COVID and consent

Sir, prior to the COVID-19 pandemic, patients undergoing invasive procedures were subject to confirming their consent through written means, a process which is considered common within surgical fields.[1] The guidance issued by the FGDP on 1 June suggested a move towards provision of 'digital packs' and it seems many standard operating procedures (SOPs) being issued by practices include the provision of digital information packs with consent forms to patients.[2]

Patients being issued consent forms to complete on their own may require additional support in order to ensure their validity so that consent is maintained and not overlooked, in light of the new working protocols the profession faces. Furthermore, in cases where patients are being triaged remotely, a complete exam may not be possible prior to execution of treatment: a key difference which has to be considered when exploring the options for consultation and delivery of clinical information.[3]

There is a risk due to patients' comprehension of the intended procedure and the lack of opportunity to fully appreciate or discuss the risks and benefits. Additionally, the change from a face-to-face consultation and 'cooling-off' period, as is the case with the gold-standard two stage consent, is likely to be affected. There is also a risk of clinicians not engaging with such measures which could be viewed as a non-compliant attitude to SOPs and guidelines, which although essential to good practice have come to be a burden to many.

S. Stagnell, Winchester, R. Moore, Leeds

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No chisels

Sir, in reference to the correspondence entitled *Altered exodontia techniques* (*BDJ* 2020; **228:** 811-812) advocating chisels and mallets in order to avoid aerosol generating procedures (AGP), a practical alternative is utilising a straight handpiece with a straight fissure bur and non-simultaneous irrigation. This would not qualify as an AGP and would be safer and more psychologically tolerable to patients as well.[1]

V. Sahni, New Delhi, India

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SDF – a game changer?

Sir, current guidance from the RCS *Recommendations for paediatric dentistry during the COVID-19 pandemic* is very clear: 'Access to general anaesthesia will be significantly reduced for the foreseeable future'.[1]

As a foundation dentist, I have had little exposure to silver diamine fluoride (SDF) during my undergraduate studies and so was very interested by the recent *BDJ* paper highlighting its use in the management of dental caries.[2] Through the utilisation of careful non-AGP application methods, it can prevent the progression of carious lesions and arrest them entirely although the most immediate issue is that it is currently not licensed to be used as a caries-arresting agent in the UK.

SDF has huge potential within community dentistry and general dental practices, more so at this unprecedented time. This would be particularly useful in coping with the reduced GA access and managing extensive carious lesions atraumatically, particularly in uncooperative patients. Considering all of the benefits, it begs the following questions – why is it still unlicensed as a caries-arresting agent in the UK? Where is the official guidance on its use? And finally, why has it not become a prevalent form of treatment considering its efficacy and appropriateness in the current climate?

A. Remtulla, Bedford, UK

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Sedation during the pandemic

Sir, the COVID-19 pandemic has seen the drawback of much needed pharmacological behaviour management services (ie IV sedation, IHS and GA). In experiencing such difficulties in the UDC hubs, I have become a huge proponent of the often underused and overlooked use of oral sedation techniques in the management of dentally anxious patients who have previously relied on IHS or IV sedation. Via anecdotal feedback, many patients are realising that they would be content to accept future treatment under such measures.

With dental practices now resuming a limited level of practice and possibly experiencing the level of frustrations with lack of treatment provisions for anxious patients, oral sedation with Diazepam is an invaluable tool in enabling patients the access to care they require. Increasing confidence in the use of Diazepam pre-medication is paramount for the changing face of dentistry, especially for those of us who have, in the past, become overly reliant on the GA, especially in polypharmacy patients. Careful case selection is of course key to its successful use, and requires the triaging clinician to be thorough in ascertaining dental history and indication of sedation need.

Appropriate prescription of Diazepam prior to attendance for urgent dental care can create positive outcomes for both the patient and treating clinician and just may result in a cultural shift that reduces the burden on sedation services when normal service resumes.

G. Atkinson, Salford, UK

https://doi.org/10.1038/s41415-020-1906-y

Dental dam: the time is right

Sir, dental/rubber dam has always been a strange issue in dental practice. Those of us who use it 'swear by it', but those who don't, decry its use, often in most strident terms.

There is absolutely no doubt that one of the major advantages of using it is the reduction in bacterial (viral) aerosol. Given the difficult and troubled time we now work under we must assume that dental dam could be a life saver, and it would seem to be professionally

irresponsible not to use it when clinically appropriate. I am well aware that there are many general dentists out there who have always been in the anti-dam brigade who would now find themselves in a position where they would like to use it but find it 'difficult'.

