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.

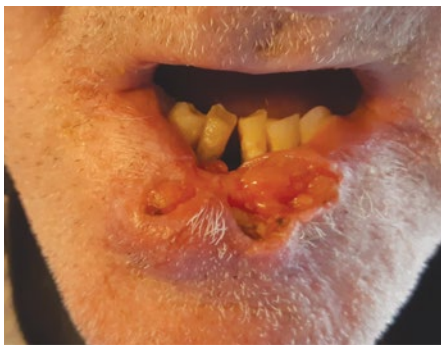

Fig. 1 A 78-year-old patient with an advanced lower lip squamous cell carcinoma

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.

J. Virdee, Harrow, UK

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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,

digital planning and remote consultation! It was nice to see confirmation of my own contribution into orthodontic teaching.[4] When inspired and encouraged by Chris, some of us 'up north' undertook an RCT into CAL in orthodontic teaching using programs developed by Chris.

Chris Stephens was truly ahead of his time in promoting and developing computers in teaching into what is now 'the norm' and he should be recognised for his pioneering work.

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https://doi.org/10.1038/s41415-020-1805-2

Law and ethics

Expert witnesses

Sir, experts called to criminal or civil courts observe, respectively: Parts 33 and 35 of the Criminal and Civil Procedure Rules. In whichever domain, the expert must remain independent, uninfluenced, provide an opinion on the facts, referring to the latest evidence-based and peer-reviewed literature, provide options capable of surviving logical scrutiny before arriving at an outcome on which the court can decide whose opinion carries the side over the threshold of proof.[1,2]

The documented increase in Registrants Referring Registrants to the GDC (R3) invariably demands the involvement of expert witnesses, with peculiar problems for the dental expert witness, who must resist the inclination to partisan persuasion.[3] Despite dento-legal training, the expert is neither a resident, nor a participant, but only a visitor to law. Becoming an expert after mastering clinical skills comes after a recommended minimum five years of consultancy.[2] But this is not an invitation to provide legal advice, to become adversarial or stoop to unattractive court-room rhetoric.[2,4] One fundamental truth is the expert-witness carries no legal authority. Another is, despite defined parameters of practice, there is no agreed definition of what an expert is.

The only control restricting the R3-reaction is the GDC Standard 9.1.1 stating: '*All team members, other colleagues and members of the public must be treated fairly, with dignity and in line with the law*'.[5] Expert or otherwise, if we are not prepared to deal with the consequences of having gloves laid on us by lawyers not bound by Standard 9.1.1, we should treat our colleagues as fairly as we wish to be treated ourselves.

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Volunteering

A valuable experience

Sir, a recent return from a dental aid programme in rural Bangladesh has highlighted the invaluable experience that dental professionals can gain from volunteering.

With the support of the Dental Aid Network charity, a team of six dentists triaged over 1,500 adults and children across rural villages in limited facilities. We provided extractions, delivered oral health advice, and distributed antibiotics and analgesia to those that required them. The gratitude expressed by the patients and families treated was overwhelming; many had been in pain for months, unable to afford basic medical or dental help and pain had become a part of their everyday lives.

A notable proportion of the patients we treated had significant dental side effects from the frequent use of betel nut. This is used widely throughout Asia, and there are ever increasing numbers of communities within the UK that are now using betel nut and various forms of smokeless tobacco. With betel nut being the world's fourth most commonly used addictive substance, education on its potential to cause oral cancers and diseases was imperative, and a key theme of our programme.[1]

As dental professionals, we are fortunate to have a unique skill set that enables us to relieve people of pain. In some situations, this can be almost life changing for those who would not otherwise have access to the medical and dental facilities that we often take for granted.

There is no doubt that the clinical experience we gained on this programme will add to our skill set and benefit our patients in the long term. We would wholeheartedly encourage anyone who would be interested to take the opportunity to contact these charities and get involved with similar programmes, whether it be abroad or closer to home.

E. Swinnerton, O. Barraclough, M. R. Miah, Leeds, UK

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Periodontology

Are we recording BPE?

Sir, a colleague and I recently carried out an audit at our respective dental practices looking at whether clinicians were performing Basic Periodontal Examinations (BPEs) on patients aged between 7–17-years-old. After looking at patient records, only seven out of 40 showed that a BPE had been recorded.

The British Society of Periodontology (BSP) states that the BPE gives clinicians guidance on whether further periodontal treatment is required for a patient during a routine examination. They advise that the BPE should be recorded on all patients from the age of seven at every check-up.[1]

The Child Dental Health Survey 2013 stated that around 40% of 15-year-olds in the UK have gingivitis.[2] A BPE is a useful tool to demonstrate this to a child and/or parent, to motivate them to improve their brushing. Additionally, there are medico-legal implications of not recording