

with betamethasone valerate 0.05% cream (Betnovate), which, they report, seems beneficial in controlling painful symptoms.

This is perhaps not unexpected, as a wide spectrum of corticosteroid formulations including mouthwashes, creams, ointments, sprays and intralesional injections have been reported in the treatment of symptomatic OLP. Nevertheless, there remains a lack of well-designed clinical trials in this field, with a relatively recent systematic review indicating that there is little robust evidence for the efficacy of any single treatment for the management of erosive OLP.³ Although grateful to the authors, we highlight that comprehensive management of OLP can be a significantly more complex matter. For example, the medico-legal responsibility of prescribing, dispensing and administering an agent outwith its licensed indication. It is important that clinicians inform patients of the off-label use of these agents and detail possible side effects.⁴ Patients should be carefully reviewed for such events. OLP management must also encompass its malignant potential and oral cancer development which may be in up to 3.5% of cases^{5,6} with essential long-term monitoring of patients to identify and diagnose early dysplastic and malignant changes.⁷

Any patient with possible OLP should be initially referred to specialists to ensure that the diagnosis is formally confirmed, appropriate treatment is provided and adequate, evidence-based information is given. Simply telling a patient that they are likely to have OLP is often unhelpful and sometimes they can become alarmed after surfing the Internet. Patients' perspective and expectation are also important, as conversations regarding the chronic nature of the disease and associated increased risk of cancer may sometimes become difficult.

S. Porter, V. Mercadante, S. Fedele, London

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INFECTION CONTROL

Ebola aware; beware; healthcare

Sir, Ebola virus disease (EVD) is a lethal viral haemorrhagic fever (VHF) that has been smouldering in Sub-Saharan and West Africa at least since the 1970s and possibly for many decades. We previously sensitised the dental community to the infection which, in earlier days, was mainly in rural West Africa and had a lower mortality.¹ Its current virulence (nearly 70% mortality); epidemic spread in West Africa including in urban conurbations; and sporadic appearances in many geographic locales already including resource-rich areas in North America, Europe and the Antipodes, mainly through infected travellers, raises grave concerns of an impending pandemic.

Recognition of EVD, infection control and containment are the major healthcare concerns. In oral healthcare, oral bleeding (gingival mainly) is a main manifestation usually also with epistaxes and bleeding from other orifices. Oral mucosal lesions

and discomfort are yet to be thoroughly described as most patients are too ill and rapidly decline, and healthcare resources too stretched. Universal infection control is mandatory, especially in the later stages when viral loads are at their maximum.

Host-to-human transmission of EVD is only through direct contact with or consumption of the tissues, blood, secretions, or other bodily fluids, of infected hosts such as non-human primates or fruit bats (in 'bush meat' and environments contaminated with such fluids). These products appear outwith Africa, often transported illegally in personal luggage.

Human-to-human transmission of EVD is only through direct contact with the tissues, blood, secretions, or other bodily fluids, including saliva, of infected hosts, and with environments contaminated with such fluids. There is no evidence of airborne spread. Infections in healthcare settings have been due to healthcare workers treating patients with suspected or confirmed EVD when infection control precautions were not strictly practised. To date there are no reported cases of transmission of EVD in dental settings.

However, the fact that Ebola virus may be transmitted through human secretions, including saliva, that 1–6% of infected individuals are asymptomatic or mildly symptomatic and that the incubation period could last up to 21 days, implies that oral healthcare workers (mainly in the endemic areas) may run the risk of acquiring EVD if meticulous infection control measures are not always routinely adhered to.

If an EVD risk is possible, it would seem logical that elective oral healthcare be deferred 21 days.

C. Scully, L. Samaranayake, S. Petti,
R. G. Nair, by email

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