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

Unaffected in Cambodia

Sir, since we have had an overwhelming number of publications and letters published related to the traumatic and depressing scenarios brought about by the COVID-19 pandemic, I wanted to report something on the positive side. As a practising dentist in Cambodia we have remained unaffected by the pandemic largely due to the effective preventive measures being taken here.

Initially the clinics were mostly asked to either implement strict infection control measures, if they wanted to resume their daily operations, or close until such measures were adopted. Since March, when the virus spread became a major cause for concern, we have largely remained operational thanks to the strict infection control and quarantine measures adopted by the government. The ministry of health was efficient in disseminating infection control guidelines and ensuring that dental clinics strictly adhered to them. Many clinics resorted early to online consultations, controlling the patient inflow and rigorous screening at their entrances.

In dental schools the daily outpatient departments were shut down initially and only emergency patients were seen; with time things have gone back to normal. To minimise any spread, patients are always asked to strictly follow two-metre distancing, all dental chairs have been separated by plastic curtains and all treating dentists must follow the mandatory PPE protocols. At present classes are still being conducted online but the laboratory work and practical sessions have resumed with students attending physical classes on alternate days.

The government has also implemented strict quarantine measures for all passengers flying into the country making it very secure for the local population in terms of containing virus spread. With time not only the dentists but also the public have regained confidence in resuming dental treatment as there has not been a single case of dentist-to-patient transmission or *vice versa*. Collectively, the measures from the government, the ministry of health and the local dental council have all resulted in dentists being able to continue their work throughout the pandemic period without apprehension.[1] At the time of sending this letter the entire country has reported only 290 cases with 283 recoveries and no mortalities making it one of the few countries with a 100% recovery rate and incredibly low incidence.

A. Marya, Phnom Penh, Cambodia

Reference

1. Karobari M I, Marya A, Venugopal A, Nalabothu P, Parveen A, Noorani T Y. The state of orthodontic practice after the outbreak of COVID-19 in Southeast Asia: the current scenario and future recommendations. *Asia Pac J Public Health* 2020; doi: 10.1177/1010539520962919. Online ahead of print.

https://doi.org/10.1038/s41415-020-2355-3

Realistic dentistry

Sir, as bright idealistic dental students, my friends and I often pictured what it would be like starting our careers in dentistry. Coming up to the end of October, almost two months of VT is over and our pandemic-ridden reality has come with continuous challenges, not least that the unremarkable procedure of a scale and polish now requires an outfit similar to a hazmat suit.

Two months of endless emergency appointments have left me with more experience in extracting teeth than the past four years of dental school. Although I am very grateful to gain this experience, it is glaringly obvious and bleak to see the effects of closing dental practices. Currently, the message is realistic dentistry: placing repetitive temporary fillings with quietly stirring caries below is not the type of dentistry we as a profession are taught. Seeing patients lose teeth that could have been saved in a parallel universe without coronavirus is sad to witness.

As newly qualified dentists of 2020, we lack the standard transition into busy general practice and are slowly coming to terms with the considerable experience we will miss out on. It is still unknown how NHS dentistry will resume and what form it will take while we sit and endure this storm of uncertainty. And, as with all storms, one should be concerned about the damage left in its wake.

P. Balaji, Dundee, UK

https://doi.org/10.1038/s41415-020-2356-2

PPE update

Sir, I write further to the letter *Why PAPR suits us* (*BDJ* 2020; **229:** 500) by H. Mostafa. The author provides some practical advantages to powered air-purifying respirator (PAPR) use over other respirators but PAPRs are available with either a tight-fitting facepiece (requiring fit testing)[1] or facepiece, helmet or hood that is loose-fitting.

PAPRs also possess a greater Assigned Protection Factor in comparison to filtering facepiece respirators (FFRs). Apart from the advantages listed by the author, others include amenability to wearing with a limited amount of facial hair, splash protection for the eyes and face provided by models with hoods or helmets ranging from a limited to a more significant extent. A PAPR could also be more physiologically conducive for the wearer by offering less breathing resistance. The majority of PAPR components can be re-used or shared after being cleaned and disinfected.[1]

That being said, the author raised the matter of having issues with vision while using FFRs; a

PAPR may also interfere with the field of vision as a result of the downward vertical visual field being rather limited, powered PAPRs may impair the hearing ability of the wearer due to blower noise and noise created by the loose head covering during movement.[1] PAPRs also require considerable storage space, an approved staff training protocol in maintenance and disinfection, and timely battery replacement or charging to maintain optimal performance.

PAPR components exhibit significant variability across manufacturers and in their reaction to various cleaning, disinfectant methods and solutions which can cause damage or deterioration of components. They are also very specific in how they are to be used and require training to avoid contamination and infectious liability. Most manufacturers recommend the filter be discarded. CDC cautions against the use of these filters for a live virus and recommends the institution of a replacement cycle which is practical to implement till more evidence emerges.[1]

Therefore, before adopting PAPRs, practices should seriously consider various factors to decide suitability.

