to many patients, especially in developing countries. Moreover, the accuracy of CBCT imaging for the diagnosis of subtle VRFs in endodontically treated teeth *in vivo* has been reported to be poor, which questions the excessive dependence on CBCT.[2,3] Therefore, giving critical importance to detailed history taking, meticulous clinical and radiographical examination remain the best diagnostic aids.[4] The authors' experience points out two major diagnostic clues that can indicate a VRF early:

1. Bifurcation radiolucency in bone in mandibular molars
2. Presence of swelling with or without a sinus opening on the lingual aspect of an endodontically treated tooth.

These signs and symptoms can be an early indication for suspecting a VRF, which should become an affirmative indication for a further CBCT assessment. Early diagnosis will allow for a decision regarding extraction if indicated, as long-standing root fracture will result in excessive bone loss, which can impede or complicate any implant options in the future. Early signs, as discussed here, indicate high chances of a VRF, and identifying and responding to early signs is a wise choice as it is better to be early than to wait until it is too late.

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Restorative dentistry

Indirect adhesive controversies

Sir, I read with interest the recent well-reported and discussed review paper by O'Connor and Gavriil that addressed factors that increase the success of bonding of adhesive indirect restorations.[1]

Diverse clinical restorative scenarios are solved with adhesive indirect restorations, a practice that is becoming more common. Thus, dental professionals are expected to understand their mechanism of action to maximise predictability and excellent clinical performance.

Nonetheless, I intend to draw attention to controversial points raised when bonding indirect restorations preclude solid clinical recommendations. For instance, to adhesively cement indirect composites, precious alloys, or polycrystalline ceramics, there is not a single established protocol considered superior. More specifically, indirect composites' bonding options range from air-particle abrasion alone; air-particle abrasion with silanisation; and tribochemical coating with silanisation.

In conclusion, there are controversies in adhesive cementation of different indirect restorations that I hope become less blurry soon as biomaterial science advances to deliver long-lasting, biocompatible restorative materials.

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Public institutions

Reading suggestions

Sir, institutions and holders of high office including the BDA and OCDO have extended their traditional warm congratulations to the incoming GDC Chair, Baron Harris of Haringey (Lord Toby Harris). Such gestures are professional and proper. However, we would like to offer something potentially more substantive for the public and wider profession: some reading suggestions.

The first is *Black box thinking* by Matthew Syed, who advocates that after things have gone wrong, genuine change can only occur through a process of open learning.[1] Syed explains how over successive decades, diverse industries have benefitted from such a culture, dramatically improving their safety and performance (notably in aviation).

Our public institutions on occasion appear to react as if the nation would benefit without those healthcare professionals (HCPs) who persevere despite suboptimal working environments. The treatment of Dr Bawa-Garba creates the perception that UK regulatory/legal framework adjudicates individual HCPs' performance as if supposedly working in an idyllic environment, with unlimited resources, where everything works, communication errors do not happen and staff are never unwell. Dr Bawa-Garba is a medical doctor. However, for those who work in any field of healthcare (including dentistry), that a single HCP can be censured for system-wide failings is both intimidating and discouraging.

The second is not a book but an inspirational interview with the late Nobel laureate physicist Professor Richard Feynman.[2] Even for those with no interest in physics, Feynman elegantly demonstrates the beneficial intellectual discovery when an enquiring mind continues to ask: 'Why?' It would appear our current healthcare regulatory mechanisms neglect to embrace this enquiring thought process, and accordingly, fail to discover the fundamental causes which are necessary to understand for developing genuine and beneficial change.

A healthcare regulator seeking genuine change in the safety and performance of all stakeholders requires its leadership to acknowledge organisational failings and that resource limitations genuinely do exist. Limitations and failings upon which, no matter how devoted or capable the individual HCP is, they have little or no influence. Syed observes that genuine progress fails to occur when individuals are considered solely to blame for endemic systems failings. Feynman simply asks why? Dentistry would do well to learn from both.

