is a workable alternative approach and it relies on two fundamental factors:

- In dental practice the vast majority of dental patients are booked as 'elective' patients. We know who they are, we know when they are coming and we know what we are planning to do for them when they arrive. This means we can plan in advance of treatment and we can choose to delay treatment if necessary. Medical personnel in ICUs at hospitals have to be in close proximity to infectious patients – we do not have to be, nor should we be
- The only patients who present any form of risk from dental treatment (AGPs included) are those patients who are actively infectious at the time of treatment. Someone who has not been infected by the virus poses zero risk and someone who has been infected but recovered and seroconverted poses zero risk. Only a very small percentage of the population are infectious at any one time and these individuals are infectious only for a limited time.

The smart strategy means we need to identify the risk patients by advance swab testing of our patients when they require an appointment. Swab testing could be done onsite by a trained practice member in advance of any appointment booking. Those who test negative would be allowed normal full access to dental services. These appointments would be undertaken using exactly the same protocols as were used prior to the COVID-19 outbreak. Those who test positive will need to delay booking until they have a negative test – presumably about four weeks later if they remain well.

The main advantage of this approach is that it is proportional, specific and minimally disruptive. Furthermore, if the dental profession begins to test all of our patients this will have a significant advantage for the population as a whole, taking a burden away from the government or other healthcare sectors.

Therefore, we do not need to change dentistry fundamentally forever, we need to be SMART and TARGETED for now. If testing is done by the dental profession there will be spin-off benefits for all. To use the current 'management speak' it is a win/win situation.

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https://doi.org/10.1038/s41415-020-1800-7

A new era for dental education

Sir, while going through a large pile of past copies of the *BDJ*, a front cover image is shown of a 'Face-mask for the protection of the dentist while operating' circa 1920, 100 years ago (Fig. 1).

It is important to reflect that we have always been an infection aware profession and have therefore often been at the forefront of infection control in the surgery for both our patients and the whole dental team.[1] Along with other dental schools,[2] we stopped student patient contact before lockdown, however, we have continued with online lectures, tutorials, one to ones and imaginative online remote assessment. We are now grappling with the expectation of teaching again in September. Naturally, much important education can occur for example, with group work on evidence-based dentistry and with teaching preclinical skills in skills laboratories. Indeed, some elements of education, such as case reports, clinical reasoning and team care planning are probably easier to timetable across year groups and inter-professionally in the virtual environment, than face to face.

As primarily a school teaching dental nurses to certificate level, separate degree programmes in dental therapy and in dental hygiene, as well as teaching final year students from King's College London integrated team care, our focus on minimal intervention comes to the fore in a post COVID-19 era.

Fig. 1 The cover image of the BDJ Volume 227 issue 8, published on 25 October 2019

However, even behind our FFP3 masks and visors, the logistics of teaching clinical skills and caring for patients will remain a significant but critical challenge in our large open clinics with narrow passageways between clinical units. In addition, the need for one to one qualified dental nursing and new equipment that produces less aerosol, will not just need imagination, but like all of high street dentistry, considerable financial investment. We are about to enter a new era of dental education.

D. R. Radford, C. Louca, Portsmouth, UK

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https://doi.org/10.1038/s41415-020-1801-6

Diagnosing OSCC via video

Sir, we would like to highlight a case of oral squamous cell carcinoma (OSCC) brought to our attention via digital and virtual communications methods. A 78-year-old male, in the midst of the recent pandemic lockdown, could not access an in-person consultation at his local GP surgery. His son was able to arrange tele-communications with the GP using a smartphone to take photos at the patient's home and email them to the GP who, after review, forwarded these via email to our Oral and Maxillofacial Surgery Department for assistance (Fig. 1).

On receiving the photos an immediate video consultation was set up between clinician, patient and family member using NHS Attend Anywhere to allow an initial history and assessment to be undertaken. It was suspected that the lesion was sinister and further higher quality photographs were requested and received reinforcing concern of an advanced lower lip SCC.

Urgent head and neck scans and biopsy investigations were organised for a one-time hospital visit, to reduce the number of in-person interactions for this shielded patient. By this stage a primary care assessment, secondary care referral, subsequent history and examination and planning of one-day further investigations

were all undertaken virtually without the need for the patient to have an in-person consultation at his GP surgery or hospital. Following his one-stop in-person hospital visit, a diagnosis of SCC was confirmed, and the patient is receiving ongoing care for this.

