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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