dation of endocarditis prophylaxis and its compliance in their practice. (4) To find the effect on the factors on knowledge of infective endocarditis (IE) and compliance to latest regimen of endocarditis prophylaxis (EP). *Materials and methods*: The study design A descriptive, cross-sectional study was performed among the general dental practitioners in the state of Tamil Nadu. Respondent in the presence of the investigator filled a 10-question semi-structured questionnaire with one open-ended question. Each respondent was given a time of 15 min to complete the questionnaire. The 1997 guideline of ADA was used as the standard regimen. *Results*: There was generalized awareness among GDPs regarding the dental aetiology of IE (94.58%). The knowledge of IE was very poor as only 13% had good knowledge (average knowledge 36.82%, poor knowledge 50.18%).

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How to do a safe tracheostomy—a novel technique

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Introduction: Tracheostomy is a common procedure. Complications are common and can be dramatic. During tracheostomy, there is increased risk of aspiration, loss of positive pressure ventilation, inadequate oxygenation and sometimes hypercarbia due to rupture of the endotracheal tube (ETT) cuff. A technique is described to avoid this. Various measurements were recorded to substantiate the value of the technique. *Methodology*: Twenty patients had a modified surgical tracheostomy technique by positioning the end of the ETT at the level of the carina. This prevents the rupture of the cuff as it will be below the site of tracheotomy. Length of the cuff, distance between the carina and the tracheal window were measured to substantiate the technique. *Results*: Distance between the carina and the site of the tracheotomy was around 9.7 cm (7.5–12.5 cm). The length of the cuff was 6.8 cm. The length of trachea available above the cuff to avoid rupture was around 2.95 cm (0.7–5.9 cm). There was no period of desaturation. *Conclusion*: We therefore recommend that the modified technique is essential during a tracheostomy procedure, especially in difficult patients. Also consideration should be given prior to shortening of ETT in ITU so that sufficient length is available to advance the tube to the carina.

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Burning mouth syndrome

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Burning mouth syndrome is a chronic, idiopathic intraoral pain condition that is not accompanied by clinical lesions or systemic disease and characterized by pain and burning sensations in one or more areas of oral cavity. It primarily affects females in their middle aged. Usually, no obvious aetiology is found, but several possibilities exist that can be divided into local and systemic causes. Numerous causes implicated which locally may include allergy, denture irritation, oral habits, infection (e.g., oral candidiasis) and reflux oesophagitis. Systemic causes include vitamin and mineral deficiency and diabetes mellitus. In this paper, a review of the literature is presented and recent advancement on clinical, aetiologic, diagnostic and therapeutic aspects of BMS are discussed as well as our experience with vitamin B complex therapy in patients with burning mouth syndrome.

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Panoramic radiographic study of mental foramen in a selected Pakistani population

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Objectives: The main objectives of this study were to:

1. Determine the position of MF horizontally in relation to apices of teeth in panoramic radiographs (OPG), and
2. Determine the position of MF longitudinally in relation to supra crestal alveolar bone and the inferior border of the mandible.

Results: 1000 OPGs of adult dentate patients were viewed under standard X-ray illuminator for most common position of MF in horizontal and vertical axis. The results revealed Position 4 that is position of MF below the root of second premolar to be most common. Its frequency was 47.2%. Position 4 is closely followed by Position 3 being Position of MF between the roots of both premolar teeth in 40.4%. In horizontal axis Position 1, which is the location of MF anterior/median to the root of first premolar tooth, was not found in any of 1000 OPGs. Its frequency is reported as 0%. Position 2, which is the location of MF below the root of first premolar tooth, is found to be in 45 OPGs. Its frequency is reported as 4.5%. Position 3, which is the location of MF between the roots of first and second premolar teeth, is found to be in 404 OPGs. Its frequency is 40.4%. Position 3 is the second most common location of MF in Pakistani population as viewed in OPG. Position 4, which is the location of MF below the root of second premolar tooth, is found to be in 472 OPGs. Its frequency is 47.2%. Position 4 is the most common position of MF in Pakistani population as viewed in OPG. Position 5, which is the location of MF between the root of second premolar and mesial root of first premolar tooth, is found to be in 71 OPGs. Its frequency is 7.1%. Position 5 is the third most common location of MF in Pakistani population as viewed in OPG. Position 6, which is the location of MF below the mesial root of first molar tooth is found to be in only eight OPGs. Its frequency is reported as 0.8%. Position 6 is the least common position of MF in Pakistani population as viewed in OPG.

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