COMMENT

Letters to the editor

Send your letters to the Editor, *British Dental Journal*, 64 Wimpole Street, London, W1G 8YS. Email bdj@bda.org.
Priority will be given to letters less than 500 words long. Authors must sign the letter, which may be edited for reasons of space.

Holistic dentistry

Sex conscious clinicians

Sir, during a recent consultation, a patient asked me when it was suitable for him to engage in sexual activity after his tooth extraction. Initially, this question took me aback, as it is not something I had ever been asked before. I gave the usual advice of no vigorous exercise in the first 24–48 hours after an extraction due to risk of bleeding. However, this scenario made me think, is there a deeper conversation to be had?

Patients are more open to discussions surrounding their health and ways in which they can prevent disease. As dentists, we are aware of the head and neck cancers associated with human papillomavirus (HPV), a type of sexually transmitted disease (STD). It has been estimated that over 80% of the population will acquire HPV before they reach the age of 45.[1] HPV-related cancers have been on the rise for a number of years. Certain types of oropharyngeal cancers are associated with HPV, particularly HPV 16 and 18.[2] There have been great efforts to immunise adolescents against HPV, aiming to administer the vaccine at an age before they are sexually active. Originally, this vaccine was only offered to girls; however, from 1 September 2019, boys were also offered this vaccine from 12 years of age.[3]

As dentists, we undertake oral cancer screens at every routine check-up. We also give smoking cessation and alcohol cessation advice where appropriate, both of which are risk factors for oral cancer. HPV and other STDs can present in the oral cavity. Perhaps as clinicians we have a wider role to play in sexual education and prevention. This could be in the form of patient information leaflets and posters raising awareness of HPV-related head and neck cancers, emphasising the importance of safe sexual practice and early vaccination. These could be placed in waiting rooms and in surgeries, giving patients the opportunity to start the conversation if they wish to do so.

F. Doughty, Liverpool, UK

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Systematic reviews

Systematic reviews of reviews of reviews

Sir, as a Master of Clinical Dentistry postgraduate student at the Eastman Dental Institute (2001–2004), the publication of a series of systematic reviews (SRs) in the *Journal of Clinical Periodontology* was an epiphany for a busy clinician trying to base clinical decision-making on best evidence. The systematic nature of these reviews ensured evidence was readily available to make key decisions such as determining likely outcomes from surgical versus non-surgical periodontal therapy.[1]

The proliferation of SRs since my training was noted in the recent *BDJ* editorial:[2] 'While the expansion of exposure of systematic reviews is welcome, what is striking when reading them is that little has changed'. This got me thinking (the point of editorials) about the development of SRs, and in an excellent *Evidence-Based Dentistry,* I read about SRs of systematic reviews[3] that concluded 'less than 1% of recently published SRs in dentistry were classified with high methodological quality'. I then wondered will the next stage be systematic reviews, of systematic reviews of systematic reviews?

As a clinician involved in primary clinical research, I envisage an inverted pyramid where the primary research is analysed along with other randomised controlled trials by a group of systematic reviewers who highlight the flaws in the primary research, and subsequently have their systematic review analysed, exposing the flaws in their SR. My evidence-based epiphany at the start of the millennia now seems a distant memory, as I grapple with a plethora of SRs, with less certainty about the quality and applicability to my patients.

E. McColl, Plymouth, UK

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https://doi.org/10.1038/s41415-022-5159-9

Endodontics

No squirting

Sir, I read with interest the concerns of Dr Vivekananda Pai about using sodium hypochlorite for endodontic irrigation.[1] I decided many years ago to stop squirting anything into a root canal even with so-called 'safe tipped' syringes.

A method I find seems to work very well is to dry the canal, place a dry paper point into the canal, then with a pair of closed tweezers transfer (with a gloved hand underneath to catch any drops) a small

drop of NaOCl into the pulp chamber and then to allow capillary action to move this into the canal. Further drops can be added until the paper point is soaked and the pulp chamber full. To remove – yet further paper points until dry – then it's probably safe to use any water irrigation for debris removal, but I favour ultrasonic irrigation.

