COMMENT

Letters to the editor

Send your letters to the Editor, *British Dental Journal*, 64 Wimpole Street, London, W1G 8YS. Email bdj@bda.org. Priority will be given to letters less than 500 words long. Authors must sign the letter, which may be edited for reasons of space.

Mouth cancer

Refer with CLOTHS

Sir, the simplest mnemonic, 'CLOTHS' can act as a helpful tool for clinicians when describing oral soft tissue lesions within referral letters. With an increasing incidence of head and neck cancer and GDPs being on the front line for detection of these suspicious lesions, communication with secondary care must be improved.

A teaching session was held at Ipswich Postgraduate Centre as part of a CPD course covering 'Soft Tissue Lesions'. CLOTHS (Table 1) was created to act as an *aide-mémoire* for busy practitioners when writing referrals. The feedback was very positive and many clinicians suggested that a poster explaining how to use CLOTHS could be displayed on the surgery wall and would assist GDPs with referral

Table 1 Table showing how to use CLOTHS

Colour	Red; White; Speckled; Pigmented
Location	Lesion in relation to anatomical sites
Outline	Well demarcated; Diffuse
Texture	Ulcerated; Indurated; Granular; Smooth; Flat; Raised; Hard; Soft; Verrucous
History	Onset; Duration; Symptoms; Any changes
Size	Length; Width; Depth (mm)

Fig. 1 Graph showing results of 30 referral letters that were audited

letters. Communication between primary and secondary care is vital in providing optimal care for patients.

A well described lesion could potentially allow the referral to be upgraded to a two week wait pathway, therefore permitting earlier detection of head and neck cancer. Using CLOTHS at the point of referral assists the secondary care clinician to establish whether the lesion has changed.

Thirty referral letters from GDPs to the Oral and Maxillofacial department at Ipswich hospital were audited (Fig. 1) and the results clearly highlighted the need for change. Only 6% (2/30) of the letters used all of the components of CLOTHS. After delivering the session and raising awareness of CLOTHS we hope that the quality will improve. We are planning to re-audit in six months.

Although the best attempts can be made to describe a lesion in words, nothing is better than a clinical photograph; 'A picture is worth a thousand words'. In a world of fast developing technology, it begs the question as to why clinical photography is so underutilised?

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Holistic care

Flawed consensus documents

Sir, I write regarding *Dental Record Keeping Standards: a consensus approach*.¹ It is remarkable that NHS England and NHS Improvement consider that recording of a patient's anxiety at a new patient examination is merely aspirational. That conclusion cannot result in effective clinical judgements and evidence in the decision making process. When this suggestion is combined with aspirational recording of smoking, alcohol and diet it seems that this document has lost all sense of proper holistic care.

The document simply does not reconcile itself with many of the *Standards for the dental team* published by the General Dental Council. The regulator requires dentists to take a holistic and preventative approach to patient care which is appropriate to the individual patient. The GDC expects dentists to manage patients' dental pain and anxiety appropriately. How can this be done without proper recording at initial examination? As a profession we must be very aware not to hinder genuine patient care with well-meaning but flawed consensus documents.

C. G. P. Holden, Chesterfield, UK

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Dental trauma

E-cig explosions

Sir, we are writing to express concern about our increasing clinical experience regarding the incidence of oro-facial trauma while using electric cigarettes (e-cigs), commonly known as vapes.

'Vaping' is used to describe the action of inhaling nicotine vapour using an e-cig, and this practice is adopted by an estimated 2.9 million adults within the UK.¹ Emerging evidence suggests when e-cig use is combined with face-to-face stop smoking support, people are twice as likely to quit smoking; therefore, NHS authorities are recommending e-cig use as a valid option available to people within smoking cessation services.²

The long-term health risks associated with e-cigs are not fully known and following a recent outbreak of lung illness within the United States of America which has accounted for over 2,000 illnesses and 40

deaths, the American Medical Association have suggested a range of public health policies to tackle this emerging epidemic. A key suggestion being proposed is an outright ban of e-cigs which are not FDA approved.³ As healthcare professionals we should be aware of current guidance on their use, potential benefits and risks.

