# Letters to the Editor

## Basic Erosive Wear Examination (BEWE)

Even though each type of tooth surface loss (TSL) or tooth wear (TW) has its clinical appearance when present on its own, abrasion, attrition and erosion may co-occur and interact to create a mixed TSL lesion which may make diagnosis difficult.[1–3] However, the Basic Erosive Wear Examination (BEWE) is based on identifying and scoring the most severely affected tooth in each sextant.

The term refers to only the erosive cause, as other factors, such as abrasion, attrition, and abfraction are not taken into account. The last factor, abfraction, has very little support in the literature.

According to a King's College London/Dental Defence Union (DDU) YouTube video, BEWE will soon become a legal issue because it affects more than 30% of people.[4,5] As a result, proper TSL documentation in the patient's dental record is critical.

As a result, the term BEWE is inadequate and misleading. I suggest adding the other two factors (abrasion and erosion) to the term to make it Basic Erosive Abrasive and Attrition Wear Examination (BEAAWE).

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## RUNX1–FPD MM: considerations for the GDP

RUNX1-FPD MM is a rare familial platelet disorder (FPD) inherited in an autosomal dominant manner. It is caused by a mutation to the germline runt-related transcription factor 1 (RUNX1) and is associated with myeloid malignancy (MM). Patients with RUNX1-FPD MM experience abnormal platelet function, and blood investigations often reveal mild to moderate thrombocytopenia; however, the platelet count may be within normal limits (150–450 x $10^9$/L).[1]

Almost all patients with RUNX1-FPD MM experience prolonged bleeding and this may be their first clinical manifestation of the disorder. This is of significance to the GDP because these patients may complain of excessive bleeding following oral hygiene measures. Furthermore, after an extraction there may be bleeding that is not controlled through local measures of placing a suture and a haemostatic agent in the socket. In this case, an urgent referral should be made to the local oral and maxillofacial or accident and emergency unit.

Owing to the risk of bleeding in patients diagnosed with RUNX1-FPD MM, they are more appropriately managed in secondary care if any invasive dental procedures are required. Input will be sought from their haematologist regarding the need for a clotting promoter, such as the antifibrinolytic medication tranexamic acid. Rarely, these patients may require a platelet transfusion pre-operatively if there is a high bleeding risk associated with the planned procedure.

Myelodysplastic syndrome and a range of haematological malignancies have been associated with RUNX1-FPD MM, including acute myeloid leukaemia and T cell lymphoblastic lymphoma. There is reportedly a 44% lifetime risk that someone with RUNX1-FPD MM will develop a myeloid malignancy.[2] Therefore, the GDP should be highly vigilant for any oral manifestations of these malignancies. Manifestations may include spontaneous gingival bleeding, gingival hyperplasia, petechiae haemorrhages, opportunistic infections, and generalized oral ulceration. If these features are noted, they should be referred to their general medical practitioner for further investigation.

While many GDPs will not encounter patients with RUNX1-FPD MM, for those who do, they should remain mindful of their patient's increased bleeding risk and recall them regularly for examination, while being alert for any oral manifestations of haematological malignancy.

**References**


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