We can confirm that an error was introduced to Figures 4–15 by the publisher. We note that the print version of the journal reversed the Likert scale on the y-axis of these figures. Fortunately, this detail was picked up timeously and corrected on the online version which correlates with the prose within the results and discussion. As such, based on these corrected figures and as published online, we stand by our conclusions in this study.

Editor's note: the correction relating to this error can be found here: https://www.nature.com/articles/s41415-020-2021-9.

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Dental records

Photos please

Sir, photography can be used to accurately record the appearance of the oral cavity as well as following specific clinical conditions over time. With observance to current legislation,[1] photography can facilitate diagnosis, treatment planning and surgical procedures.[1,2] It is also useful both as a medicolegal tool and treatment goal conformational record.[3] Historically artists were used to produce illustrations from the descriptions of surgeons and physicians, which were highly influenced by their interpretation.

I carried out an audit to determine how often clinical photographs were present with a referral or taken at initial consultation in our department before biopsy of a suspected squamous cell or basal cell carcinoma. Photos were only present in 25% of cases, yet 85% of clinicians responded that they would have benefited from one. A diagram was present in 85% of cases, but this returns us to the same difficulty of subjectivity that was present in the late nineteenth century where the artist's illustration was influenced by the interpretation of the clinician.

In conclusion, clinical photos should become a standard part of the initial referral. Most referrers (GPs or GDPs) have access to a camera and with the implementation of e-referral systems across most UK Trusts, uncomplicated image acquisition and uploading should become standard. This is even more vital in this unprecedented time due to the risk posed by COVID-19 and will ultimately grant clinicians the ability to triage more effectively, improve patients' standard of care and prevent suspected cancer lesions being missed.

A. A. Zaki, Liverpool, UK

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Dental careers

Female career progression

Sir, you recently published an interesting research article regarding the career aspirations of female dental students and trainees.[1] It is well documented that there are increasing numbers of females entering the profession but this study further showed that more young female dentists are considering specialties that were traditionally male dominated. However, leadership positions are still disproportionately filled by males. This highlights the need for more female role models and mentors to be present in these positions. It is also important that dental institutions play an increasing role in educating their students regarding the career options available to them, including those that may allow them to continue working or continue specialty training pathways whilst affording them the flexibility that they may want.

The results from this study showed that 63% of respondents, of which 70% were females, wanted to work part-time 15 years post-qualification. This decision may play a role in hindering their progression to more senior roles. Therefore, there should be provisions in place to improve chances of career progression for those working part-time. The decisions regarding an individual's career flexibility are personal and everyone is entitled to make these according to their own priorities. However, if their progression is being affected due to a lack of accommodation for those females who want to take career breaks or work part-time then, as a profession, we are failing 50.4% of our colleagues.

A. Tahir, Birmingham, UK

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https://doi.org/10.1038/s41415-020-2187-1

Oral health

Eponym confusion

Sir, many clinical signs and syndromes in medicine are named eponymously after the person who supposedly originally described them. In dentistry a common example is Sjögren syndrome.

These eponyms can be stated in the possessive, ie Sjögren's syndrome or non-possessive, ie Sjögren syndrome. Whilst this distinction may appear overly pedantic it does have importance and has been debated since the 1970s. Possessive eponyms have been argued as incorrect since the discoverers generally neither had nor owned the disorders, and having the two forms can generate confusion and problems with databases and literature searches.[1]

The World Health Organisation actively discourages use of eponymous terms in medicine.[2] Furthermore, along with other bodies such as the American Medical Association and US National Institutes of Health, they specifically advocate that the possessive form is not used. However, there is no overall consensus, particularly among editors of medical journals where both forms continue. For example, in this journal's ten most recent papers mentioning the above example, seven state Sjögren's, two Sjögren and one uses both terms. Use of the possessive is now much less common in American than European journals.[3]

Therefore the current state of affairs is of mixed and arbitrary usage of possessive and non-possessive forms of eponyms throughout medicine. The main practical implication here, beyond being merely a technical point, is that literature searches using either form will yield different results.[1] Standardisation could solve this, however, is acknowledged

to be very difficult owing to long ingrained traditions of using possessive eponyms in medicine.[4]

The purpose of this letter is to flag up this issue to clinicians working in dentistry and encourage clinicians, authors and journal editors to consider this when documenting, writing and publishing.