I don't know if this has been tested in the lab, but intuitively it seems to be as effective as any for introducing NaOCl and again intuitively seems to be a lot safer.

D. Burton, Leatherhead, UK

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Digital dentistry

Maxillofacial app

Sir, I read with interest the recent publication in the *BDJ* entitled 'Mobile apps for oral healthcare: recommendations for navigating uncharted terrain' by C. Seeballuck *et al.* in which the authors mention that apps need to be accountable, reputable, evidence-based as well as contemporaneous.[1]

Although there might be 'several' apps available which fit the bill as far as oral healthcare is concerned, there remains a lacuna in terms of one catering to maxillofacial injuries. The ZS score, a maxillofacial trauma scoring system, developed by Z. Ahmad *et al.* is available as an elegant and user-friendly app which is composed of the ZS score, the science behind it, as well as a guide on using it.[2,3,4]

The ZS score is based on scientific evidence and translates this into quite a user-friendly experience by way of an interactive facial skeletal map (including teeth), which dentists and medical professionals can utilise to indicate injury patterns which are subjected to varying levels of severity.[2,4] The result of this apparently effortless experience is the determination of the score which is basically a summation of the individual scores selected by touching the injured elements of the facial skeleton on the screen. The app allows for the user to add notes and obtain a printable version of the report which can be emailed as well.

Such apps, or certainly some elements of these, should be utilised to act as potential blueprints for development of others in the same direction.

V. Sahni, New Delhi, India

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Dental education

Liverpool admissions

Sir, we read with interest the recent article entitled 'The current dental school applicant: an overview of the admission process for UK dental schools and the sociodemographic status of applicants'.[1]

As BDS and BSc Programme Directors, and the Admissions Tutor, in the School of Dentistry at the University of Liverpool, we would like to correct an inaccuracy within the information provided. The authors state: 'Liverpool University provides a foundation year with the aim of consolidating the acquired skills and knowledge to study dentistry. The applicants are required to reapply to the undergraduate dentistry course, following completion of the one-year course, separately'.

The University of Liverpool does offer a year zero foundation programme for dentistry. This allows mature applicants, or those who have undertaken qualifications that do not traditionally facilitate entry to dentistry, the opportunity for an alternative route to a dental career. Interviews to determine the suitability of candidates for entry to either the BDS or BSc Dental Therapy programme take place before admission to the foundation programme. Places on the foundation programme are offered to those who meet the academic requirements for that programme, but who are also judged at interview to be suitable for admission to the BDS or BSc programmes. Students who successfully complete the year zero foundation programme commence directly onto the BDS or the BSc Dental Therapy programme without the requirement for another application or another interview.

A number of schools accept students from the national Realising Opportunities programme[2] and offer contextual admissions.[3] These measures aim to widen participation and broaden the sociodemographic status of dental applicants.

L. Gartshore, J. Bowles, L. Jones, Liverpool, UK

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https://doi.org/10.1038/s41415-022-5162-1

Oral health

Refugee oral health

Sir, according to the United Nations High Commissioner for Refugees (UNHCR), by the end of the year 2017, 68.5 million individuals had been forcibly displaced worldwide.[1] Refugees have limited access to both therapeutic dental care and preventive services. The Refugee Oral Health Promotion and Care Project was launched in 2018. Refugees remain vulnerable to acute food insecurity, malnutrition, and their inadequate food and nutrient intake after migration. This is regardless of the economic level of the host country.[2] The common dietary risk factor for caries and other chronic diseases is the high and frequent consumption of fermentable carbohydrates (ultra-processed foods), which have high amounts of refined starches and free sugars.[3] The important effect of nutrition on teeth is the local action of diet in the mouth on the development of dental caries and enamel erosion.[4] Dentists can help in improving oral health of affected people.

S. M. Math, Carmarthen, UK

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