multiple studies have demonstrated the benefits of providing routine HIV screening in the A&E environment to be both feasible and effective. We are aware of the oral manifestations which are common in HIV-positive patients, such as candidiasis, RAS, hairy tongue and periodontal disease.

In providing routine HIV screens as a form of investigation, we can collectively increase the number of undiagnosed positive patients which would in-turn not only aid in the appropriate management of these patients, but also reduce the risk of HIV transmission to other members of the population. I feel that all clinicians should consider the deduction of STIs, particularly HIV, when investigating and thus diagnosing oral diseases.

A. Shathur, Aintree, UK

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Primary care

Aptly coined acronym

Sir, I was pleased to read the article *Introducing the FATLIPS acronym for assessing the red flag clinical features of dental infection*.[1] As a DCT in oral and maxillofacial surgery I am familiar with assessing patients who present to A&E with dental infections and regularly receive referrals from GDPs for suspected infections. I believe this acronym is readily applicable for GDPs as it is based on assessments that don't require tests that are likely to be unavailable in practice. Even with the increased frequency of phone triaging and patients emailing in photographs of suspected swellings, GDPs should be able to successfully work through this aptly coined acronym, identifying those that require management in secondary care and those that don't. Furthermore, this acronym provides not only a useful tool by which a referring GDP can assess patients, but can also provide a framework to facilitate communication between the referring practitioner and accepting on call DCT. This will ensure only appropriate referrals are accepted and avoid patients attending hospital unnecessarily, which is particularly pertinent in the current COVID-19 climate. Upon reading this article I promptly shared it with my other DCT colleagues and it made for an interesting talking point.

C. Devine, Bath, UK

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Romanian insight

Sir, we read with great interest the letter by Dadnam *et al.* presenting the case of a Romanian patient and we felt it might be helpful to provide some additional insight as dentists who trained and/or are practising dentistry in Romania.[1]

We agree with the authors that most dental care in Romania is delivered privately and as evidence suggests, treatment costs can present a significant barrier for accessing care for certain members of the community. However, it is important to point out that socio-economic inequalities regarding access to oral healthcare are not a problem unique to Romania but are prevalent worldwide.[2] Furthermore, it is important to consider the significant limitations of interpreting health insurance data for international comparisons and the need for additional research in this area.[3]

Evidence suggests that privately delivered dental care is being consistently underreported in various Eastern European countries as a way of avoiding fiscal duties.[3] For context, the tariff paid through the limited national health insurance system for a non-surgical extraction is around £12 (free for low income patients) meanwhile the same treatment delivered privately could cost starting from £10 or more depending on the location of the practice (urban/rural) and other factors such as being delivered by a GDP or specialist. It is worth noting that the national minimum wage is around £400/month.[4]

Considering the limitations of the available data, our direct clinical experience of working both in the private and public healthcare systems suggests that the case presented in the letter might be an exception rather than a representative example for the entire population. These are uncertain times for ethnic minorities, and it is important to remember the risk of stereotyping which might lead to some unintended consequences through unconscious bias and may inadvertently increase the levels of inequalities experienced by vulnerable populations.

C. B. Bellu, Cluj-Napoca, Romania; I. F. Dragan, Boston, US; S. Serban, Leeds, UK

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Dental physiology

Dentine as a pain perceiver

Sir, the essence of dentistry is pain perception and the alleviation thereof. Accordingly, the existence of the dental profession is essentially founded upon the peculiarities of dentine sensitivity which is undoubtedly the most frequently experienced form of pain perception. The exposure of dentine to salivary solutes of acidity and temperature variations within the mouth make dentine perception as the *sine qua non* of painful experiences. The ability to transmit 'sweetness' as a stimulus for pain is a property shared by no other tissue, and the mechanism of this peculiarity has hitherto never been explained.[1] Presumably, the high osmotic pressure of a sugar solution acting on exposed dentine is productive of a painful sensation. Yet even a strong isotherm salt solution does not elicit a reaction from dentine.