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Oral health

Oral rinse digestif

Sir, recently I was invited to a dinner party hosted by a well-trained chef and sommelier. After several courses of fine food and wine, an impromptu double-blind trial took place with all guests and the sommelier taking part as participants to compare Fernet-Branca (a famous Italian herbal digestif with many

similarities on the palate to Corsodyl), Pernot, Corsodyl standard and Corsodyl Mint. Much to my surprise, the unanimous conclusion was that Corsodyl Mint was the superior digestif when scored on mouth feel, taste and participants' inclination to serve again. All of the drinks served were swallowed, with only Corsodyl standard found to be poorly tolerated in this way.

Although a wide range of digestif drinks have been advocated over the centuries, all tend to be strongly flavoured and to have distinctive mouth feel which provides a cleansing refreshment to the palate after a large meal. These attributes and often flavours are shared by most oral rinses; however, the two concepts remain stubbornly separate in use despite the potential dental and gastronomical benefits of uniting the digestif drink with an oral rinse.

A search of both Google Scholar and PubMed revealed no results relating to the use of Corsodyl as either an aperitif or digestif; however, a recent paper in *BDJ Open* did advocate the use of mouthwash following meals but lamented the relatively large dose volumes required and suggested this requires the development of new products.[1] I suggest that rather than a new product, perhaps we need a new appreciation of Corsodyl Mint served as a digestif to both settle the stomach, aid the digestion and improve oral hygiene.

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OMFS

The old tea-bag trick

Sir, the management of post-operative bleeding following dental extractions continues to be a familiar task for the oral and maxillofacial surgery (OMFS) out-of-hours on-call clinician.

The 'old tea-bag trick' refers to the practice of using a tea bag (or two) in replacement of gauze packs to deliver pressure and promote haemostasis to the extraction site. Tea bags contain astringent tannic acid which contributes to the contraction of damaged capillaries and accelerates clot formation.[1] It has also been found that green tea extract-impregnated gauze reduced post-operative bleeding sockets and consequent oozing, attributed to the tannin content.[2]

The trick was recently advocated over the phone during an early hours on-call shift when a patient called complaining of post-operative bleeding. They had already used up all their gauze pressure packs and the next stage would usually be attendance to the Emergency Department (ED). The use of a tea bag successfully controlled their bleeding and consequently prevented the patient from attending the hospital and adding further pressure to the ED. This trick can complement our familiar local haemostatic measures, especially during the remote or out-of-hours management of bleeding sockets, due to its accessibility and low cost.

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Scientific publishing

Risk of editor bias

Sir, several biases have been identified that may affect the results of a study. For example, systematic reviews may be sensitive to publication bias because studies with some specific characteristics (with significant or interesting results) are more likely to be published than studies without such characteristics,[1] or exaggerated treatment effect estimates may be produced when a clinical study does not observe high methodological standards in the randomisation procedure.[2] However, there is a specific bias that has not been commonly discussed and that deserves attention: editor bias.[3] The two examples reported below raise questions on potential editor bias in dental journals.

My research portfolio is mainly based on meta-research over recent years.[4] Some of these publications were submitted to another journal (not the *BDJ*), with most submissions surviving desk rejection. However, this situation changed as of February 2020, since when two submissions were desk-rejected, which may be perfectly understandable, but what intrigued me was the identical reason reported by the (new) editor-in-chief (EIC) for rejecting both manuscripts: 'your manuscript did not reach the priority level required to be considered further for peer review in the journal'. Had the journal's policy been explicitly changed by the new EIC? My personal experience suggests that the old and new editors had different priorities for publication. Editors may obviously have different opinions about priorities for their journals, but these priorities should be explicit and clearly reported to the readers.

A second case was the submission of the two previously rejected manuscripts to another dental journal in the same specialty and similar ranking, as measured by impact factor. Both manuscripts could be considered as having similar levels of 'innovation/quality'. The first received a revision outcome and was accepted for publication, while the second received a desk rejection as follows: 'We have made the editorial decision to limit reports to those that are exceptionally novel, within the scope of the Journal, and of great interest to a broad audience of clinicians and researchers'. It is important to emphasise that this associate editor (AE) was not the same as from the first submitted and accepted manuscript. This outcome might suggest, again, that both AEs had different opinions about the priorities of that particular journal.

This conflicting information creates difficulties for those selecting a journal for submission. The key factor is transparent and detailed information on the hierarchical priorities for the acceptance of submissions. Furthermore, better reporting will increase the trust of authors and readers and, as a consequence, reduce the risk of potentially biased decisions towards submitted manuscripts.

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