document and quick reference guide in relation to apixaban, rivaroxaban and dabigatran (the other three licensed UK DOACs); however, this was prior to the official licensing of edoxaban in the UK. Since acquiring its UK licence, edoxaban has become a commonly prescribed medicine with 763,700 prescriptions in 2019.[2] While this still makes it the least commonly prescribed DOAC in the UK, it is certainly a drug that will be encountered by clinicians on a regular basis. Injectable anticoagulants such as enoxaparin and dalteparin, despite being more rarely encountered in general practice, certainly affect patients' dental management. Clinicians will greatly value the specific management outlined in the new guidance.

The SDCEP have developed a comprehensive quick reference guide alongside the full guidance, meaning clinicians can easily access and interpret the recommendations in the clinical setting. Other resources include patient instructions, information leaflets and templates for liaising with other healthcare professionals.

We thank the SDCEP and recommend all practitioners refresh their knowledge on this topic and familiarise themselves with the updated guidance to support their management of patients taking 'blood thinning' medications.

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### References


1. Scottish Dental Clinical Effectiveness Programme. *Management of dental patients taking anticoagulants or antiplatelet drugs*. 2nd edition. 2022. Available at https://www.sdcep.org.uk/published-guidance/anticoagulants-and-antiplatelets/ (accessed March 2022).
2. Afzal S, Zaidi S T R, Merchant H A, Babar Z, Hasan S S. Prescribing trends of oral anticoagulants in England over the last decade: a focus on new and old drugs and adverse events reporting. *J Thromb Thrombolysis* 2021; **52:** 646–653.


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## Dental radiography

### Condyle orientation

Sir, I read with interest the recent publication in the *BDJ*, entitled 'Heart your condyles'.[1] An interesting aspect to bifid condyles is that the orientation of the heads has been associated with their aetiology. A medio-lateral orientation may indicate an aetiology of a non-traumatic nature, such as the presence of fibrous septa, while an antero-posterior orientation may be related to a history of trauma.[2] The case presented by the authors seems to defy these findings. In addition to the issues listed by the authors, bifid condyles may present with a distinctive range of symptoms and signs such as swelling, myalgia, osteoarthrosis, non-reducing/reducing disc displacement, deflection upon opening, growth disorder, facial asymmetry, capsulitis and/or synovitis.[3]

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### References


1. Simpson, C., Graham, A. Heart your condyles. *Br Dent J* 2022; **232:** 423.
2. Szentpétery A, Kocsis G, Marcsik A. The problem of the bifid mandibular condyle. *J Oral Maxillofac Surg* 1990; **48:** 1254–1257.
3. Borras-Ferreres J, Sanchez-Torres A, Gay-Escoda C. Bifid mandibular condyles: A systematic review. *Med Oral Patol Oral Cir Bucal* 2018; DOI: 10.4317/medoral.22681.


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## GDC registration

### Not just another loophole

Sir, it has been a rollercoaster since the day I aspired to register with the GDC as an internationally qualified dentist. For booking the exam, it's been futile depending on ORE/LDS exam dates and their fastest-finger-first/lottery system respectively. Hence, recently I have been considering getting registered with the GDC as a dental therapist/hygienist using the controversial loophole in the GDC legislature everyone keeps talking about.[1,2]

I couldn't consider this option sooner because I happen to have done a Masters in Prosthodontics and was hoping to work my way up in the UK from a GDP position after clearing ORE/LDS. But now I feel I might as well be working as a dental therapist/hygienist rather than just waiting here in the UK. Moreover, this would help me get clinical exposure and I would be more confident to start working as a dentist once I clear my licensure. I understand the treatment quality, patient care and safety concerns displayed by the British Association of Dental Therapists (BADT) and the British Society of Dental Hygiene (BSDHT) regarding this route. It was the first thing that crossed my mind when I had initially heard about this option.[3]

However, I do feel that using the reasoning where the high failure rate of dentists sitting the ORE's Part 2 dental mannequin test, with an average failure rate of 50% and 69% at one sitting being particularly alarming, is one way to look at it. This evaluation does hold for 50% to 69% of dentists. But, the benefit of the doubt still applies to 31% to 50% of dentists. Those who would otherwise pass the rigorous exams are highly skilled, and they can be an asset in this route as well.

Hence, I feel the need to bring to your notice that dentists with few clinical skills as well as the aptly skilled are opting for this route. It is imperative to regulate this route as an opportunity to fill in the critical shortage of manpower in dentistry.[4,5,6] Clinical assessment and official training can be among some options to help regulate the internationally qualified dentists entering through this route and integrate them into the workforce, which is equally important.

I sincerely feel that blocking this route due to the fear of substandard dental care will be like closing just another loophole without exploring the opportunities that could help make standard dental care accessible to many patients waiting on long lists.

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### References


1. Hancocks S. Alignment. *Br Dent J* 2020; **228:** 135.
2. Hemington D. Dental therapists: 'no exams necessary'. *Br Dent J* 2020; **228:** 395.
3. Hellyer P. Learning about working in the UK. *Br Dent J* 2022; **232:** 325.
4. Riall T. Dental recruitment: Acute shortage of clinicians. *Br Dent J* 2018; **225:** 2–3.
5. Carmichael N. A crisis a decade in the making. *BDJ In Pract* 2022; **35:** 12.
6. Ashiti S. Nearly two years without the Overseas Registration Exam: what's next for internationally qualified dentists in the UK? *Br Dent J*; **232:** 303–306.


https://doi.org/10.1038/s41415-022-4306-7

## Head and neck cancer

### PROMIS

Sir, head and neck cancers are associated with pain at the time of diagnosis and pain due to side effects of treatments. Oral mucositis after chemotherapy or radiotherapy is a cause of significant morbidity for the patient as well as a public health concern. Patients report high pain interference scores and reduced quality of life as pain impairs speech and normal masticatory function.[1]

I am writing to highlight the need for proper characterisation of symptoms related to cancer pain, with an emphasis on the assessment of orofacial function. It would address the personal concerns of patients about how pain affects their daily life and identify treatment outcomes that matter the most to them.

To make the assessment of pain more patient-based, a study has reported the use of patient-reported outcomes (PROs) dubbed 'precision PROs' to be reliable.[2] Based on the PROMIS (Patient-Reported Outcomes Measurement Information System) measures,[3] it has shown that the individual