

## Shielded colleagues

Sir, in mid-March when the lockdown began I was contacted by the NHS and notified that due to my diagnosis of Crohn's disease I had been placed in the highly vulnerable category and thus was advised to shield for 12 weeks.

Whilst the CDO issued guidance on 28 May 2020 that dentists will return to work on the 8 June in England there has been no guidance on how this applies to those, such as myself, who are in the shielded category.

The initial 12-week period of shielding is set to finish at the end of June, however, there are now suggestions that this will be extended further. Despite this, there has been no clarification as to whether this applies to all shielded individuals or whether this should be decided on a case by case basis on the advice of one's doctor (my own medical team have informed me they are unsure of how the shielding rules apply to dentists and have not received any further guidance on this matter to date).

As a general dental practitioner, I am anxious to get back to work and to provide a much-needed service to my patients and I am sure there are many colleagues who find themselves in the shielded category that share this sentiment. It would be much appreciated, therefore, if the CDO, NHS England or the BDA could consider cases of dentists, and other healthcare professionals, such as myself and issue further guidance as to when it is safe to return to practice.

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## Paediatric emergencies

Sir, whilst there has been a significant decrease in attendance to Emergency Departments during the COVID-19 pandemic,<sup>1</sup> the Paediatric Emergency Department (PED) at Alder Hey Children's Hospital has observed little change in the number of dental attendances. We compared the characteristics of attendances in March, April 2020 to the same months in 2019 with three key findings to consider in the months ahead, as we resume dental services.

Firstly, the number of children attending the PED with traumatic dental injuries (TDIs) increased in the COVID-19 affected period. This may be due to decreased availability of primary care dental services in the region. Additionally, with more

children undertaking exercise and activities at home with school closures, more accidental injuries may occur. It is also important to consider the possibility of TDIs related to non-accidental injury during lockdown, with children living in violent or dysfunctional families having limited access to safe spaces, friends, teachers and support outside the home in this period, leading to an increase in domestic violence and abuse.<sup>2</sup> On presentation, it is important to take a thorough history and examination, identifying any discrepancies which may raise suspicion.<sup>3,4</sup> The BSPD have published excellent guidelines to aid us with the management and follow up of TDIs during the COVID-19 pandemic.<sup>5</sup>

Secondly, we found that the number of admitted patients decreased, suggesting that conditions of lower severity were presenting to the PED. This may also be attributable to a lack of alternatively available dental services.

Finally, as a result of the pandemic, thousands of children nationally have experienced cancellation of dental general anaesthetics (GA), with cases being prioritised as per national guidelines.<sup>6</sup> Subsequently, thousands of children have been left in pain, taking regular analgesics and sometimes requiring multiple courses of antibiotics. Indeed, the number of children receiving repeat courses of antibiotics from the PED increased in the COVID affected period.

With GDPs reopening and reaching a 'new normal', the emergency management of TDIs and children in pain should be considered a priority in paediatric primary care triage to reduce the subsequent burden on tertiary services, which carries increased expense to the NHS.

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## Child-friendly PPE

Sir, eye contact and verbal communication with a child play a key role in nonpharmacological behaviour management. During this pandemic, when I visited a patient for dental urgency, I addressed the child in a conventional PPE kit abiding by the disinfection and safety protocols. The child was completely surprised and frightened and was hesitant in allowing examination. So I spent a couple of hours tweaking the conventional PPE kit with a child-friendly touch that included incorporation of famous cartoon characters and emoticons to make the child happy (Fig. 1). I performed this in a sterile environment following the sanitisation protocols. Next time I entered the treatment room in the customised PPE kit there was an overwhelming response from the child who underwent the treatment procedure with no sign of anxiety or fear. In addition, the



Fig. 1 Customised PPE for paediatric dentistry

parents showed signs of contentment upon the timely action. Henceforth, I strongly urge readers to instigate the creative artist in each one of us while dealing with child patients.

