

Other journals in brief

A selection of abstracts of clinically relevant papers from other journals.

The abstracts on this page have been chosen and edited by John R. Radford.

BURNING MOUTH SYNDROME

Steroid dysregulation and stomatodynia (burning mouth syndrome)

Woda A, Dao T *et al.* *J Orofac Pain* 2009; **23**: 202-210

An aetiology for burning mouth syndrome.

This issue contains five papers on burning mouth syndrome. In this 'focus paper', a cause for the condition is proposed. There are then three commentaries exploring this hypothesis and a fourth paper responding to the critiques. There is even debate as to what the condition should be called. The consensus is stomatodynia or burning mouth condition. Traditionally, stomatodynia has been labelled as a 'functional' condition, grouping it with others such as fibromyalgia. The proposed aetiology proposed in this paper suggests that chronic anxiety results in steroid dysregulation. This, together with the dramatic reduction in gonadal steroids associated with menopause, causes neuropathic changes in the oral mucosa. The hypothesis attempts to embrace what the authors claim are the characteristics of the condition, namely, 1) over representation in pre/post menopausal women, 2) high prevalence in those with anxiety disorders and 3) symptoms that are localised to the mouth.

DOI: 10.1038/sj.bdj.2009.1153

STOMATODYNIA

Authors' response to critical commentaries

Woda A, Dao T *et al.* *J Orofac Pain* 2009; **23**: 219-220

Stomatodynia may offer an investigative model for other 'functional disorders'.

The major criticism of the proposed aetiology (*J Orofac Pain* 2009; **23**: 202-210), is that steroid dysregulation is generalised, although it is purported that stomatodynia occurs only in the oral cavity. In this rebuttal, it is argued that there is 'compelling evidence that neurosteroids can act locally (as in stomatodynia)...to locally influence neuronal activity'. Furthermore, the responding authors state that the reason why systemic steroid therapy does not resolve the condition is that irreversible neuropathic damage has already occurred. In addition, some of these synthetic steroids cannot be metabolised into neurosteroids. Saliva could have a particular role in the aetiology of stomatodynia, as the condition is restricted to those regions, bathed in this fluid. Intriguingly, a higher density of taste buds has been found in those with stomatodynia.

DOI: 10.1038/sj.bdj.2009.1154

COST EFFICACY

Evaluation of the cost-effectiveness of root canal treatment using conventional approaches versus replacement with an implant

Pennington MW, Vernazza CR *et al.* *Int Endodont J* 2009; **42**: 874-883

Implant placement is only cost effective after endodontic treatment has failed twice.

The aim of this study was to compare the cost-effectiveness of different treatment interventions for a compromised central incisor tooth. The costs were based on those of a secondary care setting in the UK National Health Service. The longevity of the different treatments were obtained from a literature search. Estimates for failure were calculated using Markov modelling (random events over time). The authors reported that 'Implant placement is expensive, and is cost effective...only after endodontic treatment has failed twice. If orthograde endodontic re-treatment fails, 'the benefits of additional apical surgery do not justify the additional cost'.

DOI: 10.1038/sj.bdj.2009.1155

DIAGNOSING TMD

Adapting the diagnostic definitions of the RDC/TMD to routine clinical practice: a feasibility study

Hasanain F, Durham J *et al.* *J Dent* 2009; **37**: 955-962

'more appropriate and attractive (method for diagnosing temporomandibular joint and muscle disorders - TMD) for day-to-day busy clinical practice'.

The Research Diagnostic Criteria for TMD (RDC/TMD) is rarely used in general practice, although this tool is the 'gold standard'. The aim of this study was to determine if a simplified version of the RDC/TMD's clinical examination, called the Clinical Examination Protocol-TMD (CEP-TMD), would have similar validity but be quicker to carry out than RDC/TMD. Using both versions, three examiners examined 41 patients with TMD and 8 symptom-free subjects. There was 'substantial overall agreement between the CEP-TMD and the RDC/TMD ($\kappa = 0.70$)'. When compared with RDC/TMD, CEP-TMD reduced the time for the examination from a mean time of 10.3 to 7.5 minutes. The time required to diagnose these conditions is trivial in comparison with the significant impact they can have on patients' quality of life. CEP-TMD can be seen as an online video at <http://www.ncl.ac.uk/dental/AppliedOcclusion>.

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