tumour was diagnosed and excised.

At review appointments there was a dramatic improvement in oral symptoms and a return of hormone levels to normal.

Oral symptoms (BMS) have been reported before in similar cases[3] and it has also been shown that ovarian hormones do act upon the oral mucosa.[4]

In conclusion, it would appear that hormonal imbalance could be considered as a possible cause of symptoms in patients with BMS and that the General Medical Practitioner may be able to arrange for hormone assays from blood tests on appropriate patients, at the same time as requesting the tests as indicated in Professor Lamey's article.[1]

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THE AUTHOR'S REPLY

Sir, I thank Richard Graham for pointing out another rare aetiological factor in Burning Mouth Syndrome (BMS). I think he needs to appreciate that in writing an article for *Dental Update* of necessity one has to take a general viewpoint and I therefore was not attempting to be encyclopaedic. What I did attempt to do was suggest management protocols based on scientific studies and not anecdotes. Spontaneous remission in BMS, for example, has been reported and may have been the case in the patient they quote.

Incidentally, I was incorrectly quoted in the BDJ letter[1] and am attributed to report "Oral symptoms seem to occur in approximately half of females with climacteric problems". What I did say in the BMJ paper[2] was that of 104 female patients "in only six were the symptoms of burning mouth syndrome eventually attributed solely to the climacteric".

There is no scientific evidence linking hormonal imbalance as a precipitating factor in BMS. In one double-blind controlled study of 145 women, oestrogen therapy produced no change in the burning sensation.[3] Another similar study of 102 patients also failed to improve the patients' BMS.[4] The response as evaluated by exfoliative cytology, of the oral epithelium to oestrogen therapy is minimal[5] and indeed local application oestrogen or a combination of oestrogen or progesterone on a burning mucosa was ineffective.[6]

Great care is required when discussing oestrogen receptors as there are two broad categories of receptors, those with high affinity and those with low affinity. For example, salivary gland tumours have oestrogen receptors but they are low affinity and therefore not biologically important.[7]

In conclusion, in a world increasingly concerned with evidence-based medicine I would not advocate 'hormone assay' in the routine management of patients with BMS.

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HOLISTIC CARE AND DENTAL PRACTICE

Sir, I was interested to read your comment about 'Holistic Care and Dental Practice' in the December issue of your *Dental Update*.

However, I was both horrified and embarrassed that out of 54 volunteer dentists to find 25 smokers amongst their patients, less then half provided any patients and only two actually provided the right number.

As always, there are no doubt many reasons why there was such a small response, although I would suggest that few of the reasons given can be termed valid excuses, and wish that I could have been one of those 54 as hardly a day goes by when I don't make a gentle suggestion to a patient to give up smoking.

One of the satisfying aspects of dental practice is being able to improve in some way the quality of our patient's lives, but, in the majority of patients, that overall improvement would be nothing compared to the overall improvement in the quality of life if smoking was given up, and to have been a part of that happening would, I imagine, give the practitioner a great deal of satisfaction.

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