COMMENT

Letters to the editor

Send your letters to the Editor, *British Dental Journal*, 64 Wimpole Street, London, W1G 8YS. Email bdj@bda.org.
Priority will be given to letters less than 500 words long. Authors must sign the letter, which may be edited for reasons of space.

CORONAVIRUS

Restorative consequences

Sir, the last four months of my dental core training post at Guy's Hospital in emergency dentistry, restorative dentistry and oral surgery have highlighted challenges and complications presented by the COVID-19 pandemic.

A large proportion of patients attending our unit have been diagnosed with irreversible pulpitis and acute periapical periodontitis. Root canal treatment, if possible, would be ideal but due to the restrictions of PPE and limitations of aerosol generating procedures, many of these teeth were extracted. Other teeth which were successfully extirpated at the start of the pandemic have subsequently not been root filled due to the length of time that dental practices have been closed.

Consequently, patients have sadly returned to us due to reinfection of the root canal system. In most cases, these patients declined re-extirpation in fear that the tooth will continue to cause pain and infection prior to them being able to see their regular dentist, with extraction being the only alternative option.

Firstly, this raises the question as to whether extirpation was the best option to begin with or whether the time and resources spent on them would have been better served elsewhere.

Secondly, we must also consider the future implications of the increased number of dental extractions. For example, there will be restorative considerations which will need addressing for these patients in the future, with strategic teeth such as last standing molars being lost. This will present dentists in practice with challenging cases and confound the overall impact on oral health presented by COVID-19, such as caries going undiagnosed for long periods of time and relapse of patients' periodontal condition.

P. Menhadji, London, UK

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Immunity from legal action

Sir, there seems to be an inordinate amount of largesse being dispensed by the government and the Treasury in particular. I wonder therefore if dentists, along with other healthcare professionals, should be protected with civil immunity from injury (or death) alleged to have been sustained directly as a result of an act or omission by them in the course of providing healthcare services in support of the government response to the COVID-19 outbreak.[1] Perhaps we should follow the example set by New York Governor, Andrew Cuomo who has issued an Executive order to this effect.

GDPs in the UK have been deluged with a multiplicity of guidance and face the anxiety and stress of deciding what to do or to do anything at all. Potential claims relating to how patients were managed during this crisis and the return to practice may come long after the public adulation of the NHS has been forgotten.

Clinicians should of course be accountable for their decisions and action but the circumstances in which that care was delivered should be contextualised. The delivery of care through the urgent dental centres should certainly be protected from civil suit but at the very least be defended through the Clinical Negligence Scheme for Trusts (CNST) via the Coronavirus Act 2020. They have a good record in dealing with cases made against NHS healthcare workers. The majority of claims are resolved without formal court proceedings and in the early stages, more claims are resolved without payment of damages than with payment of damages. In 2017/18 just under 1/3 of claims ended up in litigation with fewer than 1% going to full trial (with most ending in judgement in favour of the NHS).[2]

The public shouldn't be clapping the NHS one week and suing them the next but if they do, we should have State backed indemnity.

L. D'Cruz, Woodford Green, UK

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https://doi.org/10.1038/s41415-020-1929-4

Small succeeds

Sir, the financial impact of the COVID lockdown would not have featured in even the most beautifully crafted business plan. The more that I read and hear of the problems which different practices are having, on their roads to recovery, there is one feature that stands out above all others: the bigger the practice, the bigger the problem.

The recent letter from the Chair of the BDA's Board ('The $10 billion question: what is dentistry worth?') tells us that some practices are able to see only 10% of their previous volume, a situation which is not financially sustainable. The economies of scale, which were such an asset of large practices, have turned into a burden from which they may not be able to recover. In

contrast, single-handed practices have been able to benefit from the Small Business Rate Relief Scheme, including a £10,000 grant, and this has greatly helped them to get through this crisis.

This contrast in fortunes begs one question: is it time for the profession to reconsider its fondness for larger practices and to cherish anew, its rich heritage of small, family practices?