We are hoping in this letter to highlight the potential risks of e-cig 'explosions' and the consequences of such events. Within the last six months alone we have seen several cases of oro-facial trauma due to exploding e-cigs within OMFS and acute oral surgery settings. Injuries included multiple extra-oral and intra-oral hard and soft tissue injuries which has led to facial scarring and loss of tooth structure.

It is acknowledged that e-cigs are rechargeable electrical appliances and so an inherent risk of explosion and fire is possible. We wonder how often the current readership discuss the possible risks and consequences of such occurrences with their patients on a day to day basis.

We feel the use of e-cigs are an important tool to be used in smoking cessation and with evidence suggesting it is 95% less harmful than smoking¹ dental professionals should have insight on the benefits of their use. We have, however, a duty to protect patients and help inform their oral and overarching healthcare decisions and due to this we feel it is pertinent to highlight the small but present risk of 'explosion' during our smoking cessation sessions with patients.

M. Dingle, A. Travers, Liverpool, UK

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Oral medicine

Diabetic ketoacidosis

Sir, SGLT2 inhibitors are used to treat diabetes. They inhibit sodium-glucose transport protein 2, preventing glucose resorption in the kidneys, and lowering blood sugar.^{1,2} These drugs increase the risk of

diabetic ketoacidosis (DKA), which can be a life-threatening condition. This manifests as nausea, abdominal pain, tachypnoea, fatigue, and ketotic breath.³ DKA is usually associated with very high blood glucose levels.

DKA is said to affect one in a thousand individuals taking SGLT2 inhibitors, but the real incidence may be higher, given the tendencies to misdiagnosis and underreporting. The risk of DKA in all diabetic patients is increased in fasting, dehydration, acute illness or following surgery,^{3,4} and so healthcare professionals working in secondary care must remain vigilant to this risk of SGLT2 treatment.² Diagnosis is more difficult as the DKA can exist with near-normal blood glucose levels. Once diagnosed, management involves insulin therapy, fluid replacement and electrolyte correction.⁴

Dental surgeons working in hospitals may not yet be aware of the NICE guidance recommending that these drugs are discontinued during admissions to hospital for acute serious illnesses or major surgery.³ *F. Chasma, Liverpool, G. Cousin, Blackburn, UK*

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Dental public health

Aggrieved of Jeddah

Sir, as an aggrieved public health dentist, I would like to express my concerns over the fading speciality of dental public health. According to Wikipedia it is a speciality that deals with prevention of oral diseases and promotion of oral health but with growing dental practice across the globe, prevention of oral diseases and promotion of oral health has become the norm.¹ As a public health dentist, it is my primary duty to educate the masses and other clinicians to practise preventive strategies. I am required to instruct and

encourage other dental specialities to have a preventive approach to oral diseases, however, if all the other specialities adopt this utopian strategy I have no other option than to stand aside as a mere spectator.

Almost all the public health dentists I know are attached to teaching institutes, for instance in the Indian subcontinent they view themselves as teachers or referral units.² They participate in oral health camps all over the country and instead of providing oral health prevention or treatment, they end up 'referring' the patients to their respective dental schools and thus increasing the school's patient quota (patent requirement mandated by the dental governing body).² In a recent study assessing the inclination of undergraduate students towards public health dentistry, Naidu *et al.* state that only one third (35%) of them had a positive attitude towards the speciality.³ This attitude could be viewed as a direct testament to the demise or waning of the speciality in the region. Now is the time to act. A failproof strategy has to be devised and mobilised before this speciality becomes an entity of the distant past.

Increasing the prospects of this speciality beyond teaching or providing health promotion tactics is one way. The dental public health workforce can be employed at research centres. It should be mandated that every research establishment in a country (including the pharmaceutical corporations) should have an oral health division manned completely by public health dentists. All the primary healthcare centres or rural health centres in a country should have a team of exclusively public health dentists. Every country should have an efficient School Oral Health Programme as mandated by the World Health Organisation (WHO).⁴ Thus, prompt action should be taken before this already diminishing speciality is no more.

F. Taha, Jeddah, Saudi Arabia

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