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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References

1. Dacre J, Woodhams C, Atkinson C *et al.* Mend the Gap: The Independent Review into Gender Pay Gaps in Medicine in England. Department of Health and Social Care, 2020. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/944246/Gender_pay_gap_in_medicine_review.pdf (accessed February 2021).
2. Watson N, Tang P, Knight E. Survey of Dental Clinical Academic Staffing Levels: A report by the Dental Schools Council. Dental Schools Council, 2018. Available at: https://www.dentalschoolscouncil.ac.uk/wp-content/uploads/2018/08/clinical-academic-survey-dental-2018.pdf (accessed February 2021).

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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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Reference

1. Black and Brown Skin. 2020. Available at: https://www.blackandbrownskin.co.uk (accessed 19 January 2021).

https://doi.org/10.1038/s41415-021-2795-4

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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References

1. Summary of Product Characteristics, Ledermix for dental use. Health Products Regulatory Authority, 2019. Available at: https://www.hpra.ie/img/uploaded/swedocuments/Licence_PA1321-002-001_27032019130518.pdf (accessed 9 January 2021).
2. Rodd H D, Waterhouse P J, Fuks A B, Fayle S A, Moffat M A. Pulp therapy for primary molars. *Int J Paediatr Dent* 2006; **16 Suppl 1:** 15-23.
3. NICE. TETRACYCLINE. BNF content published by NICE. Available at: https://bnf.nice.org.uk/drug/tetracycline.html#contraIndications (accessed 9 January 2021).
4. Lin S, Levin L, Peled M, Weiss E, Fuss Z. Reduction of viable bacteria in dentinal tubules treated with clindamycin or tetracycline. *Oral Surg Oral Med Oral Pathol Oral Radiol Endod* 2003; **96:** 751-756.
5. Product news. A new, effective therapeutic endodontic dressing. *Br Dent J* 2014; **217:** 384.

https://doi.org/10.1038/s41415-021-2796-3

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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References

1. Jevon P, Shamsi S. Management of anaphylaxis in the dental practice: an update. *Br Dent J* 2020; **229**: 721-728.
2. Lazenby M G, Scott C, Longhurst H J, Chong B S. *The prevalence of IgE mediated chlorhexidine hypersensitivity in a patient subpopulation*. Poster. British Endodontic Society, Spring Scientific Meeting, 2014.
3. Khazin S M, Abdullah D, Liew A K C, Harun N A, Abdullah N, Chong B S. IgE-mediated hypersensitivity to chlorhexidine among first-year dental students. *Allergo J Int* 2019; **28**: 204-208.

https://doi.org/10.1038/s41415-021-2797-2