

Letters to the editor

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CORONAVIRUS

80 years on

Sir, as a newly qualified nurse, it would be naïve of me to forget how far dentistry has come over the past 80 years. Talking recently to a nonagenarian patient brought things into focus and made me think about the future of NHS dentistry. Back in 1940, the country was in the midst of a global crisis and the *Lancet* was reporting the spectacular success of animal testing of penicillin, a new wonder drug capable of curing previously life-threatening infections such as gas gangrene. It would be another eight years until the NHS was formed.

Our patient attended an urgent appointment, during which we talked about how much visiting the dentist has changed. She reflected about the similarities to 80 years ago when (aged 14) she started working as a dental nurse. With no training or mentoring, she worked chairside full time from day one. In those pre-NHS days, dental work was avoided by patients until absolutely necessary, treatment was generally limited to extractions and anaesthesia was generally inhalation sedation. Many patients were left with missing teeth and when the NHS (free at the point of use) was formed in 1948,¹ she recalled a massive influx of patients seeking dentures to replace their missing teeth. The demand was so high, that she recalled of the dental team (and the lab technician who worked in a shed at the bottom of the garden), 'We just couldn't keep up!' Shaking her head and with a distant look in her eyes, she repeated it a number of times – it was clear it had a significant impact on her. And it made me wonder whether this is how we'll feel over the next few months as we play 'catch up' with

patients once things start getting back to normal? And as for the NHS dental services more generally? Back in 1952, dental charges were introduced because the provision of dentures nearly bankrupted the newly formed NHS.² What are the parallels for the future of NHS dentistry?

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AGPs and orthodontics

Sir, with discussion regarding the use of aerosol generating procedures (AGPs) during the pandemic we must consider the use of non-aerosol generating bonding options for treating orthodontic patients. At present there are products readily available but the only cause of concern is their strength. Traditional bonding requires enamel polishing using pumice and requires use of a three-way syringe. Two options that may be considered at this time are:

1. Self-etch primers – these may be used without the need for acid etching but the use of pumice is still required. If these are used without polishing then the enamel smear layer present may compromise the bond strength. So, these may be considered for temporary use during this period¹
2. Light cured resin-modified glass ionomer cement – the benefit of using these for

orthodontic bonding has been limited but for minimising AGPs these may be a good option as there is no requirement for acid etching or polishing.²

Also, additional suggestions may include the use of cotton rolls for drying the enamel surface as well as for maintaining isolation during orthodontic or restorative procedures. As far as the removal of excess composite/flash is concerned, under normal conditions it is considered an AGP but the use of a scalpel to trim the excess can be a helpful, although time-consuming procedure.

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College leadership required

Sir, Dr Mannan (*A centralised approach*; *BDJ* 2020; **229**: 6) makes a valid point.

The work of all the agencies and organisations which produced COVID-related guidance under the most difficult of circumstances is to be applauded. In hindsight, however, the leadership shown by the Faculty of General Dental Practice (UK) and College of General Dentistry in forming a Task Force to produce 'back to practice' guidance (<https://cgdent.uk/2020/06/01/safe-return-to-dental-practice-during-covid-19/>), with a membership drawn from across dentistry, will be seen as the way

for the profession to work together in the future. Facilitating and coordinating such working, including relevant expert input, is a key aim of the new College (<https://cgdent.uk>). As an independent, standard setting, UK-wide organisation for all members of the dental team, the College will be best placed to provide the leadership Dr Mannan correctly identifies as missing.

To enable the College to become fully established at the earliest possible opportunity and provide the collegiate leadership which the dental profession requires, all dental healthcare professionals, who have not already done so, are encouraged to become a Foundation Member of the College – a quick, simple, inexpensive online process (<https://cgdent.uk/join/>). Dentistry must no longer be the only major healthcare profession in the UK without a College, let alone a Royal College.

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Temperature and mouth opening

Sir, during the pandemic, facial swellings which do not require an urgent referral to a local maxillofacial unit may initially be managed in practice or by an urgent dental care centre through use of the AAA approach (advice, analgesia and/or antimicrobials) or source control through pulp extirpation, extraction or incision and drainage. The Scottish Dental Clinical Effectiveness Programme (SDCEP) recommends that patients treated for these conditions are reviewed within two to seven days.¹

In the secondary care environment, haematological and biochemical investigations can be undertaken alongside clinical examination to provide reassurance that the patient's condition is improving following treatment. These tests are not available to the primary care dentist; however, there are two objective, quantifiable measurements which may be used, namely temperature and mouth opening.

Patient-reported symptoms of fever correlate poorly with measured temperature.² Therefore, SDCEP recommends temperature measurements for all patients with suspected bacterial

infections.¹ Some dental practices may have recently invested in temperature screening products, although the Medicines and Healthcare products Regulatory Agency (MHRA) advises caution when interpreting readings from devices that measure skin temperature.³ There may be value in utilising these temperature screening products, or preferably thermometers which measure core temperature for assessment of patients with facial swellings even after the pandemic restrictions are eased.

Restriction of mouth opening may result from infection in the masticatory soft tissue spaces (trismus), or as a product of pain (guarding). Severe trismus in the context of infection demands an emergency referral. Measurement of the number of fingers that can be inserted into the mouth is imprecise and lacks reproducibility, and therefore use of a sterilisable or disposable ruler is recommended to evaluate the inter-incisal distance in millimetres.⁴

Thermometers and stainless steel rulers are an inexpensive but valuable addition to the general practitioner's armamentarium and may be particularly useful during the current period of increased emergency care provision.

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Dental team immunisation

Sir, this year, in order to reduce the risk of the dual threat of seasonal influenza and coronavirus, the UK government has expanded the eligibility criteria for flu vaccinations to include those over 50 years of age, shielding households and all school year groups up to year 7.

This represents approximately 30 million people.¹ The operational challenges provide an opportunity for innovative models of delivery. Underpinned by collaborative discussions between various organisations we propose potential models to support the delivery of this enhanced programme:

- Foundation dentists to provide additional immunisation capacity
- Dental team members to deliver vaccinations with Primary Care Network (PCN) teams or School Aged Flu Provider workforce in school, primary care and/or community settings
- Use of dental surgery premises by immunisation teams to complement existing community settings that are known and accessible to the public
- Flu vaccination in a dental setting. This could reduce the number of contacts between the public and clinical settings and could be done for specific cohorts and/or opportunistically.

Another avenue is the potential for dental workforce vaccinators to support the catch up of adolescent immunisation programmes such as HPV and meningitis, delayed due to pandemic school closures. Once a safe and effective vaccine for COVID-19 becomes available, it is expected that delivering a large-scale immunisation programme will raise significant logistical issues. If the above models have evaluated well, dental care providers would be well placed to support the delivery of such programmes.

Any of the above models would need to take into consideration certain factors such as training, competency sign-off, indemnity, funding and regulatory approval. There is now a short window of opportunity before the beginning of the flu season to explore these possibilities but the lessons learned from the pandemic response might provide an opportunity to strengthen the dialogue between medicine and dentistry.

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