Letters to the editor

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CORONAVIRUS

Testing the limits of UDCs

Sir, a 77-year-old male attended the Emergency Dental Clinic at the University Dental Hospital of Manchester (UDHM). The main complaint was an ongoing, non-specific facial pain of the right face following extraction of the 16 two months previously.

History revealed that the 17 had been removed four months prior to presentation due to similarly vague symptoms. The pain failed to settle so the 16 was subsequently removed. The patient reported both teeth to have become mobile prior to extraction. Ten days after the extraction of the 16 he presented at UDHM with ongoing persistent symptoms. He had already begun a course of antibiotics and was using chlorhexidine mouth rinses prescribed remotely via an urgent dental centre (UDC). Radiographs ruled out any retained root fragments but clinical examination revealed an area of exposed bone. Conservative management advice was reiterated and two weeks later, the patient was seen for a review. The pain had reduced but there was still discomfort in the area and the patient reported it to feel sharp on his tongue. The socket had epithelialised but a small fragment of bone was present and this was removed under local anaesthetic. He was advised to return to his GDP for review.

The patient contacted UDHM six weeks later with ongoing pain and a face-to-face review was arranged. In that time he had not been offered a face-to-face review but rather been given a further two courses of antibiotics after remote UDC consultations. He presented with moderate discomfort, radiating around the right side of his face which he was able to manage with simple analgesia. He had no extra-oral swelling, temperature sensitivity or tenderness to

chew. He reported no history of swellings. Examination revealed friable red and white speckled tissue fungating from the socket with adjacent ulceration extending around the 15 mesially and 17 region distally. There was an area of indurated tissue extending 1 cm into the hard palate with rolled borders.

He had no risk factors in his medical or social history. A provisional diagnosis was made of squamous cell carcinoma and an urgent biopsy was taken. Histopathology confirmed moderately differentiated SCC and he has been referred via an urgent pathway to maxillofacial services.

Reflecting back over this patient's history and clinical encounters there were signs that may have pointed towards a non-odontogenic diagnosis. Certainly, it would appear there was no indication for repeated courses of antibiotics. The picture is further complicated by the number of clinical and remote contacts with different clinicians. We hope this may serve as a timely reminder of the limitations of remote consultations and the possible consequences of a lack of continuity of care in any one setting.

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Teaching remote consultation

Sir, the *BDJ* has recently published articles describing the use of remote consultations in dentistry during the COVID-19 pandemic.^{1,2,3} I would like to draw attention to considerations for teaching undergraduate students and trainees this new type of communication skill.

While demonstrating their value, remote consultations also have limitations, for example being unable to carry out a full soft tissue examination,² and may increase the risk of

missing a serious diagnosis or misdiagnosing. This has also been noted by the medical profession, particularly around telephone consultation, where clinician experience and skill are deemed to reduce risk.⁴

From my experience working in hospital oral surgery and oral medicine services during the pandemic, a multitude of factors inform a risk assessment that influences whether a patient is seen remotely or face-to-face, including: patient complaints/concerns about their oral health, NHS trust policy, patient wishes, type of oral disease/problem (confirmed or suspected), patient's accessibility to a device for a remote consultation, distance a patient would travel to our clinic, prevalence of COVID-19, patient's general health and vulnerability to COVID-19. Furthermore, remote consultation requires a different communication approach and arguably more thorough history taking to triage those that require a face-to-face appointment.

It seems inevitable that remote consultation will become a permanent and useful element of dentistry owing to the potential for improved efficiency and accessibility. With the start of the academic year upon us, as dental hospitals and schools, we will need to consider how to teach this new skill set to our students and trainees. This could involve utilisation of observation, role play and peer review to develop both remote communication skills and competencies in facilitating a joint decision with patients about the most appropriate consultation mode.

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References

1. Rahman N, Nathwani S, Kandiah T. Teledentistry from a patient perspective during the coronavirus pandemic. *Br Dent J* 2020. doi:10.1038/s41415-020-1919-6.