alone; children are bombarded everywhere – whether as part of the supposedly healthy free school meals or at friends' houses and parties. We live in a culture where we use junk food as bribery, reward and a pacifier for our young. Until the culture and the environment we live in changes, then I do not see the situation improving. To get environment and behaviour change, I see no other option than government regulation, much like we have for tobacco and alcohol. We cannot expect the food companies to change themselves.

As a dental profession, I understand the need to 'educate' the public, and these campaigns should be done. However, information alone – I find often interpreted as lecturing and condescending – rarely induces behaviour change.[3] With this in mind, we should not lose momentum and loudly and publicly continue to lobby government to introduce regulation to curb processed junk food in general, especially when targeted to the most precious and impressionable in our society, the best asset we have, our children.

S. Nolan, by email

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Oral cancer

Indian pandemic

Sir, the Indian National Cancer Registry Programme report shows worrying rises in cancers of the upper aero-digestive tract (mouth, tongue, oro-pharynx, hypopharynx, larynx and oesophagus) among both sexes as important sites for undertaking risk factor research and implementing early detection programmes.[1]

The Global Adult Tobacco Survey India, conducted in 2009-10, revealed that 35% of adults used tobacco.[2] Tobacco-related cancers are expected to constitute 30% of the total cancer burden by 2020.[1] It is important to elevate smokeless tobacco, areca nut and oral cancer as an even greater problem than smoking for the Indian nation, and South Asia. The Indian subcontinent accounts for one third of the global burden of cancers of lip and oral cavity.

Cancers of mouth and tongue, taken together, overshadow cancer of lung.[1] Likewise, in other cities of India like Delhi, Mumbai, Aurangabad and Kollam, after lung cancer, cancer of mouth [excluding tongue] is the second most common cancer among males. The projected burden of cancers among males by the year 2020 in India shows the number of cases will be lung (102,300), mouth (99,495), prostate (61,222), tongue (60,669) and larynx (36,079). Cumulatively, this makes 'oral cancer' the leading cancer site for men in most of India.[1]

Improved public health education and promotion is vital, as are top down policy approaches such as those of the Framework Convention on Tobacco Control, extended to include all forms of smokeless tobacco. Much excellent work on the control of the continuing pandemic of oral cancer in India is ongoing[3] and we write to draw these issues to the attention of clinicians, public health specialists and policy makers.

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Saliva for biopsy

Sir, salivary biomarkers have been identified in different tumours distant to the oral cavity including brain, pancreatic, breast, ovarian, lung, gastric, prostate, and oesophageal cancer.[1] Saliva therefore represents a potential source of tumour markers (proteins, metabolites, mRNA, micro-RNA and microbial) but the development of this as an effective diagnostic modality requires further research. Because carcinogenesis is a complex process, it is necessary to know the molecular changes in primary tumour initiation, promotion and progression with a double objective: to detect early disease *and* to improve clinical management. For this, saliva could be a potential biofluid showing the heterogenecity of the tumour at different stages of the disease compared to tumour tissue and plasma. Research efforts should be directed to assess the diagnostic capacity of the different salivary tumour biomarkers as well as its biological function on the pathogenesis and progression of the disease. This will require the participation of different researchers (medical, dental, biologists, bioinformaticians, statisticians, engineers etc) and it is a matter of urgency to train such researchers and convince institutions about this excellent opportunity to finance projects in this field. New perspectives must be directed towards finding specific salivary biomarkers in cancer, with the aim of improving the diagnosis, prognosis and monitoring disease.

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Patient support

High-risk behaviour

Sir, the case of National Aids Trust vs NHS England[1] in late 2016 stemmed a revolutionary breakthrough in the management of HIV in the UK which all medical professionals should be aware of. The court ruling deemed that the NHS can fund pre-exposure prophylaxis (PrEP) for those at risk of contracting HIV.

A 2014 government report[2] stated there are about 107,800 individuals living with HIV in the UK with an overall prevalence of 2.8 per 1,000 population aged 15–59 years. PrEP is a method to reduce the rate of transmission of HIV. The brand name Truvada consists of two anti-retroviral agents, emtricitabine and tenofovir. The logic is to give the medication to HIV negative patients prior to high risk behaviours to reduce the chance of later obtaining HIV. It can either be taken regularly ie one tablet per day, or only taken when needed, just prior to or following intercourse. The PROUD study[3] indicated that there was a relative risk reduction of obtaining HIV of 86% in high risk sexual intercourse.

Despite the positive court ruling, the NHS has not yet started rolling out the medication en masse, largely due to the cost of the medication. A pack of 30 days of treatment costs £355.73.[4] Instead a three-year trial starting in December 2016 consisting of 10,000