95% CI – 0.002 to 0.827) and s-VCAM-1 (SDM – 0.047, 95% CI – 0.27 to 0.18).

Thus, PT has a moderate effect in lowering s-E-selectin in patients with moderate to severe periodontitis. E-selectin is expressed by the endothelium and helps in migration of leucocytes to arterial sub-endothelium in an important mechanism by which atherosclerosis starts and progresses. Lowering of E-selectin may be a mechanism by which PT improves endothelial function and cardiovascular outcomes.⁴ However, our study has limitations. None of the studies checked if the change in the biochemical markers translated into clinical outcomes.

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Dental products

Dietary restrictions

Sir, while we may well be aware of what medication is necessary to manage a clinical presentation, we may not always appreciate that a given preparation may be unsuitable for certain patients due to cultural and religious backgrounds with a prescription liable to cause distress, delay, and possibly offence.

For example, some observant Jews make specific dietary changes at Passover and some medications may contain ingredients which make their ingestion impermissible at this time, but permissible during other times. Online resources exist which outline these medications and the dental professional is well-advised to consult these.¹

Muslims do not consume food or water during daylight hours in the month of Ramadhan. The dosing regimen of prescribed medication may need to be altered to account for this dietary restriction. It is important to note that a discrepancy between the Lunar and Gregorian calendar means Ramadhan

falls at different times of the year each year when considered from the perspective of the Gregorian calendar.

Readers may be surprised to see the list of commonly prescribed medications and products not considered Kosher ie permitted for use.¹ These include denture and oral hygiene products, as well as certain antibiotics and analgesics. Simply having an awareness of the possible suitability of prescribed products, and that this may change at different times of the year, has the potential to save both patient and practitioner distress and delay. In addition, the dental professional may consult the local pharmacist who often has experience in the unique needs of members of the locality they serve.

However, it is imperative to state that not all patients from a given community may adhere to any dietary restrictions, and as such every patient should be treated on an individual basis with questions asked regarding any restrictions to diet before a prescription is provided.

S. Adam, N. Adam, E. Walshaw, Leeds, UK

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Dental trauma

Milk allergy and tooth reimplantation

Sir, traumatic dental injuries (TDI) are very frequent and comprise 85% of patients presenting with injuries to the oral region.¹ In the UK, one in five children have experienced TDI to their permanent anterior teeth before leaving school, and dental avulsion is common within this group.²

One such six-year-old attended our emergency department with avulsion of the upper right permanent central incisor. The parents had stored the tooth in milk for the two hours since the injury. The history revealed that the child had asthma and an intolerance to multiple allergens including dairy products with a previous mild reaction. Taking into account the history, the tooth was thoroughly rinsed with saline and reinserted. Within minutes, the child displayed signs of anaphylaxis and was transferred to resus for treatment. He was appropriately resuscitated, the offending

tooth was removed and he made a full recovery. He was discharged the next day and follow-up was arranged for the child to attend the dental institute after discharge for dental rehabilitation.

Cow's milk protein allergies (CMPA) are a range of adverse reactions to cow's milk that can be reproduced and are immune-mediated. They are immunoglobulin E (IgE)-mediated, cell-mediated (non-IgE), or a combination of the two. It is estimated that up to 4.9% of children suffer from CMPA and although it will resolve in 85-90% by three years of age, the natural history is actively changing, showing a definite trend to persist longer.^{3,4}

Considering the increase in CMPA, and the high number of traumatic dental injuries including avulsion, we should always be mindful when reimplanting teeth stored in milk to decrease possible serious life threatening reactions.

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Titles and terminology

Call me doctor

Sir, it was a delight to be reminded by Douglas Pike about the copious work he undertook in the early 1990s, to enable dentists to use the courtesy title of 'Doctor' if they wish.¹

In the article, he refers to the organisations that did and do continue to decline to address dentists as Doctor. However, upon my election as Chairman of the BDA's General Dental Services Committee in January 1997, I received a congratulatory letter from the then Secretary of State for Health: it was addressed to Mr Anthony Kravitz. In my reply I politely requested that I was referred to as Doctor in future correspondence, and from that time all correspondence from the

Department of Health was addressed to me as Doctor.

