OTHER JOURNALS IN BRIEF

A selection of abstracts of clinically relevant papers from other journals.
The abstracts on this page have been chosen and edited by John R. Radford.

MANAGING CARIOUS LESIONS

Managing carious lesions; consensus recommendations on terminology

Innes NP, Frencken JE *et al. Adv Dent Res* 2016; **28:** 49–57

Managing carious lesions: consensus recommendations on carious tissue removal

Schwendicke F, Frencken JE *et al. Adv Dent Res* 2016; **28:** 58–67

If biofilm control is considered insufficient, the integrity of a fissure sealant should be monitored until more is known of the 'trampoline' effect (the sealant may not be able to resist occlusal forces when there is softened dentine beneath the weakened enamel).

This abstract summarises a consensus statement of 21 experts in the field of cariology. A pre-meeting was held as part of this rigorous process. At this, several contributors were asked to explore key areas; one was somewhat derisively entitled '*Why we've covered all this – Restoring excavated teeth*'. In both the introductory and substantive paper (*Adv Dent Res* 2016; **28:** 46–48 and *Adv Dent Res* 2016; **28:** 49–57) it was argued that there is a disconnect between the research findings and clinical practice because of 'inconsistencies in clinical guidelines, dental education, national healthcare policies, and remuneration systems.' For example, 42 terms were identified and others were advanced to describe essentially the four following different strategies for managing carious lesions: 1) 'atraumatic restorative treatment', 2) 'no removal: no dentine carious tissue removal' (that include the use of a resin or glass ionomer sealant materials, the Hall Technique and non-restorative cavity control), 3) 'selective removal of carious tissue' including stepwise caries removal, and 4) 'nonselective removal to hard dentine'. Nonselective removal to hard dentine (formerly known as complete caries removal), often accompanied with 'extension for prevention', is unequivocally no longer recommended; the quest for 'cri dentinaire' (the scratchy sound when a straight probe is taken across the dentine) has been relegated to history.

It was highlighted that 'carious tissue is removed purely to create conditions for long-lasting restorations'. But the primary aim is to manage carious lesions before cavitation using a non-invasive approach. This involves 'biofilm removal (toothbrushing) and/or remineralisation'. And then it may be possible to transform noncleansible, into cleansable carious lesions (see *Adv Dent Res* 2016; **28:** 58–67).

The same first authors in an *Invited Editorial* (*J Dent Res* 2016; **95:** 485–486 – *Advances in Dental Research* publishes supplements to the *Journal of Dental Research*) offer reasons why such recommendations are not implemented. They argue practitioners can be categorised into 'don't know', 'can't do', or 'won't change'. But they also implicate effete education; 'in some countries and some schools, new dentists are still taught to remove all infected carious tissue, and it is actually not possible to pass professional examinations without demonstrating this'.

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ORAL CANCER

Incidence and survival trends of lip, intra-oral cavity and tongue base cancers in south-east England

Olaleye O, Ekrikpo U *et al. Ann R Coll Surg Engl* 2015; **97:** 229–234

Despite an increasing incidence, the 'mortality from oral cancer appears to remain static...' (five-year relative survival = ca. 60%).

Each year, one quarter of a million people in the world develop oral cancer. There is a wide variation in the incidence of oral cancer among different countries; for example, there are reported differences in incidence between Scotland and England. Kaplan-Meier (proportion of patients who survive after diagnosis and treatment) and Cox regression analysis, were calculated from data obtained from the Thames Cancer Registry, London between 1987 and 2006 (n = 9,318; ICD-10 code C00–C06 and C14). The investigators found 1) the incidence was more common in men than women (1.6:1), 2) there was a mean incidence of 13.8 for tongue and 2.3 for lip cancer per million people, 3) a median survival time for tongue base cancer was 2.42 years whereas for lip cancer it was 11.09 years, and 4) the prognosis is worse for men and those who were older when diagnosed with cancer. The authors speculate that the increase in incidence of oro-pharyngeal cancer is associated with HPV infection.

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QUALITY OF LIFE – ORAL CANCER

How will I be after my operation for oral cancer?

Kanatas A, Singh P *et al. Br J Oral Maxillofac Surg* 2015; **53**: 538–545

'...give clinicians a better understanding of their patients' needs.'

The authors state that the treatment of head and neck cancer, can have a 'negative impact on breathing, eating, and swallowing, and on speaking and body-image.' In addition, such changes in appearance and functional loss can cause severe psychosocial problems. These commentators claim that the completion of both the University of Washington quality of life head and neck cancer questionnaire (UWQoL – not only measures the patient's physical, mental and spiritual health, but also that of family and friends) and the PCI (Patient Concerns Inventory – referred to only in references) together better inform the care team of their patients' needs. On interrogating their results, it would appear that tumours of the tongue and floor of mouth affect 'physical function' more than 'social/emotional function'. It was noted that differences were only considered significant at less than 0.01, 'to reflect the large number of statistical tests done'. This observational study collected, among other data, patient-reported outcomes (n = 1060 patients) following treatment for squamous cell carcinoma of the head and neck. Only those questionnaires completed around 2 years from diagnosis or operation were analysed.

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