

effects are supported by both experimental and population-based research, but further research is required to fully understand the mechanism and health implications of PFAS.⁴

The results of a study on PFAS exposure related to various behaviours and product use raise concerns about the use of certain PFAS containing dental floss, especially since they are used in the oral cavity making it highly likely to be absorbed or ingested through the oral tissues, leading to their potential to enter the bloodstream of the individuals and accumulate over time.⁵

Dental floss is a vital tool in maintaining oral hygiene but consumers may not be aware of the presence of PFAS in certain dental flosses. There are numerous PFAS-free dental floss alternatives accessible in the market. Further research is imperative to establish a definitive understanding of the potential adverse effects on individuals and the environment of PFAS containing dental floss. Concurrently a judicious approach is warranted; it is our responsibility to not dissuade our patients from flossing but instead equip them with the knowledge to allow them to make an informed health-conscious and environmentally conscious decision about their oral hygiene practices.

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Head and neck cancer

Are two-week wait clinics appropriate?

Sir, I read with interest the paper by Hook *et al.* regarding the appropriateness of two-week wait head and neck cancer referrals to their district general hospital.¹ I would like to share the findings of a similar service evaluation that we carried out in 2020 on our two-week wait clinics in a tertiary unit in the South West providing head and neck cancer services.

From the 131 new patients seen, 94% were referred by their GP, with a mean age of 54 years and a M:F ratio of 1:1. From this, 79% and 35% of patients underwent further special investigations which included ultrasound scans and fine needle aspiration, respectively. The overall prevalence of cancer was 20%, with a mean age of 61 years. Twenty-four percent of patients were diagnosed with benign lymphadenopathy and were subsequently discharged.

The findings of our service evaluation show a higher prevalence of malignancy compared to the findings of Hook *et al.* (20% vs 6%).¹ Rapid identification and intervention of these patients are critical for improved outcomes. However, the success of this pathway is reliant on the availability of diagnostic services, the expertise of healthcare professionals, and the patients' awareness and prompt response to any alarming symptoms.^{2,3} Ongoing training and education of healthcare professionals is needed in order to equip them with the necessary skills to make appropriate, informed and timely referrals.

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Dental education

The importance of practical skills

Sir, we would like to add our concerns to those raised by Professor Barclay in the *BDJ*.¹ The permanent withdrawal of practical skills testing in the recruitment of specialist dental trainees has seemingly been undertaken by a largely non-clinical body, the MDRS (medical and dental recruitment and selection), initially in response to the pandemic, where assessments were undertaken online to limit personal contact. Whilst this short-term measure could clearly be supported, its continuation after the pandemic has subsided cannot. As a leading specialist society passionate about the provision of training and specialist services within prosthodontics, we recognise the enormous importance of practical skills in our discipline. To ensure that our future specialists are of the highest quality is fundamental to any selection procedure, especially when training places are limited. To select candidates blind to their practical skill set, largely for the sake of convenience and without appropriate clinical consultation, does not serve our trainees well and does not ensure that the public receive the best possible specialists at the end of training. We would be delighted to be engaged by the bodies making these decisions to ensure that any recruitment process is fit for purpose.

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