were all undertaken virtually without the need for the patient to have an in-person consultation at his GP surgery or hospital. Following his one-stop in-person hospital visit, a diagnosis of SCC was confirmed, and the patient is receiving ongoing care for this.

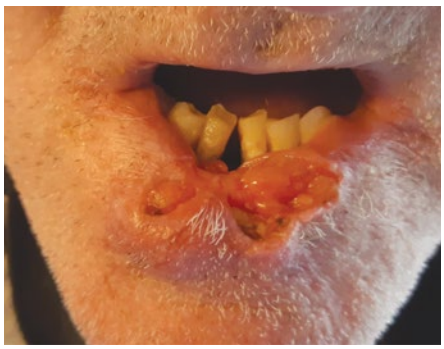

Fig. 1 A 78-year-old patient with an advanced lower lip squamous cell carcinoma

A recent survey showed 74% of patients were amenable to virtual oral and maxillofacial consultations although clinicians were concerned that a low percentage of consultations would be appropriate for this technique.[1] Virtual consultation in this case was a beneficial tool to complement conventional OMFS outpatient clinic and clinical examination, aided by one-stop clinics.

Video and virtual consultations may play an increasing role in aiding the initial stages of diagnosis and catching oral cancer in the community. It may also be a means for aiding communication between primary and secondary care clinicians to accelerate patients' pathways where appropriate.

A. Orchard, F. Shah, S. Prabhu, Woking, UK

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Coronamolars?

Sir, we have all been taught in our undergraduate training about 'mulberry molars' from maternal syphilis and hypoplastic first molar teeth in which maternal viral infection has been implicated. We wonder, due to the current COVID-19 global health crisis, will we see 'coronamolars' in six or so years' time and what will their form take?

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Dental education

Facial aesthetics

Sir, the last 18 months of DCT in Oral and Maxillofacial Surgery have highlighted challenges and complications presented by facial aesthetic treatments.

A mysterious alteration in the soft tissue profile of a pre-operative orthognathic case was explained when the patient revealed a recent use of filler injections. A similarly difficult clinical assessment involved a mucocele of the lip, in which the patient admitted to lip enhancement injections a few weeks prior to the swelling appearing. An infected facial sebaceous cyst in a history of 'silhouette face lifts', which reportedly involved insertion of needles into the face, raised questions as to appropriate follow-up and with whom responsibility should lie to identify adverse outcomes.

Reality TV, notably *Love Island* and *10 Years Younger In 10 Days,* may reflect increasing demand for aesthetic treatments. Dentists advertising themselves as an 'aesthetic doctor' seem commonplace on social media platforms, widening accessibility to these services. This may be prompting a culture of self-identifying perceived unappealing physical traits and fuelling a vulnerability towards a desire to alter facial appearance. The British Association of Aesthetic Plastic Surgeons warn that 'people who struggle with their psychological health can feel pressured to turn to "quick fix" procedures to improve their appearance' and recommend pre-treatment psychological assessments.[1] With mental health becoming increasingly topical, I question how equipped dentists are in assessing psychological wellbeing in this context. Conditions such as body dysmorphia could be implicated and missed with damaging repercussions.

I am unaware of any dental schools teaching facial aesthetic treatments including dermal fillers as part of the undergraduate course. It is therefore somewhat unsettling that dentists can attend a one-day course before providing treatments such as 'non-surgical rhinoplasty' when they have likely had no training on this in their professional degree. Increasingly concerning is the practice of non-dentists providing facial aesthetic treatments, such as pharmacists, nurses and midwives, who will have limited, if any, knowledge or consideration for oro-facial anatomy and pathology. These practitioners may underestimate the scope for serious complications alongside varied experience in obtaining informed consent.

The GDC state that you must 'undertake appropriate additional training to attain the necessary competence' and you 'must not mislead patents into believing that you are trained and competent to provide other services purely by the virtue of your primary qualification'.[2] What constitutes appropriate additional training and how practitioners can evidence competence is open to interpretation.

It seems obvious that change is required in the regulations surrounding facial aesthetic procedures, particularly training of practitioners and steps to protect psychological health. It may be sensible to include such training within the BDS degree given the large proportion of dentists going on to provide these services.

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Blended learning in teaching orthodontics

Sir, it was interesting to see how undergraduate orthodontic teaching has progressed since the early computer assisted learning (CAL) pioneers Professor Chris Stephens and Penny Grigg in the 1990s.[1,2] Chris pioneered the use of computers not only in orthodontic teaching, but also early AI in treatment planning and teledentistry for orthodontic advice.[3] But, way back then it was not known as blended learning,

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