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

Duty to extract

Sir, as a Past President of the BDA I am dismayed and bemused to read frequent reports in national newspapers decrying the number of children awaiting many months for tooth extractions in hospitals. Indeed, the *Daily Telegraph* claims that this is the most frequent referral cause for children to hospital, numbering equating to 177 cases per day nationally at an estimated cost of £41 million. A further report of this problem appears in the recent *BDJ* (*Potential surge in post-COVID child tooth extractions*; *BDJ* 2020; **229:** 278).

Is this because dentists, both in practices and community dental services, are either unwilling or unable to perform this treatment? Furthermore, it seems that frequent courses of antibiotics are prescribed to keep infection from carious teeth at bay pending hospital extraction. As we are all too aware, this repeat prescribing is undesirable, building up unnecessary resistances.
I presume dental schools still educate undergraduates in the expert technique of extractions, therefore one must conclude that the problem is due to an unwillingness of clinicians in primary care to undertake these treatments. We must remember that for every child suffering from painful teeth, there are parents having to cope with stressful situations.

Many years ago, I was a member of the then termed 'Poswillo' working party, reporting to the Department of Health on the safety of administering general anaesthetics (GA) in practices, but additionally our role included reviewing other means of anaesthesia. Whilst not advocating a return to providing GAs in outpatient clinics, in a primary care setting it is perfectly possible and permissible to extract offending teeth using either sedation or local anaesthesia or a combination of both.

As healthcare professionals, dentists have a duty to relieve pain and to prevent the risk of complications arising from long-term infections rather than referring patients to a seemingly endless waiting list, especially during these difficult COVID-19 times, which is exacerbating this dire state of affairs.

J. Stuart Robson, York, UK

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Frugal solutions

Sir, in the current pandemic, the lack of equitable oral healthcare facilities, shortfall of dental healthcare providers, shortages of equipment/materials, and inadequate management of existing services is well known in developing countries.[1] It may not be possible for such countries to upgrade the dental surgeries in their tertiary care facilities to the suggested level of ventilation, filtration, and negative pressure, due to financial limitations. The alternative solution for resource constrained environments is to explore frugal innovation approaches to make the most of existing assets and skills.[2,3]

For instance, for creating a temporary negative pressure in dental surgeries strong exhaust fans have been connected to the simple duct system to deliver the air from the surgery at the minimum three metres above the roof.[4] To prevent the transmission of infection through aerosol in the dental setting the 'protection box' is an innovative and economical solution for performing aerosol generating procedures.[5] The protection box has excellent visibility and can be reused after disinfection. Recently, in Pakistan a dental surgeon has designed and used a purpose built protection box during aerosol generating procedures (https://www.facebook.com/dentistsatwork).

These solutions may not be perfect but they can provide necessary protection in the best and quickest way possible in the face of exponential spread of the pandemic and economic limitations.

M. Javed, Qassim, Saudi Arabia, Y. Bhatti, London, UK

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Thank you Covidentologists

Sir, I would like to thank all my colleagues who have worked so diligently to up-skill and kindly help guide others through the current COVID-19 pandemic. Until six months ago, like many colleagues, I had little knowledge of this new respiratory virus and its impact on the dental profession.

Thanks to this new novel virus, we now have a growing number of colleagues within dentistry who understand much more about respiratory viruses than I ever seem to remember learning at dental school or during my postgraduate studies. If we add to this the long list of acronyms with SOPs, AGPs, Non-AGPs, FFPs, written and re-written SOPs, the latest technology to help

us filter air – I would even go so far as saying we have created a new speciality within dentistry which I believe should be named as the 'Covidentologists.'

Of course there have been many examples of exemplary leadership within our profession, where clinicians have rolled up their sleeves and got on with delivering dentistry or redeployment duties during difficult circumstances for us all. Our country and profession will continue to face unprecedented challenges over the coming months.

With many predicting permanent changes for the future delivery of healthcare, one thing remains clear, the consequences of COVID-19 are far from over for dentistry. I'm sure many of the 'Covidentologists' will have a long career ahead of them guiding the many clinicians (such as myself) through the troubles and difficulties we face. I just wish I'd paid more attention during all those lectures on respiratory viruses.

