COMMENT

Letters to the editor

Send your letters to the Editor, *British Dental Journal*, 64 Wimpole Street, London, W1G 8YS. Email bdj@bda.org.
Priority will be given to letters less than 500 words long. Authors must sign the letter, which may be edited for reasons of space.

CORONAVIRUS

COVID tongue

Sir, I read with interest the emerging media reports of a possible association between geographic tongue (GT) and SARS-CoV-2 infection, recently coined as 'COVID tongue'. These reports have been identified through the ZOE COVID-19 Symptom Study app, where participants submit symptom reports on a daily basis. Professor Spector, the study's lead researcher from King's College London, has reported a number of user submissions that seem to be consistent with GT, but to date there are only two communications in the literature reporting it as part of COVID-19 illness.[1,2]

GT, otherwise known as *Erythema migrans*, is not an uncommon finding on the oral medicine clinic. Adult incidence is around 1–2%. Typically, it presents with irregular areas of depapillation on the dorsal aspect of the tongue. These areas may change in size, shape and position, much like continental drift, as its name suggests. It affects both males and females and may be seen at any age.

While some elements of the media have called for COVID tongue to be added to the list of COVID-19 symptoms, its diagnostic value remains unknown and should be treated with caution. Such findings may represent a pre-existing GT.

However, as dental professionals, we must also be receptive to these developments. If a GT is of recent onset, could it signify COVID-19? Possibly. There is some evidence to suggest that GT might be associated with elevated levels of the inflammatory cytokine interleukin-6 (IL-6),[3] the same cytokine that is upregulated in severe COVID-19 disease.[4] It is also worthwhile remembering that angiotensin-converting enzyme 2 (ACE2) receptor expression is higher in the tongue relative to other oral tissues.[5] ACE2 receptors are the entry point of the SARS-CoV-2 virus.

Further research is necessary, but as media interest may generate some concern among our patients, we must keep abreast of these developments and remain vigilant.

R. W. Hathway, Bristol, UK

References

1. Rodríguez M D, Romera A J, Villarroel M. Oral manifestations associated with COVID-19. *Oral Dis* 2020; DOI: 10.1111/odi.13555.
2. dos Santos J A, Normando A G C, da Silva R L C *et al.* Oral mucosal lesions in a COVID-19 patient: new signs or secondary manifestations? *Int J Infect Dis* 2020; **97:** 326–328.
3. Alikhani M, Khalighinejad N, Ghalaiani P, Khaleghi M A, Askari E, Gorsky M. Immunologic and psychologic parameters associated with geographic tongue. *Oral Surg Oral Med Oral Pathol Oral Radiol* 2014; **118:** 68–71.
4. Leisman D E, Ronner L, Pinotti R *et al.* Cytokine elevation in severe and critical COVID-19: a rapid systematic review, meta-analysis, and comparison with other inflammatory syndromes. *Lancet Respir Med* 2020; **8:** 1233–1244.
5. Xu H, Zhong L, Deng J *et al.* High expression of ACE2 receptor of 2019-nCoV on the epithelial cells of oral mucosa. *Int J Oral Sci* 2020; **12:** 8.

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Advice on consent

Sir, a recent letter about consent and the need to warn about a risk of catching COVID-19 while attending for dental treatment[1] is an interpretation of the Montgomery ruling,[2] which potentially undermines the current standard operating procedure (SOP)[3] and duplicates the warnings currently issued before attending a hospital appointment. It helps to distinguish between the procedure and the environment in which it is provided.

COVID-19 is not a material risk of the dental procedure itself and prospective patients will already have been alerted to the risk of visiting the hospital setting. The risk from being in a hospital building will have been covered by the general advice/instructions for anyone attending the hospital, and the infection protection control measures the authors acknowledge are carried out and therefore do not need to be part of the consent to the procedure itself.

'Montgomery' dealt specifically with the material risks of a medical procedure. The consent process is not invalidated by adding a line about the material risks of visiting a hospital, but neither does it augment the validity of that consent. The aim of an effective consent process is not to overwhelm the patient with so much information that they are left unable to process it all.

General dental practitioners who follow the SOP when providing dental treatment should continue to follow the BDA advice on consent[4] without adding any additional warnings about their surgeries. Dental surgeries that are non-compliant with the current SOP in their jurisdiction should not treat patients.

L. D'Cruz, Head of BDA Indemnity, London, UK

References

1. Liew J, Winston M. Informed consent. *Br Dent J* 2021; **230:** 59.
2. Montgomery v Lanarkshire Health Board [2015] SC 11 [2015] 1 AC 1430.
3. Office of the Chief Dental Officer. Standard Operating Procedure: Transition to recovery v4. October 2020.
4. British Dental Association. BDA advice: Consent. February 2020. Available at: https://www.bda.org/advice/ba/Documents/Consent.pdf (accessed February 2021).

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Help is at hand

Sir, I was pleased to read the item 'Addiction and alcoholism in dentistry'.[1] In these COVID-19-dominated times, many of our colleagues are turning to drugs, alcohol and other behaviours to combat their work-related anxieties and stresses. In many cases, this can lead to dependency and addiction, which can ultimately lead to their