varnishes on the market. They may not be licensed for caries control, although they may have similar formulations, and this should be taken into consideration with respect to prescriber's responsibilities.'[2]

The use of fluoride varnish other than Duraphat is a frequently asked question within the Childsmile programme in Scotland. The answer states: 'Duraphat is the only fluoride varnish licensed for use as a preventive product in the UK so is always the varnish of choice in the Childsmile programme. If you choose to use another fluoride varnish (containing sodium fluoride 22,600 ppm) then you must have a sound clinical reason for doing so as you would be using it "off label" and our advice is that, in those circumstances, you must give an explanation to the parent/guardian as to why you are using an "off label" product and record this in the notes. You would also assume all responsibility for any adverse event associated with an alternative varnish – whether it is applied by a dentist or a suitably trained dental nurse. It is likely that the main reason for considering the use of an alternative to Duraphat would be when a patient has an established allergy to colophony (a constituent of pink sticking plaster) and again, this should be clearly explained to the parent/guardian and recorded in the patient notes.'[3]

Both fluoride varnishes Duraphat and Profluorid contain colophony. Therefore they are contraindicated in patients with known allergies to colophony. For these patients, other fluoride varnishes (eg Fluor Protector) should be considered.

The responsibility that falls on healthcare professionals when prescribing an unlicensed medicine or a medicine off-label may be greater than when prescribing a licensed medicine within the terms of its licence. Dentists should pay particular attention to the risks associated with using unlicensed medicines or using a licensed medicine off-label. These risks may include: adverse reactions; product quality, or discrepant product information or labelling.[4]

C. A. Yeung, Lanarkshire

1. Sherborne M, Oliver S. Prevention: Fluoride varnish flavours. *Br Dent J* 2017; **222:** 142.
2. Public Health England. *Delivering better oral health: an evidence-based toolkit for prevention.* 3rd ed. London: Public Health England, 2014.
3. Childsmile. FAQs for dental staff. Online information available at http://www.child-smile.org.uk/professionals/information-for-dental-practice-staff/faqs-for-dental-staff.aspx (accessed 17 February 2017).
4. Medicines and Healthcare products Regulatory Agency. Off-label or unlicensed use of medicines: prescribers' responsibilities. *Drug Safety Update* 2009; **2:** 6.

DOI: 10.1038/sj.bdj.2017.290

NHS dentistry

A lack of help

Sir, it is with trepidation that I am writing this letter. I am a full-time NHS dentist, an associate in a busy practice, an essential member of the BDA, and as a precautionary measure I have a policy with Dentists' Provident. Over a year ago in December 2015 our daughter was diagnosed with a germ cell tumour that was suffocating her pituitary gland. Her treatment included chemotherapy, a six-hour brain operation to remove the residue of the tumour and radiotherapy. As you can imagine not only did this put immense emotional pressure on us but also physically I had to attend meetings and hospital appointments. This would obviously affect the fulfilment of UDA targets. I phoned the BDA where an advisor told me that since I am only an essential member I am not really entitled to advice. Nevertheless, due to the circumstances the advisor agreed to talk to me on compassionate grounds. However, he told me that only if I were to claim that I was incapacitated would I be able to ask for help. I phoned the NHS and asked for advice. They told me that they weren't my employer since I was only a performer so they didn't have any legal or ethical obligations towards me. I would have to discuss UDA targets with the practice owner and maybe organise a locum. Then I phoned Dentists' Provident and they said that since it wasn't me who was ill they wouldn't help. I felt that there was a lack in our professional organisations regarding help in such circumstances. Eventually the lacking UDAs were clawed back but at least my daughter has had her all clear. I sincerely hope that if any other colleague were to find themselves in this situation that they find better help.

M. Glickman, by email

Simon Elliott, Executive director of Dentists' Provident, responds to Dr Glickman: I was very sad to read about the incredibly difficult time you and your family have been through over the last year but I am pleased to hear that your daughter has now had the all clear.

While we can't comment on your individual call here, our head of claims will be contacting you shortly to discuss this more fully. However, I can say that our primary motives are not sales or profits but, as a mutual membership organisation, to always try to do the best by our members in their times of need. Every day I see my colleagues make decisions based on principles and decency rather than simply 'the terms and conditions of membership'.

