

An additional consideration is that smokeless tobacco users constantly spit their saliva that can harbour viral strains 29 days' post infection.⁴

Perhaps there is a silver lining with nature providing the possibility of substance 'disuse' during actions to stem this unprecedented crisis.

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A plausible transmission mode

Sir, the established modes of SARS-CoV-2 transmission may be an incomplete picture. In their most recent scientific brief, the World Health Organisation acknowledge the evidence to support contact and respiratory droplet transmission of SARS-CoV-2. Accordingly, much of the government's infection prevention and control guidance for COVID-19 is centred around minimising transmission via these methods. The coronaviruses implicated in the previous SARS and MERS outbreaks caused enteric manifestations in conjunction with the respiratory symptoms experienced by many with COVID-19. Since the early retrospective cohort studies of patients in Wuhan, more recent observational studies report common gastrointestinal symptoms to be more prevalent than previously thought.¹

SARS-CoV and MERS-CoV RNA were frequently detected in stool specimens of infected individuals. The *New England Journal of Medicine* case report of the first COVID-19 patient in the USA detected high SARS-CoV-2 viral load in their stool sample.² Experts recognise the hypothesised faecal-oral route to be a plausible mode of transmission.

This route can facilitate transmission via fomites in the surrounding environment, in much the same way as indirect respiratory droplet transmission. Where toothbrushes are placed in close proximity to a toilet, there may be a heightened risk of harbouring SARS-CoV-2 from infected individuals. That families often house toothbrushes together, the risk of infecting other individuals could be made easier.

Rightly, the dental profession have reason to fear the aerosol generation from dental handpieces, particularly when the inverse-square law is applied to project the extent of dispersal. In a mechanically similar way, toilet plumes may pose a similar challenge. Professor Addy offered reason to reinforce the role of toothbrushing with toothpaste, given the antimicrobial properties of toothpaste ingredients.³ Awareness and advice to limit toothbrush contamination might prove beneficial. Though the evidence base is yet to be established, no harm exists in recommending this as a precautionary measure in the preventive approach to COVID-19.

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Progression of specialist trainees

Sir, amid the many current uncertainties dental practitioners have, trainees also have an additional worry regarding their training and how this will impact them in the future. The bearing COVID-19 has had on clinical activity means that many patients being treated and prepared for cases will be delayed, target case numbers and important clinical exposure will reduce, negatively impacting trainees' progression. Additionally, redeployment into other areas of the trust to aid with the response to COVID-19 may divert trainees' attention from their own speciality. With royal colleges already cancelling and postponing courses and exams, this adds the stress on

trainees approaching the end of the pathway across all specialities.

All resources should and will be directed into ensuring facilities and measures to protect the safety and wellbeing of patients. However, a structure needs to be developed to account for the disruption in training COVID-19 has caused and facilitate the progression of the trainees without compromising the quality and integrity of the respected specialities.

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COVID PDPs

Sir, the COVID-19 pandemic has caused significant disruptions in dental services including both undergraduate and postgraduate dental training. Newly qualified dentists who commenced dental foundation training in September 2019 would have only had seven months of clinical practice before the lockdown resulted in cessation of routine dentistry in the UK.¹ There are likely to be outstanding competencies and the loss of clinical experience and mentoring will need to be identified and fulfilled through a personal development plan (PDP).

The enhanced continuing professional development (CPD) scheme was introduced by the General Dental Council (GDC) on 1 January 2018 for dentists.² This involves completion of the prerequisite 100 hours of CPD per cycle but also in ensuring that this is tailored to meet individual PDPs to make sure maximum benefit is gained and to encourage reflective practice.

At present, PDPs are not a routine part of the undergraduate curricula³ and as such, newly qualified dentists will be faced with the new challenge of having to proactively plan their CPD to fulfil outstanding competencies from their current training course. This is also likely to be the case for dentists in dental core training, speciality training and those undertaking formal postgraduate qualifications.