The histology of dentine revealing the contents of the dentinal tubes to be extensions of peripheral odontoblasts in the dental pulp categorises these cells as extensions of the peripheral nervous system. Thereby, the inclusion of odontoblasts as 'nerve tissue' is justified on the basis of their physiological activity rather than their histological appearance. The expanded classification of nerve tissue to include odontoblasts calls for a denouement of neurons and odontoblasts as equal pain perceivers. Essentially then, dentine is

a component of the peripheral nervous system as a nociceptor.[2] Remediation to alleviate or minimise the sensitivity of dentine has recently been published.[3] The first ever approval by the FDA has been granted to a fluoride-containing bioglass toothpaste: https://www.biomin.co.uk/, testimonials wherein the toothpaste uses bioactive glasses that protect teeth over 12 hours to reduce sensitivity and possibly dental caries.

G. H. Sperber, Alberta, Canada

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Aesthetic dentistry

Smile makeover generation?

Sir, I read with interest recent letters acknowledging the increasing influence social media has on patients' views of their dentition.[1,2]

Currently, composite bonding is gaining exponential interest, commonly advertised on platforms such as Instagram under tags of 'smile makeover', 'no injection, no drilling', 'smile design' etc. The growth in demand for the perfect smile is synchronous with a generation that uses multiple social media networks, thereby propelling the market.

The advent of dental tourism means some patients go overseas for their makeover, returning with extensive veneers, crowns and bridgeworks, often with a very short lifespan, mostly as a result of poor patient education. One can argue that composite bonding is minimally invasive in comparison, hence the much preferred and safer option. However conservative, these treatments are rarely truly reversible, and it is inevitable some tooth structure will be removed with each replacement, when they stain, fracture, or develop caries.

The Steele Review[3] highlighted a demographic bubble of the 'heavy metal generation' from the 1950s–1970s who have retained most of their teeth but are heavily restored with amalgam. I wonder if we are repeating this phenomenon with the creation of the 'smile makeover generation', which in the next few decades will present a different restorative challenge as we know that no treatment is permanent. I trust these patients have consented to a lifelong commitment to dental treatment, and dentists offering smile makeovers have carefully selected only those proved capable of maintaining their dentition. Hopefully too, the NHS will not have to foot the bill for eventual failure of these treatments.

M. Wooi, Wirral, UK

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Oral surgery

Wrong-sided?

Sir, my oral surgery colleagues and I were rather surprised by the recent announcement that wrong tooth extraction is to be removed from the list of Never Events (NE) as stipulated by NHS Improvement on 1 April 2021.[1]

The reason given for this change is that 'The systemic barriers to prevent the removal of wrong teeth are considered not to be strong enough to prevent these from occurring eg lack of standardisation in types of tooth notation and difficulties with site marking'. On initial reading of this, one may feel that this is a victory for common sense, although I feel that the interpretation of this is slightly more nuanced. Removal of the wrong tooth is still considered to be a serious event which must be reported and investigated, however, this announcement changes the framework through which such events will be investigated.

Having devoted much time and effort to patient safety in dentistry, this is broadly a positive step. The removal of this from the list (frequently the most common surgical NE) will allow more focus on other NE.[2] However, I am slightly cautious about what this means for dentistry within the NHS. I hope that this change does not lead to a downgrading of patient safety in dentistry which is still an area that requires development.[3] Safety and quality are inexorably linked and I worry that if the first is dimmed a decline in quality may follow. There is still no accepted framework that defines patient safety incidents in dentistry.[4] Too much focus has been on wrong tooth extractions because, aside from death in the dental surgery, this is the most tangible adverse event that can occur.

I was never at ease with the term 'Never Event', feeling that it has too much onus on the negative. In my experience, the approach has improved in recent years, with 'patient safety cultures' developing across the profession. Perhaps a framework of 'Always Events' for dentistry is the way forward: we always check we have the right patient, we always provide the correct treatment, we always report and learn from incidents.

E. Bailey, London, UK

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Referrals

Reply please

Sir, whenever I make a referral for oral medicine or oral surgery to my local hospital, all subsequent correspondence from the hospital is invariably addressed to the patient's GMP with a copy sent to me. I find this rather insulting; as the referring practitioner, I expect the reply to be addressed to me.

A. Walley, Wallingford, UK

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