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## Virucidal activity

Sir, I was disappointed to read the statement in an otherwise excellent document from the FGDP and College of General Dentistry that pre-treatment antiviral mouthwash was not recommended because of 'a lack of evidence of virucidal activity for use of pre-operative mouthwash'. I wonder if a flurry of recent papers, possibly overlooked, might lead to a questioning of that statement. What is now known is that SARS-CoV-2 replicates in the oral cavity and that extremely high numbers (>10 million) of infectious viral particles per ml saliva can be found at an early stage in SARS-CoV-2 infection.<sup>1</sup> The virus in saliva is not contamination from elsewhere, but reflects active replication probably in ACE2 positive epithelial cells in minor salivary glands.<sup>2</sup> Similar high levels are found in the nose.<sup>3</sup>

This is clearly an infection risk to any clinician working around the mouth or nose. Any virucidal agent applied to those sites may substantially reduce the risk of cross infection.<sup>4</sup>

Several commonly used antiseptic mouthwashes with anti-bacterial activity also have anti-viral activity against coronaviruses demonstrated *in vitro*.<sup>5</sup> Two (povidone iodine and ethanol) have been shown to have substantial activity against SARS-CoV-2 and one (PVP-I) SARS-CoV in the presence of organic matter designed to replicate *in vivo* conditions.<sup>6</sup> What is not known is how effective any anti-viral mouthwash actually is *in vivo*, nor how long the antiviral effect lasts. This has been estimated as greater than 20 minutes.<sup>4</sup> Thus, does one recommend withholding a potentially effective agent (thus potentially exposing substantial numbers of dental HCWs to extra risk), or does one recommend that a simple, cheap, safe and potentially effective agent is used to help safeguard the profession while the extra information is sought?

PVP-I has been used in dentistry for over 60 years and its safety profile well

established.<sup>4</sup> Over 24 dental HCWs have now died with SARS-CoV-2. Anything which helps to keep the profession as safe as possible is surely to be supported.

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## Oncology patient support

Sir, each year there are approximately 12,200 new cases of head and neck cancer diagnosed in the UK.<sup>1</sup> For patients undergoing radiotherapy (either alone or in conjunction with resective surgery), the detrimental effects on oral health are well established, including the risk of developing osteoradionecrosis (ORN) of the jaws.

Preventative advice is paramount to reduce the need for future 'high risk' procedures including exodontia, which could initiate ORN. Clinical guidelines on the oral management of oncology patients recommend that adults are prescribed 5,000 ppm fluoride toothpaste and to rinse at least once daily with an alcohol free fluoride mouthrinse (0.05%). However in reality, this is not always the case. For oncology patients without a regular GDP, or those who may have intermittent treatment in a tertiary dental centre, accessing prescriptions for high fluoride products may be particularly challenging during COVID-19. Although fluoridated products could be prescribed by

patients' general medical practitioners (GMPs), funding restraints have resulted in NHS Clinical Commissioners advising against the routine prescription of high fluoride toothpaste in primary medical settings.<sup>2</sup>

We conducted a pilot survey investigating the awareness of ORN amongst GMPs and GMP trainees in the Midlands in 2019, the results demonstrating that this was very limited, but that there was a willingness to engage in teaching and education. The potential role for GMPs to support with preventative measures and vulnerable patients struggling to access routine dental care was identified. While dentists can continue support for these patients, future education and collaboration with our medical colleagues in primary care must also be considered in order to improve patient access, and ensure holistic patient care is being provided across all clinical settings.

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## Test, test, test!

Sir, there are two reasons why the current guidelines pose an existential risk to dental practice:

- The additional costs involved plus the required fallow periods make general practice dentistry unsustainable
- The necessity to approach our patients while dressed like Darth Vader will raise perceived levels of fear and panic among them. Many will think that our practices are 'hot beds' of COVID-19 infection and they will simply stay away.

The policy as it stands (both in terms of national control and the dental protocols) will simply allow us to lurch falteringly to the inevitable second lockdown, due in the autumn or winter. The only way forward is to take charge of our own profession and use our own applied knowledge and skills. There