Many of these bacterial infections present predominantly with characteristic oral signs and symptoms. As a result, it is imperative for the oral physician (stomatologist) to keep abreast of the latest updates in the behavior and to be aware of the whole spectrum of clinical manifestations of these diseases. Orogenital bacterial infections may be divided into two major categories: (i) Common including syphilis and gonorrhoea and (ii) Rare, including chlamydia trachomatis infection and tropical sexually transmitted infections (chancroid, donovanosis, lymphogranuloma venereum). Syphilis is the leader of sexually transmitted diseases and has been of great interest in the past and today and has played a central role in medicine for several decades. The oral lesions of syphilis (primary secondary and tertiary stages) have a broad spectrum of manifestations, which mimic a lot of other oral lesions. The recent incidence data, the oral manifestations, the laboratory tests and treatment of both categories of these diseases will be discussed, as the increased practice of oral sex has become a more important potential route of transmission for oral and genital bacterial pathogens. Stomatologists and Dentists, frequently evaluate oral mucosal manifestations and thus play an important role in the diagnosis and treatment of many of highly infectious sexually transmitted infections.

PL11
Infections – past, present and future

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The reasons that some past infections, including smallpox and diphtheria, have been conquered or controlled will be explored, as will the reasons that some other infections such as tuberculosis and leprosy remain a problem. At present HIV remains a major problem. All antiretroviral drugs are viristatic and thus, even in combination, not curative. Killing HIV will require a 'guided missile' drug that will penetrate every infected cell to remove the HIV-directed DNA within the host genome and this will not be possible, I predict, for decades. Even if a vaccination were available there will be numerous practical problems. The reasons why Edinburgh (incorrectly) received the accolade 'The AIDS Capital of Europe' will be explored and dismissed as a media creation. In the future influenza will cause a world pandemic (the question is not if, but when). Drug resistant infections will continually develop in, and be spread from, hospitals. Most bacteria divide rapidly and it is surprising that drug resistance takes so long to develop. Jet travel will allow infections to spread to anywhere on the globe within 36 h. The fact that HIV and similar retroviruses insert themselves into host cell genomes, and that these sequences can thereafter function genetically, raises the possibility that some genetic disorders were originally infections and also that such inheritance of acquired characteristics opens the door for genetic manipulation which has implications for manipulation of Darwinian evolution in humans and their pathogens.

Update Sessions

US1
HIV – changing patterns in HAART era, patients' quality of life and occupational risks

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Oral manifestations are early and important indicators of HIV-infection. Several lesions with strong association to HIV infection have been described: oral candidiasis (OC), oral hairy leukoplakia (OHL), Kaposi's sarcoma (KS), Non-Hodgkin-Lymphoma (NHL), necrotising ulcerative gingivitis and periodontitis. These lesions may be present in up to 50% of patients with HIV-infection and up to 80% of those with AIDS. *Changing patterns in HAART era*: With the advent of highly active antiretroviral therapy (HAART) the prevalence of OC, OHL and HIV – associated periodontal disease has decreased in adults. The prevalence of KS has not changed. However, there has been an increase in HPV-associated oral lesions (papillomas, condylomas and focal epithelial hyperplasia) and HIV-related salivary gland disease. In children receiving HAART no change in the prevalence of HIV-related oral lesions has been found. *Quality of life*: The presence of oral lesions has a marked impact on health related quality of life. HIV-associated orofacial lesions may lead to facial disfigurement (KS, NHL) or may impair speech and swallowing. Consequently, weight loss and pain may be result. Studies have shown that patients with OC, angular cheilitis and OHL have a high score of decayed teeth (DMFT). Xerostomia and taste disturbances may also be factors with impact on quality of life. *Occupational risks*: Occupational exposure to HIV has resulted in 57 documented cases of HIV sero-conversion among healthcare workers in the US (December 2001). Exposure to HBV and HCV carries a much higher risk of occupational infection than that for HIV-exposure.

US2
Drug related oro-facial disease

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Drugs may be defined as substances used in the diagnosis, treatment, or prevention of a disease or as a component of a medication or alternatively as chemical substances, such as a narcotic or hallucinogen, affecting the central nervous system, causing changes in behavior and often addiction. Orofacial drug-related adverse reactions may present initially to the dental surgeon or doctor and require specialist opinion. Due to the complexity of clinical presentation including symptoms (pain, dysgeusia, xerostomia and dysaesthesia) and signs (mucosal and bone pathology) diagnostic problems are common and a detailed prescribed and non-prescribed medication history invalid. New therapeutic interventions are continually introduced across Europe and health care practitioners should be vigilant for unreported oro-facial adverse reactions and be able to access the local reporting mechanism. The benefits of the drug prescribed weighed against the risk from the oro-facial adverse reaction will determine if drug cessation is appropriate. This paper aims to update practitioners on the spectrum of drug-related oro-facial disease, review factors to be elicited from the drug history, focus on newly introduced drugs and their, in some cases devastating, oro-facial adverse effects and discuss management options.

US3
Allergy in dental practice

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Allergy reactions of the oral mucosa comprise an array of clinical manifestations, some of them difficult to differentiate from toxic reactions. Type-I reactions are most frequently seen related to application of polymers in the oral cavity, such as orthodontic bonding and fissure sealant materials. There may also be systemic manifestations such as urticaria. Type-IV reactions may be seen related to most dental materials used, from amalgam and gold to polymers. These reactions appear as chronic reddening and/or ulceration of the oral mucosa. Lichenoid reactions have histopathological characteristics compatible with type-IV allergy reactions and are the most prevalent material-adverse reactions seen in the oral cavity. Recent advances have been made in characterizing the more prevalent allergens on oral mucosa, such as methacrylates, natural rubber latex (NRL) proteins, rubber glove chemicals and disinfectants. This improved understanding has clearly enhanced the success, particularly for type I NRL allergies. Skin patch tests, applying a series of dental materials in non-toxic concentrations on the skin, have been used to identify sensitization. However, the value of those tests can be questioned. Although obvious advances have been made in characterizing dental allergens and understanding potential exposure, improved diagnostic and management techniques are still needed. Corticosteroid therapy is all too often the only treatment. Drug allergy including local anaesthetics, and systemic antibiotics and NSAIDs, may also present in the dental environment, causing life-threatening emergencies specially in 'at risk patients'. The GDP has to know the principles of prevention, diagnosis and management of these situations.

US4
Pharmacotherapy complicating dental surgery

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Planning dental treatments for patients taking antithrombotic can be difficult for the general dental practitioner, particularly when surgical interventions are needed. The drugs employed in the long-term treatment of such patients include platelet aggregation inhibitors and oral anticoagulants. Platelet aggregation inhibitors do not represent a contraindication to oral surgery. The activity of oral anticoagulants can be affected by many substances, for this reason it is necessary to monitor by INR the patients taking those drugs. When INR is within therapeutic limits for the more common conditions, most of the oral surgery interventions do not need any special precaution. Evidence indicates that suspending antithrombotic drugs is not indicate, as complications following a thrombotic accident are more frequent and serious than bleedings following oral surgery. It is well known that systemic corticosteroid therapy due to the effect on adrenal suppression can interfere with dental surgical procedures. However, that is largely dependent on the type and dose of corticosteroid that patient is currently taking, or has been taking in the last 12 months and on the type and extent of surgical procedure which is to be performed. Surgical management of dental patients with history of systemic corticosteroid therapy is proposed from the existing literature.