5. Alvarado-Omenat J J, Llamas-Ramos R, García-García D, Correyero-León M, Fonseca-Sánchez E, Llamas-Ramos I. Effectiveness of virtual reality in cancer patients undergoing chemotherapy. Systematic review. *Int J Cancer* 2024; DOI: 10.1002/ijc.35258.
6. Lee J J. How precision cancer prevention can promote health equity. 2022. Available at https://prevention.cancer.gov/news-and-events/blog/how-precision-cancer-prevention-can-promote-health-equity (accessed 11 January 2025).
7. Chow R, Drkulec H, Im J H B *et al.* The use of wearable devices in oncology patients: A systematic review. *Oncologist* 2024; DOI: 10.1093/oncolo/oyad305.
8. Hawley S T, Haymart M R. The potential of wearable devices in cancer care delivery. *JAMA Oncol* 2024; **10:** 573–574.

https://doi.org/10.1038/s41415-025-8516-7

Temporomandibular disorders

TMD management standards updated

An open working group discussion was held at the IADR General Session in New Orleans (March 2024), where members of the INfORM network finalised the proposal of a list of ten key points for good clinical practice for the field of temporomandibular disorders (TMDs). These ten points represent a summary of the current standard of care for TMD management.[1] The key points and their main contents mirror the recommendations recently released within England by NHS England's GIRFT programme and the Royal College of Surgeons of England for the TMD Care Pathway,[2] and include:

- One statement on general principles: patient-centred decision-making as well patient engagement and understanding of expectations are critical aspects in the management of TMDs
- Two statements on aetiology: TMDs are disorders of musculoskeletal origin that occur within a biopsychosocial framework and are precipitated by a multifactorial aetiology
- Three statements on diagnosis: diagnosis of TMDs should be based on a careful and standardised oral history and clinical assessment. Imaging procedures should be considered in all cases when that imaging (MRI for soft, CBCT for bone tissues) has the potential to impact the treatment plan and outcome. Currently, the use of electronic devices for diagnosis is not supported
- Three statements on treatment: outcomes should be evaluated in terms of pain reduction and improved function as well as decrease of relapses and psychosocial impact. Primary approaches should be conservative whenever possible, with a combination of counselling, cognitive-behavioural treatments, provisional use of oral appliances, and pharmacological control of pain. Surgery may be needed in a selected minority of cases. Dental and/or surgical techniques to correct occlusion and/or mandible position are not supported
- One statement on TMDs within the broader aspects of orofacial pain: cases of pain chronicity or presence of concurrent multiple pain conditions should be managed by expert practitioners and/or referred to the proper specialist.

These key points, in their simplicity, will assist general dental practitioners to advance their understanding and prevent inappropriate treatment. They can be viewed as a guiding template for other national and international associations to prepare guidelines and recommendations on management of TMDs; those can be adapted to the different cultural, social, educational, and healthcare requirements in countries around the world.

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References

1. Manfredini D, Häggman-Henrikson B, Al Jaghsi A *et al.* International Network for Orofacial Pain and Related Disorders Methodology. Temporomandibular disorders: INfORM/IADR key points for good clinical practice based on standard of care. *Cranio* 2024; DOI: 10.1080/08869634.2024.2405298.
2. Beecroft E, Palmer J, Penlington C *et al.* Management of painful temporomandibular disorder in adults. NHS England Getting It Right First Time (GIRFT) and Royal College of Surgeons' Faculty of Dental Surgery. 2024. Available at https://www.rcseng.ac.uk/dental-faculties/fds/publications-guidelines/clinical-guidelines/ (accessed November 2024).

https://doi.org/10.1038/s41415-025-8515-8

Sexism in healthcare

Can I see the doctor please?

We write to raise a frustrating issue that unfortunately is commonplace for many women in dentistry. A recent patient interaction has highlighted how sexism from patients is still rife within healthcare and dentistry. In this interaction, a male patient attended secondary care for a simple extraction. The team treating him were six women, comprised of three qualified dentists including a senior oral surgery specialist registrar, a dental core trainee, and a postgraduate in oral surgery; as well as a final-year dental student and two senior nurses. After team introductions were made and local anaesthetic administered, it became apparent that the patient was unhappy. He expressed that he wanted a 'real doctor' and refused treatment from 'girls'. The male supervising oral surgery consultant attended to diffuse the situation, and the patient remarked 'now the doctor has arrived' he would have his treatment. The procedure was completed by the male consultant and the patient left happy with his care.

A BMA-backed project[1] has some striking findings that are relatable for many women in dentistry. It found that 73.5% of female doctors reported that they have been assumed to be in more junior roles in the workplace by patients, compared to only 1.5% of male doctors. It is particularly prevalent for younger doctors, demonstrating how gender stereotypes in medicine are still very present. Likewise, a recent systematic review found gender-based discrimination in surgery is prevalent but has evolved from an explicit to a more subtle attitude.[2]

Women make up 52% of dentists in the UK, with 35% of specialist oral surgeons being women.[3] With an increasing number of female dental students, we are seeing a huge influx of women entering the profession, and potentially into surgical roles. As per the Equality Act,[4] the dental profession is required to ensure that women are protected and challenge the damaging stereotype that women can't be dentists or surgeons.

Reflecting on this patient interaction, it begs the question of how should we be handling these situations? Patients have a right to choice in their care, but where do we draw the line at blatant gender discrimination? It can be difficult to know how to react at the time, and often these incidents can be put down to patient anxiety and overlooked to diffuse the situation. However, dental professionals deserve to work in an environment that does not tolerate prejudice in any form, including gender discrimination. All colleagues, regardless of gender, need to play a more active role in speaking up against sexism and set a precedence that this behaviour is not tolerated, to avoid reinforcing gender discrimination as acceptable.

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References

1. British Medical Association. Sexism in medicine report. 2024. Available at https://www.bma.org.uk/