V. Sahni, New Delhi, India

Reference

1. Centers for Disease Control and Prevention. Powered Air Purifying Respirators (PAPRs). Available at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/powered-air-purifying-respirators-strategy.html (accessed 23 October 2020).

https://doi.org/10.1038/s41415-020-2357-1

Dementia guidance please

Sir, our experience in a community dental service has shown that provision of domiciliary visits to care homes, including dementia patients, have come to an abrupt halt due to the increased risks associated with COVID-19 in an enclosed setting as well as the change in provision of care as we turn into an urgent dental centre.

The COVID-19 guidance and SOP document published by NHS England highlights that vulnerable patients may be seen for urgent dental care following unsuccessful implementation of remote management via advice, analgesia and antimicrobials.[1] However, there is no further guidance regarding the factors to consider during a domiciliary visit and this is left to the individual clinician to risk-assess and decide. This document has changed three times since it was first published in April 2020, and the guidance changing numerous times during this period can leave a lack of clarity and thus inconsistencies in the provision of care.

We would greatly urge that there needs to be clearer guidance for domiciliary visits in order to provide effective and safe care to the dementia patient cohort as significant risks leading to potential safeguarding issues and increased comorbidities can arise if these issues are not addressed.

Y. Lin, B. Collard, Plymouth, UK

Reference

1. NHS England. COVID-19 guidance and standard operating procedure: for the provision of dental care in primary care dental settings and designated urgent dental care provider sites. Updated 28 August 2020. Available at: https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/08/C0703-covid-19-urgent-dental-care-sop-28-august-2020.pdf (accessed 23 October 2020).

https://doi.org/10.1038/s41415-020-2358-0

Two-tier dental system

Sir, the majority of dental practices in Scotland are mixed NHS-private practices. A recent survey from BDA Scotland revealed that 52% of largely/exclusively NHS practices and 86% of mixed practices predicted a relative reduction in NHS work during the next year because of the COVID-19 pandemic's impact on the provision of NHS dental services.[1] There is a possibility that dentistry in Scotland will move towards a two-tier system with reduced access for NHS patients. During question time on 12 August 2020, the First Minister of Scotland said: 'There is not, and there should not be seen to be, a two-tier system of oral healthcare. If dental practices are ready to do so, they can provide aerosol-generating procedures on patients with urgent dental problems from 17 August. We have 75 urgent dental care centres throughout Scotland, to which patients continue to be referred.'[2]

Since then, there has been a number of complaints about GDPs in Scotland who may be misinforming patients about the range of NHS services available following lockdown or coercing patients into undertaking private treatment. Some of these complaints were also sent to the Scottish government. On 14 September 2020, the Chief Dental Officer for Scotland wrote to the Directors of Dentistry with suggestions on how to deal with this type of complaint.[3]

On 12 October 2020, it was announced that NHS dental contractors in Scotland would, from 1 November 2020, be able to provide a full range of treatments to all NHS patients within dental practices.[4] The BDA has concerns that expanding the range of treatments will increase patient demand which may encourage a 'two-tier' dental system.[5]

In the interests of patient safety, only a fraction of the number of patients can be treated compared to pre-COVID levels. To avoid confusion, it is essential that the Scottish government provides regular and timely information to inform the public and dental professionals about changes to primary dental care services.

C. A. Yeung, Bothwell, UK

References

1. British Dental Association Scotland. Open letter to Joe FitzPatrick MSP on mixed practices. 6 August 2020. Available at: https://bda.org/advice/Coronavirus/Documents/Scotland-David-McColl-letter-on-mixed-practices-06-08-2020.pdf (accessed October 2020).
2. Scottish Government. First Minister's Question Time on NHS Dental Services. 12 August 2020. Available at: https://www.theyworkforyou.com/sp/?id=2020-08-12.18.0 (accessed October 2020).
3. Scottish Government. CDO(2020)14: Letter to Directors of Dentistry. 14 September 2020. Available at: https://www.sehd.scot.nhs.uk/cmo/CDO(2020)14.pdf (accessed October 2020).
4. Scottish Government. CDO(2020)15: NHS dental remobilisation. 12 October 2020. Available at: https://www.sehd.scot.nhs.uk/cmo/CDO(2020)15.pdf (accessed October 2020).
5. British Dental Association. Scotland: Concerns about remobilisation. 14 October 2020. Available at: https://bda.org/news-centre/latest-news-articles/scotland-concerns-about-remobilisation (accessed October 2020).

https://doi.org/10.1038/s41415-020-2359-z

Exam appreciation

Sir, we would like to take the opportunity of formally thanking our colleagues for the recent successful online delivery of the Royal College of Surgeons of England and Royal College of Physicians and Surgeons of Glasgow Bi-collegiate Specialty Membership examinations in Restorative Dentistry (the examination diet of which will be completed in November) and Orthodontics. In addition to all staff within the examinations department and all examiners, we are particularly indebted to the Faculty Board of Examiners Chairs Andrew Eder and Charlotte Eckhardt; and the Lead Examiners Paula Ng, Phil Tomson, Mark Ide, Andrew Paterson and Jadbinder Seehra for the restorative and orthodontic examinations, respectively.

The respective examination teams for both of these dental specialty assessments have worked tirelessly over the last few weeks to organise