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} and 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

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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