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.

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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

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