When contacted by a member we always try to get a deeper understanding of the situation they are in and encourage them to give us as much information as possible so that we can consider each case in full and on its individual merit.

Editor-in-Chief's note: I am pleased to read that Dr Glickman's daughter has received the all clear and trust that family life is returning to normal. The BDA will always take personal circumstances into consideration in circumstances such as this and, as their Journal, we are grateful to Dr Glickman for giving us the opportunity to publish his letter for the information, help and guidance of BDA members, readers and the wider dental community.

DOI: 10.1038/sj.bdj.2017.291

Child dental health

Bombarded children

Sir, I read the article on food advertisements and children with interest.[1] This is an area I feel strongly about, both as a mother to two young children and as an oral surgeon. Demand is ever increasing for GA exodontia, and children as young as three or four are often having full dental clearances. This paints a depressing picture about the national state of our physical and oral health. Such major procedures are not only traumatic but also often lead to dental phobias. These children are at risk not only of dental phobia but also obesity and type 2 diabetes; this health burden is likely to become unsustainable for the NHS.[2]

From a personal perspective, becoming a mother has opened my eyes not only to the effect advertising has on young children but also the culture we live in. My 4-year-old is like a sponge absorbing information, and he will take as gold anything said on television – far more credible than his mother. I am dismayed by the number of adverts for junk food and the wild claims attached to them; for example, a well-known chocolate spread being promoted as a healthy breakfast alternative along with most cereals, which have eye-watering amounts of sugar. I do not enjoy, but understand my responsibility, having to explain to him why these foods are not healthy and why he cannot regularly eat them. However, we cannot blame advertising

alone; children are bombarded everywhere – whether as part of the supposedly healthy free school meals or at friends' houses and parties. We live in a culture where we use junk food as bribery, reward and a pacifier for our young. Until the culture and the environment we live in changes, then I do not see the situation improving. To get environment and behaviour change, I see no other option than government regulation, much like we have for tobacco and alcohol. We cannot expect the food companies to change themselves.

As a dental profession, I understand the need to 'educate' the public, and these campaigns should be done. However, information alone – I find often interpreted as lecturing and condescending – rarely induces behaviour change.[3] With this in mind, we should not lose momentum and loudly and publicly continue to lobby government to introduce regulation to curb processed junk food in general, especially when targeted to the most precious and impressionable in our society, the best asset we have, our children.

S. Nolan, by email

1. Al-Mazyad M, Flannigan N, Burnside G, Higham S, Boyland E. Food advertisements on UK television popular with children: a content analysis in relation to dental health. *Br Dent J* 2017; **222:** 171–176.
2. O'Dowd A. 2015. Type 2 diabetes prevention programme is needed to tackle projected five million rise in cases. *BMJ* 2015; **351:** h4648. doi: 10.1136/bmj.h4648.
3. Walls H L, Peeters A, Proietto J, McNeil J J. Public health campaigns and obesity – a critique. *BMC Public Health* 2011; **11:** 136.

DOI: 10.1038/sj.bdj.2017.292

Oral cancer

Indian pandemic

Sir, the Indian National Cancer Registry Programme report shows worrying rises in cancers of the upper aero-digestive tract (mouth, tongue, oro-pharynx, hypopharynx, larynx and oesophagus) among both sexes as important sites for undertaking risk factor research and implementing early detection programmes.[1]

The Global Adult Tobacco Survey India, conducted in 2009-10, revealed that 35% of adults used tobacco.[2] Tobacco-related cancers are expected to constitute 30% of the total cancer burden by 2020.[1] It is important to elevate smokeless tobacco, areca nut and oral cancer as an even greater problem than smoking for the Indian nation, and South Asia. The Indian subcontinent accounts for one third of the global burden of cancers of lip and oral cavity.

