Besides RT-PCR-based tests, serological (enzyme immunoassays) diagnostic tests aimed at detecting IgM and IgG antibodies against the viral antigens are robust methods to diagnose current and past infections. Preliminary studies using serum samples have shown promising results for COVID-19.[5,6] The production of SARS-CoV-specific secretory IgA in the saliva of animal models was previously shown.[7] Hence, it is reasonable to speculate that anti-COVID-19 antibodies might also be present in human saliva although this has not been reported nor has their potential use for diagnostics and disease monitoring. This clearly warrants future studies.

Studies are needed to analyse the sensitivity and specificity of saliva based COVID-19 tests before they could be made available as a convenient and cost-effective diagnostic method. Since the presence of live COVID-19 in saliva identifies it as a potential source of viral transmission any collected saliva samples must be handled with care to avoid spilling and spreading of live viruses.

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Redeployment positives

Sir, with the coronavirus situation many DCTs have been redeployed to medical specialities including Accident and Emergency, General Medicine and ITU. The roles of these redeployed dentists are now similar to that of junior doctors, which include cannulation and venepuncture, discussion of treatment plans and general ward duties. Understandably, there was anxiety over the readiness and preparedness to assist on medical wards from DCTs. However, the overwhelming response has been that of support, understanding and gratitude from our medical colleagues.

A positive, even in this time of crisis, is that redeployment has allowed DCTs to gain experiences far beyond their normal day to day scope, gaining a better understanding of emergency medicine, dealing with crisis and managing chronically and critically unwell patients. A better understanding of the 'medical side' of dentistry, gives us extended skills, which will be transferred to our future careers. Additionally, DCTs have contributed their own specialist knowledge, improving patient outcomes and reducing the general strain on the NHS. Examples include managing dental trauma, diagnosing and managing acute dental pain of in-patients and managing soft tissue lacerations on wards. This contribution from DCTs has helped to develop a mutual respect and understanding of the roles of both medics and dentists, highlighting the value of dentistry within healthcare. I would like to express my pride and admiration for those redeployed to the NHS frontline. In this time of unprecedented crisis all DCTs across the UK have stepped up to the mark and excelled in supporting our NHS.

S. McLean, Liverpool, UK

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Check-ins not check-ups

Sir, in these uncertain times, the NHS has faced immense pressure. In response, many of us have been upskilled and redeployed to unfamiliar clinical settings in this unique fight against COVID-19. However, those awaiting redeployment, those self-isolating vor shielded members who cannot work clinically due to underlying health conditions, have a very valuable skill set. We are strong communicators and share an instinctive compassion for our communities. We also carry a moral duty of care for the public and have received training in safeguarding.

These qualities are ideally suited to befriending. Befriending offers supportive, reliable relationships to individuals who are lonely or socially isolated. Maintaining our mental health and wellbeing is so important during this time of social distancing. As we know well, we all need other people, but not everyone has someone. Befriending during COVID-19 involves contacting service users at an arranged time and chatting, listening and ensuring they are coping well. Instead of providing our usual check-ups, we could be checking in. We could be giving our time to others, arguably the most valuable of all assets.

Charities offering befriending services have fast track online modules to provide immediate training. As healthcare professionals we all have Disclosure and Barring Certificates already, which further accelerates our application. Diane Claridge from Befriending Networks believes that charities would be very grateful for any support our profession can offer. She recommends visiting www.befriending.co.uk, searching the directory for local charities and contacting them directly to get involved. Examples of charities that support befriending include Age UK, Independent Age, Royal Voluntary Service (RVS) and Re-engage (formerly Contact the Elderly).

Oyovwe Kigho is the founder of the Widows Empowerment Trust. Oyovwe has recently reported a huge increase in the number of vulnerable widows seeking the support of her charity. We are befrienders with the Widows Empowerment Trust and have completed the online training. Providing this service is incredibly rewarding. So, in a time when negativity and fear are in the air, let us remember the positivity and support we can bring to others.

