retrieved from the apical region. Moreover, regenerative endodontic procedures using triple antibiotic paste, platelet-rich fibrin, and tricalcium silicate biomaterial showed promising results in necrotic teeth with replacement resorption.[4] For teeth treated with this regenerative procedure and later indicated for decoronation, retrieval of the biomaterial is much easier due to its more coronal position in the root canal than apical plug biomaterials. On the other hand, closed apex teeth need root canal obturation, resin-based sealer, tricalcium silicate sealer, glass ionomer sealer, and fibre post systems preferably to be avoided due to the same retrievability issue. In cases where passive primary closure of the wound after decoronation cannot be achieved, the application of absorbable collagen plug dressing coronal to the amputated root can be applied combined with horizontal mattress sutures to stabilise blood clot and enhance primary closure of the wound and thus probably allowing more bone deposition coronal to the amputated root.

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Oral health

Periodontal testing

Sir, I read with interest the recent publication in the *BDJ* entitled 'Diabetes mellitus and periodontal disease: the profession's choices' by C. Turner.[1] The author emphasises the value of involving the medical profession in referral of diabetic patients in light of the association between periodontal disease and diabetes mellitus and discusses the BPE, CPITN as well as HbA1c levels.

Progress around educating and involving medical practitioners would greatly benefit from the incorporation of simpler and more straight-forward point of care testing technology as is readily available in the form of PerioSafe and ImplantSafe. These kits, based on the aMMP-8 levels have been multiply validated across different age groups, ethnicities and parts of the world.[2]

The aMMP-8 POCT has both a prognostic and diagnostic role to play in periodontitis and peri-implantitis. In fact, these kits have also been reported to act as an effective screening strategy for pre-diabetic and diabetic patients reporting to the dental office in order to enhance referrals.[3] This application underscores the two-way relationship between diabetes and periodontal disease as discussed by the author.[1]

The aMMP-8 POCT has been observed to possess an enhanced ability to delineate initial/subclinical stages of periodontitis when compared to bleeding on probing in the adolescent population.[4] The test is safe, standardised, non-invasive and is available in both full-mouth (PerioSafe) and site-specific (ImplantSafe) variants. The results can be made available in both the quantitative as well as qualitative forms, with the latter being as simple as two lines denoting a positive test while a single line indicating negative results.[2]

The aMMP-8 POCT has also been demonstrated to suitably enhance periodontal disease diagnosis when utilised as an adjunct to a questionnaire/interview conducted by medical practitioners.[5]

V. Sahni, New Delhi, India

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Oral disease

Plethora of drugs

Sir, the recent article by Ali *et al.* (*BDJ* 2022; **233:** 564–568) is relevant to present and future oral health care as the plethora of drugs available to prevent and/or treat disease is ever increasing and indeed, it is hoped, will continue.

All articles published in journals must be accurate, up to date and provide readers with information that they may be able to act upon. The article of Ali and co-workers does not meet such expectations. There are numerous inaccuracies, that include, amongst others, the incorrect use of 'Wegener's granulomatosis', inclusion of *Neisseria gonorrhoeae* but exclusion of *Treponema pallidum*, a failure to mention that it's Non-Hodgkin's Lymphoma that is much more likely in the mouth than all lymphomas, that black hairy tongue is not just mucosal discolouration and that MRONJ does not occur only after dental procedures. The authors fail to detail that the features of the ulceration can often easily point to a diagnosis and there is an inconsistent use of generic versus trade names of drugs.

The section on the management of oral ulceration is rather bereft of information that will be helpful to the majority of readers of the journal – general dental practitioners. For example, not all the cited preparations are readily available in the UK or indeed many other countries (triamcinolone in sodium carbnoxymethylcellulose paste). Additionally, the evidence that some of them are effective is lacking (eg topical tetracyclines) and some are probably totally impractical (low energy laser). Many of the agents cited as likely causes of drug-induced oral disease are prescribed by specialists rather than generalists hence the communication should be with the former – not the latter.

Authors (and perhaps reviewers) should consider what an article is meant to be achieving – a strong accurate message that, when relevant, will enhance the knowledge and skills of the reader.

S. Porter, S. Fedele, London, UK

The corresponding author of the article, Dr Kamran Ali, responds: The authors welcome constructive feedback by readers of the BDJ. *Several points have been raised in the letter which warrant a response. The authors feel the comments in the letter use a strong language to allege 'numerous inaccuracies' in the paper. However, many comments do*

not appear to be justified and indeed some comments do not reflect the contents of the paper accurately. A brief response to the key points raised in the letter is provided below:

- *Syphilis (caused by* Treponema pallidum*) is mentioned in Table 1 – Differential diagnosis of oral ulceration*
- *Lymphoma is also mentioned in the same table; it is beyond the scope of practice of general dental practitioners to differentiate between distinct types of lymphoma which require management in specialist settings*
- *Nowhere in the paper it is stated that black hairy tongue is 'just' a mucosal discolouration; it is mentioned in the context of association with drug use. This paper is not focused on black hairy tongue so a full discussion on all possible causes was not required. Similarly, the paper is not focused entirely on MRONJ and invasive dental oral surgical procedures are mentioned as one of the causes, certainly not the only one*
- *The triamcinolone preparation mentioned in the paper is triamcinolone acetonide 1 mg (0.1%) in Orabase (Adcortyl or Kenalogue) and not the one alleged in the letter. Triamcinolone acetonide (Adcortyl in orabase) is included in the BNF*
- *It is acknowledged that the evidence regarding the use of topical tetracycline and lasers is not strong. However, these were included as options rather than a treatment(s) of choice. On reflection, we could have further explained that these options may not be viable for GDPs*
- *Generic names of drugs have been used throughout the paper except for Septrin. This is because pharmaceutical companies have previously requested additional information about the brand name of antibiotic for a previous paper on erythema multiforme by the author. It is acknowledged that the generic name (cotrimoxazole) could have been added for consistency. Nevertheless, Septrin is a recognised brand and its usage does not make this information factually inaccurate*
- *A GP is the first point of contact for patients in the UK and is most suitable to make an informed decision regarding referral. Dentists in general practice do not always have access to full contact details of all specialists in local hospitals. In any case, specialist referral (including oral medicine), is also mentioned in the paper.*

Finally, the authors would like to reiterate that we genuinely welcome peer feedback. However, on this occasion the comments appear to be somewhat 'over-enthusiastic' and a more focused response might have been more helpful.

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