Cancers of mouth and tongue, taken together, overshadow cancer of lung.[1] Likewise, in other cities of India like Delhi, Mumbai, Aurangabad and Kollam, after lung cancer, cancer of mouth [excluding tongue] is the second most common cancer among males. The projected burden of cancers among males by the year 2020 in India shows the number of cases will be lung (102,300), mouth (99,495), prostate (61,222), tongue (60,669) and larynx (36,079). Cumulatively, this makes 'oral cancer' the leading cancer site for men in most of India.[1]

Improved public health education and promotion is vital, as are top down policy approaches such as those of the Framework Convention on Tobacco Control, extended to include all forms of smokeless tobacco. Much excellent work on the control of the continuing pandemic of oral cancer in India is ongoing[3] and we write to draw these issues to the attention of clinicians, public health specialists and policy makers.

B. Gupta, N. W. Johnson, Queensland, Australia

1. Indian Council for Medical Research. Three-Year Report of Population Based cancer Registries 2012–2014. Bengaluru, India: National Centre for Disease Informatics and Research-National Cancer Registry Programme, 2016. Available at: http://www.ncrpindia.org.
2. Ministry of Health and Family Welfare, Government of India. Global Adult Tobacco Survey India 2009-2010: Country Report. New Delhi: International Institute for Population Sciences, 2010.
3. Sankaranarayanan R, Ramadas K, Amarasinghe H, Subramanian S, Johnson N. Oral cancer: prevention, early detection, and treatment. *In* Jamison D T, Nugent R, Gelband H, Horton S, Jha P, Laxminarayan R (eds). *Disease control priorities*. 3rd ed (Vol 3). Washington (DC): The International Bank for Reconstruction and Development/The World Bank, 2015.

DOI: 10.1038/sj.bdj.2017.293

Saliva for biopsy

Sir, salivary biomarkers have been identified in different tumours distant to the oral cavity including brain, pancreatic, breast, ovarian, lung, gastric, prostate, and oesophageal cancer.[1] Saliva therefore represents a potential source of tumour markers (proteins, metabolites, mRNA, micro-RNA and microbial) but the development of this as an effective diagnostic modality requires further research. Because carcinogenesis is a complex process, it is necessary to know the molecular changes in primary tumour initiation, promotion and progression with a double objective: to detect early disease *and* to improve clinical management. For this, saliva could be a potential biofluid showing the heterogenecity of the tumour at different stages of the disease compared to tumour tissue and plasma. Research efforts should be directed to assess the diagnostic capacity of the different salivary tumour biomarkers as well as its biological function on the pathogenesis and progression of the disease. This will require the participation of different researchers (medical, dental, biologists, bioinformaticians, statisticians, engineers etc) and it is a matter of urgency to train such researchers and convince institutions about this excellent opportunity to finance projects in this field. New perspectives must be directed towards finding specific salivary biomarkers in cancer, with the aim of improving the diagnosis, prognosis and monitoring disease.

O. Rapado-González, R. López López, M. M. Suárez-Cunqueiro, Santiago de Compostela, Spain

1. Rapado-Gonzalez O, Majem B, Muinelo-Romay L, López-López R, Suarez-Cunqueiro M M. Cancer salivary biomarkers for tumours distant to the oral cavity. *Int J Mol Sci* 2016; **17:** DOI:10.3390/ijms17091531.

DOI: 10.1038/sj.bdj.2017.294

Patient support

High-risk behaviour

Sir, the case of National Aids Trust vs NHS England[1] in late 2016 stemmed a revolutionary breakthrough in the management of HIV in the UK which all medical professionals should be aware of. The court ruling deemed that the NHS can fund pre-exposure prophylaxis (PrEP) for those at risk of contracting HIV.

A 2014 government report[2] stated there are about 107,800 individuals living with HIV in the UK with an overall prevalence of 2.8 per 1,000 population aged 15–59 years. PrEP is a method to reduce the rate of transmission of HIV. The brand name Truvada consists of two anti-retroviral agents, emtricitabine and tenofovir. The logic is to give the medication to HIV negative patients prior to high risk behaviours to reduce the chance of later obtaining HIV. It can either be taken regularly ie one tablet per day, or only taken when needed, just prior to or following intercourse. The PROUD study[3] indicated that there was a relative risk reduction of obtaining HIV of 86% in high risk sexual intercourse.

Despite the positive court ruling, the NHS has not yet started rolling out the medication en masse, largely due to the cost of the medication. A pack of 30 days of treatment costs £355.73.[4] Instead a three-year trial starting in December 2016 consisting of 10,000