document and quick reference guide in relation to apixaban, rivaroxaban and dabigatran (the other three licensed UK DOACs); however, this was prior to the official licensing of edoxaban in the UK. Since acquiring its UK licence, edoxaban has become a commonly prescribed medicine with 763,700 prescriptions in 2019.[2] While this still makes it the least commonly prescribed DOAC in the UK, it is certainly a drug that will be encountered by clinicians on a regular basis. Injectable anticoagulants such as enoxaparin and dalteparin, despite being more rarely encountered in general practice, certainly affect patients' dental management. Clinicians will greatly value the specific management outlined in the new guidance.

The SDCEP have developed a comprehensive quick reference guide alongside the full guidance, meaning clinicians can easily access and interpret the recommendations in the clinical setting. Other resources include patient instructions, information leaflets and templates for liaising with other healthcare professionals.

We thank the SDCEP and recommend all practitioners refresh their knowledge on this topic and familiarise themselves with the updated guidance to support their management of patients taking 'blood thinning' medications.

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*M. Adam, St Helens, UK*

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## Dental radiography

### Condyle orientation

Sir, I read with interest the recent publication in the *BDJ*, entitled 'Heart your condyles'.[1] An interesting aspect to bifid condyles is that the orientation of the heads has been associated with their aetiology. A medio-lateral orientation may indicate an aetiology of a non-traumatic nature, such as the presence of fibrous septa, while an antero-posterior orientation may be related to a history of trauma.[2] The case presented by the authors seems to defy these findings. In addition to the issues listed by the authors, bifid condyles may present with a distinctive range of symptoms and signs such as swelling, myalgia, osteoarthrosis, non-reducing/reducing disc displacement, deflection upon opening, growth disorder, facial asymmetry, capsulitis and/or synovitis.[3]

*V. Sahni, New Delhi, India*

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## GDC registration

### Not just another loophole

Sir, it has been a rollercoaster since the day I aspired to register with the GDC as an internationally qualified dentist. For booking the exam, it's been futile depending on ORE/LDS exam dates and their fastest-finger-first/lottery system respectively. Hence, recently I have been considering getting registered with the GDC as a dental therapist/hygienist using the controversial loophole in the GDC legislature everyone keeps talking about.[1,2]

I couldn't consider this option sooner because I happen to have done a Masters in Prosthodontics and was hoping to work my way up in the UK from a GDP position after clearing ORE/LDS. But now I feel I might as well be working as a dental therapist/hygienist rather than just waiting here in the UK. Moreover, this would help me get clinical exposure and I would be more confident to start working as a dentist once I clear my licensure. I understand the treatment quality, patient care and safety concerns displayed by the British Association of Dental Therapists (BADT) and the British Society of Dental Hygiene (BSDHT) regarding this route. It was the first thing that crossed my mind when I had initially heard about this option.[3]

However, I do feel that using the reasoning where the high failure rate of dentists sitting the ORE's Part 2 dental mannequin test, with an average failure rate of 50% and 69% at one sitting being particularly alarming, is one way to look at it. This evaluation does hold for 50% to 69% of dentists. But, the benefit of the doubt still applies to 31% to 50% of dentists. Those who would otherwise pass the rigorous exams are highly skilled, and they can be an asset in this route as well.

Hence, I feel the need to bring to your notice that dentists with few clinical skills as well as the aptly skilled are opting for this route. It is imperative to regulate this route as an opportunity to fill in the critical shortage of manpower in dentistry.[4,5,6] Clinical assessment and official training can be among some options to help regulate the internationally qualified dentists entering through this route and integrate them into the workforce, which is equally important.

I sincerely feel that blocking this route due to the fear of substandard dental care will be like closing just another loophole without exploring the opportunities that could help make standard dental care accessible to many patients waiting on long lists.

*S. Huda, Pinner, UK*

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## Head and neck cancer

### PROMIS

Sir, head and neck cancers are associated with pain at the time of diagnosis and pain due to side effects of treatments. Oral mucositis after chemotherapy or radiotherapy is a cause of significant morbidity for the patient as well as a public health concern. Patients report high pain interference scores and reduced quality of life as pain impairs speech and normal masticatory function.[1]

I am writing to highlight the need for proper characterisation of symptoms related to cancer pain, with an emphasis on the assessment of orofacial function. It would address the personal concerns of patients about how pain affects their daily life and identify treatment outcomes that matter the most to them.