Formally, I used to provide many dental dam courses but thanks to the wonders of YouTube, the aspiring dam user can view a myriad of presentations demonstrating application and make their choice of the technique that they want to adopt. Two current points I would make however is that it must be latex free, hence the use of the term dental dam as opposed to rubber dam. Also the dam should be brought up over the nostrils, for obvious reasons. However, patients are sometimes resistant to this and they will have to be coaxed gently, explaining why covering the nose is necessary. I have never had a problem with this and frankly if a patient was adamant now that they did not want the nose covered I would decline treatment.

C. Emery, Portsmouth, UK

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Dexamethasone for pulpitis

Sir, dexamethasone has recently been in the news as a potential treatment for COVID-19 and the severe immune response, which is believed to cause a lot of the more severe medical problems experienced by patients acutely ill from the disease.

Has this medication perhaps got a dental use also which may have been valuable during this crisis when access to urgent dental care was limited? I remember attending an endodontic course including lectures from renowned endodontist, Julian Webber. He was a strong advocate for the use of oral dexamethasone for controlling pulpitis when operative care wasn't immediately available, a treatment option which has evidence to back it.[1]

What could have perhaps been very useful was access to dexamethasone via the dental formulary to help treat many of the patients suffering with pulpitis for which the principle of AAA probably did little to relieve their severe pain in the absence of dental treatment. If deemed acceptable by the necessary experts could it be adapted more widely as an additional medication we can supply in NHS primary care?

R. Emanuel, Haywards Heath, UK

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Déjà vu!

Sir, what constitutes an aerosol generating procedure (AGP) is in dispute between the British Orthodontic Society (BOS) and the Office of the Chief Dental Officer, England (OCDO). The guidance from the OCDO is that using a slow handpiece for caries removal with high volume suction does not produce an aerosol,[1] while the BOS' view is that for removing composite after a fixed appliance debond, it does.[2]

The BOS has therefore advised its members that all orthodontic procedures could be undertaken with personal protective equipment (PPE) appropriate for non-AGP, but should include the use of a fluid resistant surgical mask (FRSM) and high volume evacuation (HVE), as well.[3] The BOS' view is that the corollary use of a rubber dam would be limited in its practical application where multiple teeth are concerned and being technique sensitive, many orthodontists would be unskilled at present.[2]

These are understandable concerns, but neither problem is insurmountable. Almost three decades ago, the use of a rubber dam while debonding fixed appliance ceramic brackets was recommended as a means of protecting a patient's airway during a process that could result in the disintegration and aspiration of a radiolucent ceramic fragment.[4]

While some orthodontists might need *ab initio* training in rubber dam placement, for others a refresher session should suffice. It would be no more time consuming or challenging than having to learn how to don and doff AGP PPE and it would generate less contaminated waste.

Should orthodontists wish to enhance cross infection control during composite removal, they could follow the BOS' advice and assess the procedure's risks on an individual basis and undertake all necessary precautions they deem to be appropriate.[3] Bar donning AGP PPE, they could otherwise enhance the BOS' FRSM and HVE recommendations, by including the use of a preformed rubber dam, bearing in mind that while HVE and rubber dam are individually effective at reducing splatter and microbial contamination, together their effects become synergistic.

R. Chate, Colchester, UK

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Updated oral health strategy

Sir, I am a community dental officer and provide dental care for a large proportion of nursing and residential home residents. In 2018, there were up to 16.007 beds in a nursing home or residential care facility in Northern Ireland.[1] We provide a combination of dental assessments for new residents, review appointments for existing patients and dental treatment as appropriate, either in the nursing home setting as a domiciliary visit or with transfer to the dental clinic where appropriate. We also carry out annual oral health screenings for private and NHS nursing home and residential facilities in the Belfast area.

Prevention appears to be the safest way forward for this group of patients, in addition to our fit and well population. The Oral Health Strategy for Northern Ireland was last updated in 2007 and our care providers will be referring to the 'Guidelines for the Oral Healthcare of Older People Living in Nursing and Residential Homes in Northern Ireland' which were published in 2012 for their oral healthcare plans, both of which are now out of date given the current climate.

Perhaps we would benefit from an updated oral health strategy with a strong emphasis on prevention, particularly in our shielding population. Should the profession also be giving specific advice to carers with regards to safe oral care for our nursing and residential care patients, given the potential risk of exposure to the care provider in the current climate of limited PPE?

E. Hunter, Belfast, UK