GDC standards allow PDPs to be completed individually or in conjunction with peers including employers.² Dentists in training should seek advice from their educational supervisors and postgraduate deaneries by identifying areas within their professional activities where further training is needed, identify suitable courses

and ensure their objectives are achievable within a set timeframe. Whilst CPD cycles are five years, the need to complete certain key foundation skills to ensure adequate competence and baseline knowledge to facilitate progression through postgraduate training pathways will result in trainees having to meet such objectives sooner. This will likely need to be achieved in liaison with their next training scheme.

There are multitudes of factors to think about during this COVID-19 pandemic and the personal development plan may be easily and understandably missed, however, its importance should not be underestimated. Early planning will help trainees of all levels overcome the challenges of disruptions and mitigate adverse effects on their training progression.

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Oral cancer patients

Sir, at the time of writing, UK wide guidance for surgical prioritisation during this pandemic indicates that resection of low-grade salivary gland tumours can be delayed for up to three months; oropharyngeal, tonsillar and tongue cancer resection and reconstruction for up to four weeks; post-cancer facial reconstruction for at least three months.¹ Consequently, cancers diagnosed may necessarily be subject to a delay in treatment with likely adverse impact on patient outcomes. Furthermore, many patients who undergo resection of oral cancer require post-operative intensive treatment unit (ITU) beds.² With approximately 8,000 more hospital deaths to date in 2020 than is routine, elective surgery poses stress on a healthcare system already experiencing unprecedented pressures in ITU, and perhaps, a redeployed staff.³

Dilemmas arise in terms of delaying or proceeding with surgery. Further useful information can be found at <https://globalsurg.org> and <https://www.rcseng.ac.uk/coronavirus/rcs-covid-research-group/>.

We admire the epic efforts of our surgical and maxillofacial colleagues in juggling these competing demands in the best interests of the population.

What can *BDJ* readers do to help? We can make at-risk patients we triage, and patients who access our practice websites, aware of the Mouth Cancer Foundation symptom checker (www.mouthcancerfoundation.org).⁴ Video consultation also offers a solution and practice websites and social media threads can include oral health advice. National Smile Month started on 18 May offering digital engagement (www.nationalsmilemonth.org/). Mouth Cancer Action Month is in November; the infamous #BlueLipSelfie might help raise awareness (www.bluelipseelfie.co.uk/). We can continue to signpost smoking cessation advice online too – perhaps this new remote practice offers an opportunity to support patients who are interested in quitting smoking and the Smokefree service allows patient to access advice and support from experts: quitnow.smokefree.nhs.uk/. We need to remember those patients who have previously received a cancer diagnosis who would usually be accessing our care to receive support and preventive dental care. Many charities such as The Throat Cancer Foundation and The Mouth Cancer Foundation are continuing to provide support to affected patients (www.throatcancerfoundation.org, mouthcancerfoundation.org/).

The primary care dental team has an important role in raising awareness and trying to mitigate where possible a post-pandemic spike in oral cancers with poor prognoses.

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Another way for fractured jaws

Sir, I write further to the letter by Holmes *et al.*¹ with regard to management of broken jaws in the wake of the COVID pandemic using closed reduction protocols such as intermaxillary fixation with the post-operative follow up of patients by GDPs.

I would, respectfully, like to add that as far as facial trauma is concerned we are fortunate to have a generous evidence base. In certain situations such as uncontrollable haemorrhage, infected injuries posing a threat for further spread, orbital trauma with progressively reduced visual acuity and any injury posing a threat to the airway must and should be addressed.² Also, while we might be deferring cases to be dealt with at a later date, the patient should, at this very stage be counselled regarding any functional impairment which might be experienced in due course of time and a possibility of performing deformity correction at a later date.

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Redeployment to research?

Sir, in relation to redeployment we write to encourage individuals to consider the full range of skills at their disposal during this crisis, particularly in support of areas that do not involve direct patient care, such as research.

Research and Innovation departments around the UK are cooperating at unprecedented speed and scale to deliver COVID-19 related projects, such as ISARIC¹ and the RECOVERY² trial. Dentists are well placed to fulfil roles in research teams, for example, making use of excellent communication skills or applying expertise in consent to complex circumstances. Other non-patient-facing roles such as applying clinical knowledge to eligibility screening,