteonecrosis of the jaw.

Guidance in Brief and Dental Clinical Guidance. Scottish Dental Clinical Effectiveness Programme ISBN 978 1 905829 30 9. First published 2017. http://www.sdcep.org.uk/published-guidance/medication-related-osteonecrosis-of-the-jaw/

The dentist should not be alarmist about the risk for the patient of developing medication-related osteonecrosis of the jaw (MRONJ). The Scottish Dental Clinical Effectiveness Programme has developed many authoritative and clear clinical resources on subjects ranging from *Decontamination*, to *Management of acute dental problems* (www.sdcep.org.uk). Guidance is available in different formats including apps and posters.

Themes running through the guidance are 1) the risk of MRONJ in patients taking such drugs is low, 2) before starting drug therapy, oral health should be secured, and 3) this should be maintained by 'personalised preventive advice'. If a dentist is alarmist, this could discourage patients from taking their medication or receiving dental treatment.

At the heart of the *Guidance in Brief* are two flow charts; one that can be used to assign a patient to no risk, low risk or higher (note higher and not high) risk of MRONJ, and another that describes which dental procedures are appropriate for those in these different risk groups. The dental procedures are also described in narrative form for those readers who are not comfortable with flow charts. A further table lists trade names and drugs names according to whether they are a bisphosphonate (such as alendronic acid, and parmidronate disodium), a RANKL inhibitor (denosumab) or anti-angiogenic (such as bevacizumab).

Patients at higher risk of MRONJ are those 1) who are receiving anti-resorptive and anti-angiogenic drugs for cancer, 2) have been taking bisphosphonates for longer than 5 years, 3) those taking concurrently systemic glucocorticoid drugs, and 4) those with a previous diagnosis of MRONJ. If they have been taking, for osteoporosis, bisphosphonates for less than 5 years, or denosumab, with no concurrent systemic glucocorticoids, they are categorised as low risk.

For those patients categorised as low risk, straightforward extractions should be carried out in primary care. Antibiotic therapy and antiseptics are not necessary. For those at higher risk, alternatives to extraction of teeth should be explored, even if this involves 'retaining roots in the absence of infection'. However, if extractions are considered necessary in the higher risk group, these can still be performed in primary care. For higher risk cancer patients on these drugs, advice about care pathways can be sought from an oral surgeon or special care dentist. If the patient taking such drugs has any unexpected pain, numbness, altered sensation or swelling, they should seek advice from a dentist. Referral is indicated to secondary care if an extraction socket is not healed at 8 weeks or if a patient has suspected spontaneous MRONJ.

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Ceteris paribus – 'all other things being equal'

Withholding treatment: what, whom and why?

Pugh J. *J Med Ethics* 2017; **43:** 279

Should a dentist triage the care of a patient who has sustained dental trauma, before treating a patient in pain because of dental neglect? This paper summaries a series of papers published in this edition of *J Med Ethics*. These papers examine withholding treatment in a medical context. In this abstract, these arguments have been illustrated with dental examples. Should treatment be withheld if an elderly patient refuses extraction of grossly septic teeth, as this decision demonstrates lack of capacity? And should a dentist deny a patient's autonomy by declining to carry out cosmetic dentistry because they fear the patient may regret this in the future? It is argued that triage is merely a protocol for allocating scarce medical resources. Healthcare providers should not 'act as agents of justice'.

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'…violates the basic principles of ethics in research.'

Comment on the paper entitled 'Arginine and caries prevention: A systematic review'

Ellwood R, DeVizio W. *Caries Res* 2017; **51:** 167–169

'The Colgate-Palmolive Company is extremely proud of the clinical program ... addition of 1.5% arginine to fluoride toothpaste.' A systematic review (*Caries Res* 2016; **50:** 383–393) has questioned the findings claiming the efficacy of toothpastes containing 1.5% arginine and fluoride and the research ethics unpinning these findings. The authors of this letter repost the assertions made in this systematic review. Much of this letter revisits the issues the same authors published (RIGHT OF REPLY – A proud contribution: DOI: 10.1038/sj.bdj.2016.6) in response to an OPINION (*Br Dent J* 2015; **219:** 567–569 – two of the authors in the OPINION published in *Br Dent J* were those who published the systematic review in *Caries Res*). The authors of the letter state that this systematic review was 'both out of date and in some instances factually incorrect.' Focusing on the research ethics, it is stated in the systematic review that several studies used a non-fluoride containing toothpaste as the control; this '…offers poorer protection against caries than the standard method… violates the basic principles of ethics in research.' Yet the authors of the letter state that permission to carry out these studies was granted by the local ethics committee [Institutional Review Board (Ethics Committee) of Sichuan University]. The Declaration of Helsinki – Ethical Principles for Medical Research Involving Human Subjects is unequivocal in stating that the international norms and standards upheld by Research Ethics Committees, '…must not be allowed to reduce or eliminate any of the protections for research subjects…' (Paragraph 23)'.

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