unethical medical experimentation, scientific racism, misinformation and propaganda have fuelled distrust and lack of participation. The Pfizer meningitis vaccine scandal in Northern Nigeria is an example which contributed to the rejection of the polio vaccine years later in 2003.[7,8] HCPs therefore, especially those from these communities, have an important role in myth busting, using an evidence-based approach to dispel misinformation across their networks in a religious and culturally sensitive way.

With the UK set to relax lockdown, we need collaborative, multifaceted approaches to support engagement from the BAME group. The University of Leeds Dental School in collaboration with the National Institute of Health Research released 'Covid and me - vaccines', a short drama series telling stories of lived experiences of vaccine hesitancy of people from the BAME group. With the help of social media, these films have been shared across different Black platforms with the aim of encouraging vaccine uptake amongst these communities.

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Dental radiography

Updated radiograph quality

Sir, in 2001, the National Radiological Protection Board (NRPB) established performance targets for dental radiographs in the publication, *Guidance Notes for Dental Practitioners on the Safe Use of X-ray Equipment*, based on a subjective quality rating system (grade 1 = excellent, grade 2 = diagnostically acceptable, grade 3 = unacceptable).[1] Performance targets for each grade were outlined at 70%, 20% and 10% respectively. Almost 20 years on, and Public Health England has co-published a second edition of the guidance notes with the Faculty of General Dental Practice UK (FGDP [UK]), endorsed by the College of General Dentistry.[2]

One of the key changes includes the new two-point quality rating scale which is recommended for all forms of dental radiography and CBCT imaging. Images are either rated as 'diagnostically acceptable' ('A') or 'not acceptable' ('N'). For digital imaging, no less than 95% should be categorised as 'A', and 5% as 'N'. For film imaging, targets are 90% and 10% respectively. The document describes these targets as representative of what is achievable in the majority of well-managed dental practices. On conducting a review of the literature, this did not identify a single publication where the percentage of grade 3 intra-oral radiographs corresponding to 'N', fell below 5% for digital imaging. This brings to question whether the target is truly achievable.

It can be debated that one of the benefits of separating the previously described grade 2 radiographs from the diagnostically acceptable group, allows for a greater identification of film faults and targeted quality improvement. The GDC principle 7.1.1 states, 'You must find out about current evidence and best practice which affect your work, premises, equipment and business and follow them'.[3] It is important that general dental practitioners and dental care professionals are aware of the updated publication, which is free to access online through the FGDP UK website. If practices struggle to achieve the 5% target, it may be beneficial to undertake audit recording all of the faults from both 'A' and 'N' groups and implement training accordingly.

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Diversity and inclusion

Time for equality

Sir, an independent review into gender pay gaps in medicine found 'the gender pay gap between men and women in medicine is highest for hospital doctors, with female doctors earning 18.9% less an hour when adjusted for contracted hours' and 'women are more likely to work less than full time (LTFT), and most never catch up with male peers even after a return to full-time working'.[1] This will apply to many of our colleagues who work in salaried services, whether it be the community dental service, within hospitals or in academia. I hope the acknowledgement of such data means we can begin to work towards a more equal approach to a career progression in salaried posts.

The report acknowledged 'an unconscious bias amongst peers, recruiters, and even the wider health and care community, that those on LTFT contracts lack the same levels of skill and experience as their full-time colleagues. We must put a value on individual talent and ability, not hours on the clock'.[1] National recruitment into specialty training in 2020 had an emphasis on time, and although I appreciate this was abnormal due to the COVID-19 pandemic, I believe this is going to continue into this year's recruitment. I feel this could cause an inequality for those that have taken time out of training, possibly due to maternity leave, but also health reasons, working abroad,

gaining experience in general practice etc. This is all valuable experience and should be what sets us apart and treasured, instead of focusing on quantifiable factors achieved within a time limit. In creating a more flexible pathway, with more emphasis on talent and ability, it will not only reduce gender inequality, but I believe dentists will be able to self-direct their learning, have improved job satisfaction and allow higher levels of taxonomy to be attained as individuals will have capacity for creative thinking instead on focusing on 'ticking the boxes'.

Once in academia, 91% of consultants work extra hours but not everyone is able to do this and should not be thus penalised in their career progression.[2] Valuing staff for their high standard of work within their contractual obligations, and assessing for talent without timeframes, will create a more inclusive workforce. These changes therefore will not only benefit women, but the entire workforce, and our patients. I look forward to seeing how, as a profession, we rise to this challenge.

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Mind the gap

Sir, there is not enough representation of people of colour in clinical imagery in medical and dental teaching. As a student, I remember the dental literature only showcasing images of conditions mostly of white patients. As we know, conditions will appear differently on people depending on their ethnic background and it would be a disservice to patients if our own knowledge of medical conditions was limited to people of a certain ethnic background.

A new clinical handbook called *Mind the Gap* has been read over 100,000 times and is currently being used by the London and North East Ambulance Service in clinical practice.[1] The aim is to demonstrate clinical signs of medical conditions in black and brown skin with the intention to better diagnose, increase patient satisfaction and improve confidence amongst healthcare professionals when treating people of colour. It is our aim to see the dental profession follow suit.

The authors encourage clinicians to submit their own clinical photography of head and neck and intra-oral conditions of patients with black and brown skin.

Submission information and consent forms can be found on https://www.blackandbrownskin.co.uk.

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Paediatric dentistry

Ledermix in children

Sir, the use of Ledermix paste (a commercially available intracanal medicament) as an anti-inflammatory and analgesic is well documented. Its formulation consists of an antibiotic component, demeclocycline calcium, which is a tetracycline derivative, and a steroid component, triamcinolone acetonide.[1]

Its use as a desensitising medicament for cariously exposed (pulpotomy) primary molars is also documented, deemed suitable for use in children in national guidelines.[2] However, the British National Formulary clearly states as contra-indications to tetracycline: children under 12 years, due to deposition in growing bone and teeth, by bonding to calcium, causes staining and occasionally dental hypoplasia.[3] Similarly, the Health Products Regulatory Authority summary of product characteristics for Ledermix states it is contraindicated in this age group, with no data to support its use in children under 12 years.[4] Does following guidelines but using Ledermix in an unlicensed way therefore put fault on the clinician if issues arise? Are dentists aware?

There is an alternative in Odontopaste, a zinc oxide-based dressing with clindamycin hydrochloride and triamcinolone acetonide. This formulation shows no contra-indication to use in children and with well-documented evidence of effectiveness in root therapy, it should be considered as the first-line agent.[4,5]

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Medical emergencies

Chlorhexidine hypersensitivity

Sir, we read with interest the article on the management of anaphylaxis in the dental practice and wish to share our observations in relation to chlorhexidine (CHX).[1]

An initial study on a subpopulation of UK patients referred for IgE testing found a prevalence of 12.2% of IgE (Type I) hypersensitivity to CHX.[2] The results indicate that sensitisation to CHX may not be uncommon. In addition, in a study on CHX hypersensitivity in a cohort of dental students, prior to starting their first year,[3] we found that although 57% had no history of allergies and less than 20% reported having had exposure to CHX-containing products, 8.6% showed CHX sensitisation suggesting unknown exposure and the potential risk of developing hypersensitivity and adverse reactions in the future. Hence, it is not just patients that are at risk but dental healthcare professionals as well. The true extent of any likely adverse reaction to CHX is yet to be fully quantified and appreciated.

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