

Letters to the editor

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CORONAVIRUS

The aftermath

Sir, during this current global crisis, is it not appropriate at this time to ask the question: 'how will COVID-19 impact on future dental care provision?' I feel it is appropriate to raise the topic early so that the dental community can begin to think about the problem and thus devise a strategy to manage the future.

Almost all dental procedures generate aerosols, from the 3-in-1 used during an examination, to the high-speed handpiece and the aspirator. We are all familiar with the concept of 'universal precautions' whereby in the past we have assumed that every individual is a source of potential cross infection, now more so than ever before our current environment exemplifies this.

Whilst we must expect that coronavirus will exist amid the general population of the world for some extended time period, we must by definition assume that the dental profession will need to adopt equally rigorous PPE and procedural policies (pending the progress of COVID-19 testing amongst the populace). This is not only to address any perceived risks from the general public, but also those real threats to patients and staff.

Arguably, should the air-flow of clinical spaces, either generally or in the immediate working area of the mouth, need reviewing? Would the return to treating patients in an upright sitting position reduce the need for aspiration? As a clinician who regularly treats some patients in this sitting position, I am aware of the limitations of some chairs and dental units in adopting this posture, as well as the differences between working with direct and indirect vision, and the postural issues for both operator and nurse. Is the modern dental surgery fit for purpose post COVID-19?

Reports seem to indicate that the current patient throughput of the Urgent Dental Care centres, recently set up to cope with dental emergencies, is around eight patients per day. Even with honing and practice this falls far below the pre-COVID-19 patient throughput figures for even private clinicians. Ultimately, should we not be recognising that the dental profession as a whole will be operating in a very different environment to that which we began the new year of 2020? This not only extends to the UDA re-imburement system but also to our mode of working.

A. Blake, Devon, UK

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The end of skill mix?

Sir, nothing has so undermined the concept of the team working in high street dentistry so much as the present coronavirus crisis. The perception that the current management of business risk and anxiety is shared between practice owners, dental therapists, hygienists and nurses can now be finally put to rest.

Skill mix was a worthy aspiration. Any notion, however, that it can lead to an equitable sharing of responsibility between team members is now finished. The present closure of practices is difficult for employees, but it is nothing compared to the financial burdens faced by dentists with debt interest on borrowed capital. Unable to demonstrate any activity, NHS practitioners will find it difficult to be prioritised in any promised government handouts.

The notion of a dental team was always fraught. Employing a dental therapist so that a practitioner as a practice owner can carry out more complex procedures is the last thing a NHS provider is looking for. NASDAC are wary of advising clients to employ hygienists

in non-mixed practices. Their contribution is only sustainable because of the ambiguities in providers' contracts. This does not apply to therapists in general practice which is the reason why the majority have to work as hygienists. The management and costs of employing dental nurses to carry out fluoride varnish application is not really a viable business model.

Granted that true skill mix, which by definition would require regulatory reform, could improve access. It might also control/ or give better value to public expenditure. However, as the present public health crisis demonstrates the term 'skill mix' remains an egalitarian fantasy supported only by salaried academic elites. They know little of the high street.

E. Gordon, Finchley, UK

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Enhanced PPE?

Sir, with routine dentistry within England halted due to the current COVID-19 pandemic and the Chief Dental Officer's limit of providing emergency care only during this time many GDPs now find themselves in a situation whereby they telephone triage patients, providing either analgesic advice or remote prescribe antimicrobials where applicable. Patients with facial swellings, uncontrolled bleeding, dental trauma or other dental emergencies are referred onward to a suitable emergency treatment centre.

A large part of why GDPs are unable to provide treatment is their lack of correct PPE. At present the guidelines regarding correct PPE for treating asymptomatic patients, as well as suspected or positive COVID-19 cases, are unclear. There is debate particularly in regard to the use of

an FFP3 mask. These masks are seen as the gold standard at present, but obtaining these masks is difficult due to the overall increased demand for PPE during the pandemic.

One thing is clear, when an aerosol generating procedure (AGP) is to be undertaken, such as during an extirpation, an FFP3 mask is necessary due to the aerosol being produced potentially acting as a medium by which COVID-19 could be easily transmitted to the operator, team members and patients.¹

Given this knowledge, it raises the questions as to why FFP3 masks, or similar PPE, are not commonly used in the dental setting already. As dental professionals, we undertake AGPs everyday as we are reliant upon high speed handpieces, surgical handpieces and 3-in-1 syringes to undertake our work.

