would amalgam be a more suitable dental material in the immediate future as it requires a shorter clinical placement time, is less technique sensitive, produces less aerosol generation for occlusal adjustment and is also less expensive than composite?

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Reference

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Spotlight on teledentistry

Sir, current teledentistry uses will influence the post-epidemic burden of dental disease. We surveyed applications, clinician experiences and conditions presenting for teledentistry amongst 115 clinicians across the UK between 24 April–15 May 2020, during the lockdown restrictions.

Most were GDPs (60%) with dental core trainees (17%), foundation dentists and orthodontists (each 5%), oral surgeons (4%), OMFS consultants and speciality doctors (each 3%), dental specialist trainees, special care dentists, and oral and maxillofacial surgery (OMFS) registrars (each 1%). Of the respondents, 76% had no prior experience of teledentistry; 63% had no access to video consulting; 39% sometimes requested photographs of the concerned area; 23% never sent patients further resources; 18% were not confident making diagnoses from telephone consultations alone; 17% couldn't request photographs as systems were unavailable in their workplace; 16% did not feel confident making diagnoses using telephone consultations alongside clinical images and 11% were unsure if these systems were available. Overall, 52% thought teledentistry would remain following the epidemic whilst 21% did not; 27% were unable to commit to a decision.

The survey highlighted areas necessitating caution in teledentistry use. Remote consultations may reduce waiting lists and financial implications when patients attend in person.[1] Conditions presenting for teledentistry, such as temporomandibular joint disorders (23%) and pericoronitis (63%), may be suitable for self-care measures, thus minimising patient-clinician contact. Yet, concerns have been raised surrounding antibiotic stewardship and the appropriateness of using teledentistry in isolation to manage patients.[2] Facial swelling (77%) and pulpitis (65%) were frequently reported remote consultations. Such acute conditions traditionally require operative intervention and should continue to do so via Urgent Dental Care centres.[3] Remote prescribing in emergencies is warranted but in the long term, could compromise care. Orthodontic problems (17%) or intra-oral swellings (60%) may result in adverse outcomes the longer operative treatment is delayed.

Diagnostic confidence was a highlighted concern. Clinical photographs can improve quality of assessment, however, in the absence of an examination, patients should be 'safety-netted' by providing information specific to the management of their condition should they deteriorate.[4] This can be readily delivered through various forms of telecommunication.[5] As we now witness reopening of 'normal' dental services, clinicians should consider developing systems to incorporate digital-consulting and improve patient resources to enhance teledentistry services.

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Urgent hub data

Sir, we are one of 40 general dental practices providing emergency treatment in South East England. There is a high demand for emergency dental services. Patients are directly contacted via telephone to assess suitability within 24-hours of referral made. Appointments are allocated depending on treatment need and in accordance with NHS England recommendations.[1] Over a one-week period we received 126 referrals, of which 57% were accepted for treatment, 41% rejected and 2% redirected to a secondary hub site. The vast majority (65%) that were rejected were due to patients reporting reduced and manageable symptoms by the time of telephone triage. Pain was notably the most common reason for referral (88%) followed by trauma (6%) and swelling (6%). Pain management is complex and may be unclear given the range of over-the-counter analgesics available.

We would like to alert our referring colleagues to the current best practice outlined by FGDP.[2] We also suggest there is a benefit in GDPs following-up patients 24-hours after initial consultation, before referring to an urgent hub. This would likely reduce the number of rejected referrals.

We have found the quality of referrals to vary significantly, in some instances giving limited information of symptoms or a narrative of any advice or treatment given up to the point of referral. Only 29% of referrals included a radiograph or image of the patient. Radiographs are critical in assessing the complexity of treatment that may be required and photographs to assess the degree of facial swellings. It is notable that only a handful of referrers utilised video-conferencing applications to triage patients. We would like to highlight the benefit of doing so in order to more accurately assess patients before referral. It is likely that some degree of social distancing will remain for the foreseeable future, in particular for the most vulnerable of patients. Indeed, the dilemma of patients with active coronavirus requiring assessment will become more common going forward. The use of telemedicine in these circumstances and potentially beyond the current health crisis may be invaluable in allowing for a patient-centred approach.

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