C. Marks, Southampton, UK

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Coping well

Sir, we read Drs Mijiti and Huojia's letter (*Psychosomatic problems BDJ* 2020; **228:** 738) with deep empathy. Japan is gradually moving out of the emergency state but remains vigilant against the second wave of COVID-19. As the authors described, patients with chronic pain like Burning Mouth Syndrome (BMS) are at high risk for depression and anxiety with social isolation a possible risk for developing further psychosomatic symptoms.[1]

As of July 2020, two weeks after the re-opening of Psychosomatic Dentistry Clinic (Dental Hospital, Tokyo Medical and Dental University), we do not observe a growing number of patients with new oral psychosomatic disorders. Also, the pandemic chaos did not necessarily worsen our patients' condition. In contrast, some even told us that they felt better by being released from the stress of commuting and mental fatigue of workplace interpersonal relationships. We suppose here that BMS symptoms might not be simply connected with anxiety and depression, as do some psychiatric conditions. In most cases our BMS patients are coping well with this unusual situation, beyond our expectations.

The activities of our psychosomatic dental services were interrupted and reduced for several months, being considered as non-urgent. Almost all patients had to be followed up with telemedicine, including brief psychological counselling via telephone; continuing the prescriptions (mainly for antidepressants) via fax services, in cooperation with nearby pharmacies. Many patients expressed thanks for keeping up the medication while being able to avoid infection risks such that we suggest online consulting was useful for BMS patients during social distancing. It would also be useful in the event of a second wave of COVID-19 and other natural disasters, like earthquakes or typhoons.

Treating a dental patient with psychosomatic problems is always difficult.[2] However, given the many fundamental changes to daily lives in the current pandemic, we suggest expanding telehealth and telemedicine to follow up oral psychosomatic patients at home. This also aligns with Dr Mijiti's idea of training dental hygienists to apply some psychological techniques of Cognitive Behavioural Therapy (CBT).[3]

T. T. H. Tu, A. Toyofuku, Tokyo, Japan, H. Matsuoka, Hokkaido, Japan

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Temporary filling anaphylaxis

Sir, a fit and well 33-year-old female presented to A&E with signs and symptoms in keeping with anaphylaxis. Prior to this manifestation she had placed an 'at home' temporary filling into tooth 35; at examination she stated an allergy to cloves and thus we suspected that the material contained eugenol.

After stabilisation in A&E, she was reviewed by our team. On discussion she decided against removal of the filling under rubber dam or the tooth itself. However, she re-presented approximately 48 hours later with recurrent symptoms of anaphylaxis at which point the tooth was extracted in a theatre setting under local anaesthetic; she made a full recovery.

We would like to highlight this concern due to the increased use of 'at home' filling kits by our patients, as a result of remote triage during the coronavirus pandemic. Here it is important to inform patients to check temporary filling material ingredients and update allergy status when advising such management.

G. Zakary, R. Major, A. Bhaiyat, York, UK

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Judgement and virtual reality

Sir, dental education is changing as a result of the COVID-19 pandemic and we highlight two aspects of this to affect us as final year students.

We have been informed that dental foundation training (DFT) interviews will no longer be taking place and the recruitment process will be solely placed upon the situational judgement test. This consists of a selection of multiple-choice and ranking-based questions to represent challenging scenarios which dentists may encounter. The news has heightened anxiety levels in many students. As this is the only exam to decide undergraduate ranking among their peers, the amount of pressure placed upon them has been amplified.

Secondly, students in their later years of training are anxious as the lack of clinical exposure inevitably decreases confidence levels. We are fortunate to have experienced hapTEL (haptics in technology-enhanced learning). This award-winning virtual reality technology consists of glasses, a foot pedal and a drill giving students a realistic 3D experience with sound, touch and vision. Benefits include improvements in the positioning of the clinician, enhanced manual dexterity and early adaption to a clinical setting. Precision can be practised as the different layers of the tooth surface can be differentiated, improving tactile sensation. It also serves as a great tool to gain constructive feedback from tutors.

We believe this device would be beneficial to use as an adjunct to fill the gap of lost clinical time and that it should be implemented across other universities to enhance clinical practice to achieve optimum care for our patients.

S. Thakkar, S. Kadia, London, UK

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An opportunity

Sir, with the increased success of identifying symptomatic COVID-19 cases followed by self-isolation, the main mode of transmission is going to be increasingly through asymptomatic spread.[1] We are not routinely testing patients who have been selected for an aerosol generating procedure (AGP) and this is based (in Scotland) on the low prevalence of