Douglas also refers to the interest from the Advertising Standards Authority (ASA). As a consequence of a press release in my local press, bearing my name and title, the ASA wrote to me, and ordered me to desist from using the title, otherwise 'action against you will be taken'. I advised them that I did not advertise so they had no authority over my use of the title and that the General Dental Council were the only body to have such authority. I did not hear again from the ASA.

A. S. Kravitz OBE, Manchester, UK

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Anaesthesia

Ehlers-Danlos syndrome

Sir, there is a wealth of evidence suggesting increased incidence of genuine resistance to the effects of local anaesthesia in patients with Ehlers-Danlos Syndrome (EDS) and other syndromes on the Joint Hypermobility Syndrome (JHS) spectrum, yet there is little guidance on how these patients should be managed.^{1,2}

As many as 88% of EDS patients report anaesthetic resistance as being either complete, partial or rapidly waning in effect. This is reported across all available anaesthetics, with articaine 4% offering only marginal benefit.³

Anecdotal evidence indicates those with anaesthetic resistance often avoid elective procedures, culminating in increased morbidity, increased incidence of extractions and repeated need for sedation or GA to undergo required treatment.⁴ There are inevitably detrimental implications to such experiences: dental neglect, dental anxiety/phobia and lowered self-esteem. A more pleasurable patient experience for this cohort of patients must become a priority and there may finally be a glimmer of hope in doing so.

A recent small scale familial study found those with a well-defined history of anaesthetic resistance and JHS to have mutation of the SCN5A gene, responsible for variant voltage-gated sodium channel 1.5 (Nav1.5) in peripheral nerves. This mutation was not present in those family members without JHS and no history of anaesthetic resistance.⁵

Given that local anaesthetics' mechanism of action depends on reversibly binding to Nav channels, it seems logical to argue that mutant variants would not be adequately bound by local anaesthetics and thus explain the lack of inactivation and ultimately lack of anaesthesia.⁶ Further study into variant Nav channels, their mutant genes and novel agents aimed at specific receptor binding is an area requiring further exploration in collaboration with geneticists. The lack of present research into the underlying mechanisms means we are no closer to doing what we are passionate about as clinicians: to offer pain free, effective treatment to this exceptional cohort of patients.

G. Atkinson, Salford, UK

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Oral cancer

Osteoradionecrosis GDP survey

Sir, we recently surveyed GDPs' understanding of the oral management of patients at risk of developing osteoradionecrosis of the jaw (ORN), a serious complication following radiotherapy for head and neck cancer treatment. The other oral impacts include, but are not limited to, xerostomia, mucositis, and trismus, which increase the patient's susceptibility to dental caries and periodontal disease. They are therefore at higher risk of needing non-surgical and surgical dental treatment that could result in the increased risk of developing ORN. GDPs have a key role in the prevention and identification of ORN and it is imperative that we have a thorough understanding of the condition and the oral health management for these patients. In the current COVID-19 climate, many

patients diagnosed with oral and pharyngeal cancers have been directed away from surgical treatment and therefore there has been an increase in the number of patients undergoing head and neck radiotherapy.

The survey we designed included questions that investigated GDPs' understanding and confidence levels surrounding ORN. They explored which prevention and treatment strategies, guideline recommendations and factors that GDPs would consider when referring a patient at risk of developing ORN to specialist care. A total of 121 GDPs, who graduated over a wide range of years, completed the survey.

The results indicated that approximately a third of GDPs did not feel confident recognising a potential case of ORN that would require a specialist referral, with some stating lack of experience in recognising the condition as the reason why. Factors affecting GDPs' decisions to refer extractions to a specialist included the number and nature of the extractions and patient comorbidities including previous radiotherapy to the head and neck. Notably, 50% of GDPs stated concerns over litigation in the event of development of ORN as a factor that would influence referral. The results also revealed a range of confidence levels in providing routine dentistry in patients with a history of head and neck radiotherapy.

Improving survival rates mean many more GDPs will be managing the long-term oral healthcare of head and neck cancer survivors. Their confidence and ability to manage the oral sequelae of radiotherapy is essential. We feel that the results highlight how further education and continued professional development surrounding ORN for GDPs is required. We would also like to draw attention to the current guidelines and recommendations by The Royal College of Surgeons of England and the British Society for Disability and Oral Health which focuses on the oral management of oncology patients.¹

A. Shah, S. Fernando, London, UK

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