F. Loy, L. Reynolds, Manchester, UK

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Call for help

Sir, I wonder if any of your readers could help at all. I am currently unemployed and on a 'gap year' of sorts whilst applying for speciality training. In fact, I am actually meant to be travelling around South America as I type this, however due to the obvious I am not. I am lucky enough to be living with my parents for the foreseeable so can use my travel savings to pay for the minimal bills and outgoings I have. What I would like to be able to do is work or help in any way possible with the fight against COVID-19. Dental core trainees and general dental practitioners are being redeployed onto wards and to Urgent Dental Care centres, but

I fit into no category. Having completed two years of core training in hospital including a maxillofacial year, I feel I have useful skills and would like to play my part be it as a healthcare assistant or taking bloods, but thus far have drawn a blank. I haven't been able to apply for anything paid as I don't fit with computer algorithms on the online application systems and so at the minute although enjoyable I find myself staying at home unable to physically help. I have also not heard back from any volunteer roles I have applied for. When we are told things are so tough, it seems a waste for me not to be applying my skills, I was hoping there may either be more people in my unemployed predicament who have found work, or someone who knows a way in which I could help?

L. Crowder, Liverpool, UK

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Aerosol box for dentistry

Sir, to reduce the risk of cross infection through aerosol generation we recommend a modified aerosol box design for viable dentistry.

The modified design (Figs 1a-b) comprises a reduced base width for adequate accommodation on a dental chair (without being hindered by the spittoon or arm rest). The patient end of the box is made 10 cm wider to accommodate wide shouldered and hefty clients. Other than two circular working ports on the doctor's end in a normal aerosol box, the dental box also has two similar working ports on the surface which is on the right side of the patient (Fig. 1c). Which is placed parallel to the U-frame base for convenient working and another single working port on the surface which is on the left side of the patient for getting assistance from that side.

The height of the box is kept at 50 cm to provide for adequate manoeuvrability, along with a front panel to reduce aerosol scatter in front of the patient. The extra 5 cm length of the frame downwards from the base U-plate will make the box more stable vertically and prevent sliding down on a tilted table (Fig. 1d). The top front 10 cm is attached to the posterior plate with a hinge mechanism so that it can be raised for making the patient sit up for spitting in between the procedure. Another modification to avoid the hinge mechanism is adding an arch shape to the plate over the client's neck. There is also a 2 cm hole on the top surface of the box to attach an aerosol suction device which can absorb the droplets from the top of the hood. It could be connected to a regular office-based suction device or a high suction aerosol suction device.

We acknowledge that the presence of the box would hinder the way a lot of procedures are performed and that there would be a learning curve to master these. However, in the wake of the current situation it would be better to not consider this device as a hindrance but more as a necessary physical infection control barrier.

B. Babu, Kerala, India, S. Gupta, V. Sahni, Chandigarh, India

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Fig. 1 Modified aerosol box design for viable dentistry

Preventive dentistry

Predicting future treatment need

Sir, the latest, thought-provoking 'big data' paper by Steve Lucarotti and Trevor Burke on patient history as a predictor of future treatment need (*Br Dent J* 2020; **228:** 345-350) provides support for a number of not-to-be-forgotten adages in justifying the pressing need to shift to preventively-orientated, patient-centred, minimum intervention care of patients. These include: restorations do not cure caries; the greater the need for repeat restorations, the greater the need for prevention; the only restorations which are 'permanent' are the ones you die with; once a restorative patient, always a restorative patient, and, prevention helps restorative hopes come true.

I fully concur with the view expressed by Lucarotti and Burke that '…for patients with a history of high treatment need, it is never too late to seek to switch to preventively-orientated (rather than traditional) care…', in other words saving rather than drilling away more tooth tissue. This together with the overwhelming evidence in favour of prevention in children to ideally prevent, or at least put off the day the young patient crosses the dental Rubicon and becomes a restorative patient, makes a compelling case for longitudinal, capitation care, underpinned by prevention, patient education and motivation and the adoption of modern approaches such as the repair rather than replacement of defective restorations.

In taking forward arrangements to form the College of General Dentistry (https://cgdent.uk), one of the mantras has been, and will continue to be, the need for new, fit for future purpose approaches and standards in patient care. 'Drill and fill' must be assigned to history and replaced with 'teeth for life'. Also, the dental educational continuum, including new career pathways for all members of the dental team, must be based on achieving and maintaining oral health rather than being driven by the treatment of disease.

N. Wilson, London, UK

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