W. Fitzpatrick, Cardiff, UK

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Winter is coming

Sir, we provide an update of the report of the enhanced Acute Dental Care (ADC) service provided by Guy's and St Thomas' NHS Foundation Trust.[1]

Between the peak (22 April 2020) and 1 August 2020, the ADC service has clinically assessed a further 4,849 patients with urgent and emergency dental care needs despite the widespread establishment of Urgent Dental Care (UDC) hubs. Approximately 1,200 aerosol-generating procedures (AGPs) have been carried out, the majority being pulpal extirpations, followed by surgical extractions. The availability of re-usable FFP3 respirators and the ability to fit test clinicians has allowed an increased provision of AGPs, with fallow times for each surgery being adhered too.

The gradual resumption of elective local anaesthetic, intravenous sedation and general anaesthetic (GA) operating lists as well as face-to-face clinic appointments from 1 June 2020 has enabled the department to also assess and treat referred patients with routine dental needs. Pre-operative isolation protocols and COVID-19 testing for patients on GA lists have ensured that patient and staff safety is prioritised. This increased workload has been facilitated by the return of staff who were redeployed to other services within the Trust.

We now face a growing pressure for the directorate to resume pre-COVID-19 levels of service provision whilst maintaining urgent care. This poses a challenge considering the newfound constraints to dentistry such as fallow time, isolation of surgeries and social distancing. This dilemma is compounded by concerns over what winter may bring with regards to a second wave and further strains placed on the healthcare system. Coupled with the recent spike and mounting number of confirmed COVID-19 cases nationwide, almost doubling from 7,995 in the last week of August to 12,217 in the first week of September 2020,[2] this challenges the practicality and sustainability of providing regular routine and elective care alongside an acute dental service.

Despite these anticipated challenges our experience of this service thus far highlights the capability of a department to effectively adapt in response to rapidly developing circumstances and can act as a framework for the provision of acute dental care in the coming months.

P. Sandhu, S. Grossman, C. Sproat, V. Patel, London, UK

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Why PAPR suits us

Sir, the move to a total airborne pathogen respiratory risk reduction in dentistry and the added burden of significant PPE changing and disinfection between patients is here for the foreseeable future.

Our options were essentially FFP3 masks or respirators. Tight fitting and designed for limited wear times, these FFP3/non powered respirators are not wholly suited to continuous wear and whilst FFP3 can be comfortable for some colleagues, others have cited varying difficulties with fogging, time taken to don and doff and exorbitant replacement costs. FFP3 therefore seemed a limited option which did not make economic sense. Let us not even consider the term 'fit testing'. What a chore that was.

The closefitting respirators offered a solution to the cost, but once again were limited for loupe wearers as the nose area creates a vertical raising of the loupes and surgeons are having to strain to focus comfortably with the resultant headaches that eye strain causes. What about the heat generated? We are essentially wearing plastic bags and the mask/visor combination meant that after waiting five minutes for fogging and focusing to start, I was then plagued with condensation forming on my glasses/loupes! In addition to this, the patient can't see my face at any stage and communication is a chore.

That was fine for four patients a day hobby horsing dentistry, but we needed to get our team back to work, furlough is ending soon and we decided it would be better to consider powered respirators (PAPR). The consideration is that a comfortable dental professional is more likely to be efficient and to enjoy their work. We were determined to buy once and buy right. It takes seconds to put on and take off, most loupes fit in them (please check as not all do), and there is a lovely flow of air across your face, mitigating well against the heat of the aprons.

It's been six weeks since I've been wearing my Centurion Concept Air PAPR and I can say unequivocally we were right to get them. We can perform treatment after treatment without fatigue, you get used to them so much so that I wear it for every patient, even non-AGP, and it is quicker than mask and visor waiting to defog. I am also really appreciating the lack of any scent in the environment. I don't miss the smell of bond or infectious teeth.

Those with a heavy NHS practice commitment might not even be back to any credible workload yet. I know many of us are soldiering on and if you are comfortable with your solutions then fine but if you are tired, irritated and not looking forward to going back to work then change your direction and consider PAPR.

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