Gloves, hand washing and full-face visors are all commonplace for all healthcare professionals as part of standard or universal infection control precautions in order to 'reduce the risk of transmitting infectious agents from both recognised and unrecognised sources of infection.'² This begs the question as to why we are continuing to use surgical masks in an environment where they are clearly ineffective, as they offer no protection against aerosols. Is it time we include FFP3 masks or similar PPE as part of our standard PPE as we are so reliant on AGPs?

J. Williams, Newcastle-Upon-Tyne, UK

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Reducing transmission in a dental setting

Sir, whilst we wait for a vaccine to control the spread of COVID-19 we need to be thinking about ways to reduce risk of transmission. Two strategies could be part of the solution, albeit yet to be developed into a recognised protocol: sorting patients and saliva testing.

Sorting patients free of COVID-19 from those who carry the disease, so that the majority of patients can safely return for

dental treatment, might involve telephone triage to assess the risk before offering low risk patients an appointment. Low risk patients would then be tested in the dental setting to confirm that they do not have the virus. An agreed standard infection control protocol could subsequently be adopted without the need for a full-face respirator.

The development of a suitable rapid saliva test is desirable but a finger prick test might also be acceptable. Training would be required which could additionally allow the dental team to be further integrated into the management of COVID disease. For example, dental surgeries could provide convenient sites around the country where any patient could access testing as part of the anticipated testing and contact tracing protocols required until mass vaccination can be completed. Vaccination is another activity which the dental team might be able to support as well as generating an income stream for the dental surgeries involved. The GDC could facilitate the strategy by recognising COVID testing as part of the practice of dentistry, thereby allowing the existing indemnity arrangements to cover the dental team for the procedure.

The oropharynx and nasopharynx are targeted by the novel coronavirus with the result that saliva contains a high viral load of COVID-19 with up to 1.2×10^8 infective copies/ml.¹ A recent paper has suggested that the use of Povidone-iodine (PVP) in a nasal spray and mouthwash might reduce cross infection and protect healthcare workers. This cheap and readily available substance in the form of 10% PVP (eg Videne)¹ can be purchased from Amazon and elsewhere and diluted one part to 20 to be used as a mouthwash and gargle by both the patient and the clinical team. An aerosol should also be sprayed into the nostrils of the patient prior to face to face contact.

The dental team can repeat the nasal spray during extended treatment sessions. Iodine is a particularly effective disinfectant when deployed against coronaviruses. Clinical studies have yet to prove the efficacy of the protocol – but with almost no risk and low cost, why wouldn't you want to use the approach on all dental patients?

PVP is currently used in ophthalmic surgery (often diluted to 5%) and occasionally during oral surgery at 10%. Anecdotally we hear that some UDC centres have already adopted the use of PVP off-label, whilst waiting for clinical

trials to prove the efficacy. For those who would like to see the technique demonstrated a video is available online (<https://vimeo.com/406479300>).

G. Pullen, D. Croser, London, UK

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Povidone iodine

Sir, dentists and their assistants as front-line healthcare workers (HCW) in close contact with the upper aerodigestive tract are at especial risk of transmission of the coronavirus from patients. In early infection, viral titres of greater than 10^7 /mL in saliva and nasal mucous can be found and thus any work within the oral cavity carries an increased risk.¹ Even a few microlitres of saliva contamination of surfaces or instruments may carry many thousands of infectious viral particles. A significant proportion of COVID-19 sufferers are asymptomatic, but shedding these viral particles.

We have been examining the potential role of povidone iodine (PVP-I) in the reduction of the risk of cross infection and protection of dentists and other HCW from COVID-19 and have drafted a paper summarising the evidence.²

PVP-I has a better anti-viral activity than other antiseptics such as chlorhexidine,³ and has already been proven to be an effective virucide *in vitro* against similar coronaviruses (SARS-CoV and MERS-CoV)⁴ although it has not been tested directly with COVID-19. PVP-I has been shown to be a safe therapy when used as a mouthwash or taken nasally. We propose that a protocolised nasal spray and oropharyngeal wash of PVP-I should be used in the current COVID-19 pandemic to limit the spread of SARS-CoV-2 from patients to healthcare workers and potentially *vice versa*. We propose that no dental patient should be examined before disinfection by PVP-I. The reduction in coronavirus titres is over 99.99% *in vitro*³ and we estimate the reduction to last for at least 20 minutes *in vivo*. The exact length of time is being researched, but should be sufficient for examination and short procedures.