Fig. 1 A 78-year-old patient with an advanced lower lip squamous cell carcinoma

A recent survey showed 74% of patients were amenable to virtual oral and maxillofacial consultations although clinicians were concerned that a low percentage of consultations would be appropriate for this technique.[1] Virtual consultation in this case was a beneficial tool to complement conventional OMFS outpatient clinic and clinical examination, aided by one-stop clinics.

Video and virtual consultations may play an increasing role in aiding the initial stages of diagnosis and catching oral cancer in the community. It may also be a means for aiding communication between primary and secondary care clinicians to accelerate patients' pathways where appropriate.

A. Orchard, F. Shah, S. Prabhu, Woking, UK

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https://doi.org/10.1038/s41415-020-1802-5

Coronamolars?

Sir, we have all been taught in our undergraduate training about 'mulberry molars' from maternal syphilis and hypoplastic first molar teeth in which maternal viral infection has been implicated. We wonder, due to the current COVID-19 global health crisis, will we see 'coronamolars' in six or so years' time and what will their form take?

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https://doi.org/10.1038/s41415-020-1803-4

Dental education

Facial aesthetics

Sir, the last 18 months of DCT in Oral and Maxillofacial Surgery have highlighted challenges and complications presented by facial aesthetic treatments.

A mysterious alteration in the soft tissue profile of a pre-operative orthognathic case was explained when the patient revealed a recent use of filler injections. A similarly difficult clinical assessment involved a mucocele of the lip, in which the patient admitted to lip enhancement injections a few weeks prior to the swelling appearing. An infected facial sebaceous cyst in a history of 'silhouette face lifts', which reportedly involved insertion of needles into the face, raised questions as to appropriate follow-up and with whom responsibility should lie to identify adverse outcomes.

Reality TV, notably *Love Island* and *10 Years Younger In 10 Days,* may reflect increasing demand for aesthetic treatments. Dentists advertising themselves as an 'aesthetic doctor' seem commonplace on social media platforms, widening accessibility to these services. This may be prompting a culture of self-identifying perceived unappealing physical traits and fuelling a vulnerability towards a desire to alter facial appearance. The British Association of Aesthetic Plastic Surgeons warn that 'people who struggle with their psychological health can feel pressured to turn to "quick fix" procedures to improve their appearance' and recommend pre-treatment psychological assessments.[1] With mental health becoming increasingly topical, I question how equipped dentists are in assessing psychological wellbeing in this context. Conditions such as body dysmorphia could be implicated and missed with damaging repercussions.

I am unaware of any dental schools teaching facial aesthetic treatments including dermal fillers as part of the undergraduate course. It is therefore somewhat unsettling that dentists can attend a one-day course before providing treatments such as 'non-surgical rhinoplasty' when they have likely had no training on this in their professional degree. Increasingly concerning is the practice of non-dentists providing facial aesthetic treatments, such as pharmacists, nurses and midwives, who will have limited, if any, knowledge or consideration for oro-facial anatomy and pathology. These practitioners may underestimate the scope for serious complications alongside varied experience in obtaining informed consent.

The GDC state that you must 'undertake appropriate additional training to attain the necessary competence' and you 'must not mislead patents into believing that you are trained and competent to provide other services purely by the virtue of your primary qualification'.[2] What constitutes appropriate additional training and how practitioners can evidence competence is open to interpretation.

It seems obvious that change is required in the regulations surrounding facial aesthetic procedures, particularly training of practitioners and steps to protect psychological health. It may be sensible to include such training within the BDS degree given the large proportion of dentists going on to provide these services.

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https://doi.org/10.1038/s41415-020-1804-3

Blended learning in teaching orthodontics

Sir, it was interesting to see how undergraduate orthodontic teaching has progressed since the early computer assisted learning (CAL) pioneers Professor Chris Stephens and Penny Grigg in the 1990s.[1,2] Chris pioneered the use of computers not only in orthodontic teaching, but also early AI in treatment planning and teledentistry for orthodontic advice.[3] But, way back then it was not known as blended learning,