To make the assessment of pain more patient-based, a study has reported the use of patient-reported outcomes (PROs) dubbed 'precision PROs' to be reliable.[2] Based on the PROMIS (Patient-Reported Outcomes Measurement Information System) measures,[3] it has shown that the individual

assessment of pain interference in cancer patients is feasible. Also, it has suggested the use of such tailored questionnaires to deliver care to patients that is more in alignment with their desired treatment outcomes.

Further research is needed to adapt it to various demographics and actual clinical setups where patients receive treatment. A holistic approach towards assessing patient outcomes and providing personalised patient care would include a further look into the impact of pain on quality of life and physical function along with pain interference. Equal input by patients can aid the clinician in better management of post-treatment symptoms.

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## MRONJ

### MRONJ and ENT

Sir, dental surgeons are familiar with the adverse side effect of medication-related osteonecrosis of the jaw (MRONJ) associated with anti-resorptive or anti-angiogenic medications. However, there is now increasing evidence that these medications are also associated with osteonecrosis of the external auditory canal. Recent case reports have reported this complication[1,2] and its significant impact on a patient's quality of life, leading to hearing loss, facial paresis and potential TMJ involvement if left untreated.[2] Early treatment may, however, prevent these complications.

Some authors have now termed this complication medication-related ear canal osteonecrosis (MRECO)[2] which may present as bone of the ear canal exposed for eight weeks in patients using risk medication (especially bisphosphonates, denosumab, bevacizumab, temsirolimus and sunitinib), in the absence of previous radiotherapy in the temporal area, exclusion of metastases and cholesteatoma.[3] Patients at risk of MRONJ may therefore be at risk of medication-related osteonecrosis of the external auditory canal.

Special care dentistry involves treating patients with medical conditions that are associated with otologic disease and who may also be taking risk medications, such as patients with osteoporosis, multiple sclerosis, rheumatoid arthritis, multiple myeloma or cerebral palsy. Many dental problems may also present as otologic diseases, including dental pain or infection, TMJD and facial pain. Patients presenting with ear pain, ear discharge, ear infection or symptoms suggestive of cholesteatoma (eg dizziness, tinnitus or facial weakness on one side) and who are taking risk medications should be referred urgently to ENT for assessment.[4]

*I. Khan, West Midlands, UK*

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## Diversity and inclusion

### Why do we accept sexism in dentistry?

Sir, sexism at work has been raised in the news recently regarding MPs acting inappropriately in the Commons. I would also extend this to the dental profession.

As a young, female dentist, we experience sexism on a regular basis so much so that it is taken as the norm. Last week, a patient looked at me and, before I even said a word, said: 'are you sure you're strong enough to take out a tooth?' I laughed it off, conducted my check-up and proceeded to successfully remove his tooth (despite him making a further comment along the same lines after the examination). I have seen patients who immediately address me as 'nurse' because they assume the dentist they are waiting to see is male.

Sexism is just as prevalent in dentistry as it is in politics but, unlike in Parliament, our issues are with the patient base themselves. In every year since 2008/2009, the number of female dentists has been growing, with just over 50% of new registrants being women in 2018/19.[1] In 2020/21, the percentage of female dentists on the register was 51.8%.[1] It cannot be expected for over half the new workforce to put up with this behaviour.

I appreciate that change takes time but it cannot simply be a matter of waiting for the public mindset to shift. I do not believe it is acceptable to tolerate such discrimination when we do the same work as our male counterparts.

A solution to the problem still eludes me. The patient-dentist relationship is crucial, and the patient must be treated with respect, so confronting them on the matter seems impossible.

I feel that we must work together as a profession to have the confidence to call out these episodes of macroaggressions against women. Only by raising awareness and changing the current system will we be able to create a positive and safe environment for women in dentistry.

*C. Dewshi, Swansea, UK*

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### Women's progress in dentistry

Sir, the issue of misogyny and workplace sexism is once again in the news with serious allegations coming to light in the UK Parliament. It prompted a group of female friends to reminisce about the everyday, casual sexist remarks that accompanied our dental training in the seventies and eighties where female students were in the minority. This was followed by stories from the workplace where examples included a junior woman being asked why she wasn't 'at home having babies?'! At that time, women were under-represented in most dental specialities, and almost unknown in OMFS.

Later that evening, I opened the *BDJ* to see a report of new BAOMS Council Members bringing 'diversity and strong skills'.[1] The accompanying photograph of six female Council Members spoke volumes about the progress women have made in dentistry.

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