B. J. Steel, Northumberland, UK

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Silver diamine fluoride

Sir, I write regarding the paper on silver diamine fluoride (SDF) (*BDJ* 2020; **228:** 831–838). It is an informative paper, but it has confounding information about the SDF application protocol.

SDF has been used in countries like Japan, Brazil and Argentina since the 1970s and with other countries beginning to use it, complete information must be provided.

SDF is a non-invasive and effective anti-caries treatment for deciduous[1,2,3] 3nd permanent teeth (root caries)[1] as shown by different systematic reviews. Therefore, the affirmative that SDF is a 'treatment for children's tooth decay' is incomplete information. It is an easy to use product and rubber dam isolation is not indicated by any of the clinical trials included in the systematic reviews. Consequently, this paper's emphasis on rubber dam, in text and images, provides an incorrect idea of SDF use.

Although the authors state that the literature does not show any benefit in selective caries removal before SDF application, they recommended the removal of 'soft, necrotic, infected dentine… in order to sufficiently reduce the bacterial load'. Two points can be addressed here: (1) SDF, as a non-invasive treatment, doesn't include any tissue removal; (2) bacterial load is reduced by the high concentration of silver/fluoride ions in SDF solution.

It was recommended that a 'microbrush should be fully immersed in SDF solution and applied directly to the tooth surface'. This sentence contradicts current guidelines, since one drop of 38% SDF solution is enough for application in five cavities.[4]

Another point is the statement that 'SDF application should be restricted to dentine… to minimise SDF contamination of enamel'. SDF use affects both enamel and dentine to achieve the full remineralisation effect resulting from the synergistic action of fluoride/silver ions. If the concern is the staining of teeth/restoration interface, the use of potassium iodide can be considered. In addition, it is important to clarify that restoration after SDF application is not part of SDF protocol and should be seen as an option. SDF is an example of non-restorative caries control treatment, as described in a recent report of a Delphi Consensus about interventions for caries control.[5]

A. C. Rodrigues Chibinski, Paraná, Brazil

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Corresponding author Dr Joseph Greenwall-Cohen responds: Thank you for your interest in our article. Our intent was certainly not to be confusing or misleading, so we appreciate the chance to expand on the comments concerning SDF application. We certainly agree that SDF is not only for use for children's tooth decay and highlighting the several potential applications of the product was a part of the article that we particularly enjoyed writing.

With regards to rubber dam, we attempted to emphasise in our clinical technique section that it is the isolation which is key and wherever possible this should be with rubber dam. However, we acknowledge that this is not always possible, as highlighted by Figure 5 and Figure 6 from our article.

As mentioned in the article, evidence does not favour caries removal with SDF and your point on SDF bacterial load reduction is valid. However, our reasoning for the authors' suggestion of removing soft, necrotic, infected dentine is built around traditional minimally invasive restorative concepts.[6]

With regards to fully immersing the microbrush, we have found that one drop of 38% SDF solution still represents an amount of SDF sufficient to fully immerse a microbrush.

Finally, as you have correctly mentioned in your letter, SDF does provide an example of non-restorative caries control treatment. However, we also believe that SDF has further potential applications as an adjunct to restorative treatment. Our suggestion of wherever possible, limiting application to dentine, was with the intention of limiting SDF enamel contamination to maximise enamel-adhesive bond strength. If no further restorative treatment is planned however, then this is of less importance.

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Terminology

Caveats still apply

Sir, for those of us who recall Douglas Pike's campaign, it is hard to believe how quickly the time has passed and interesting to be reminded of its 'journey' within the UK.[1] The worry over being mistaken for a medical doctor or public misunderstanding of the title reminds me of when a plastic surgery colleague told me (on gaining my PhD) that I was now a real doctor, unlike him. He felt that even for the medical profession, 'doctor' was a courtesy title (although it has the advantage of being gender neutral).

The title 'doctor' would appear now to have fallen into common parlance, and due to pay grade structures, it is quite common to see non-consultant dental staff appointed in district hospitals as a 'specialty doctor' (when they may not be on a specialist list and not always medically qualified). Dr Pike reminds us of the GDC's plea 25 years ago that 'the courtesy title must not be used to give the impression, even inadvertently, that they may be registered medical practitioners'. Whilst the use of the courtesy title 'doctor' may be welcomed by many, Dr Pike reminds us of the caveats that still apply.

G. Ogden, Dundee, UK

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