

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

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<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

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<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 GPs 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

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<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

and deliver robust and fair revised-format diets for these two cohorts of specialty trainees. In line with the recent General Dental Council statement relating to dental specialty training,¹ the mode of delivery for these examinations has been successfully adapted to an entirely remote format. This has meant that career progression has not been significantly delayed for these trainees, but they have been able to undertake their formal assessments in a safe and responsible manner in relation to the needs of maintaining appropriate social distancing during a period of increasing COVID-19 spread within the United Kingdom population.

M. Cobourne, M. Garrett, London; N. Cross, A. I. Edwards, Glasgow, UK

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<https://doi.org/10.1038/s41415-020-2360-6>

Postgraduate periodontal education

Sir, the pandemic has forced dental institutions to change approaches to teaching undergraduate dental students and postgraduate residents (PGR). With great interest we have read recent letters and publications in the *BDJ*^{1,2} and elsewhere that outline the approaches our European colleagues have taken. In this letter, we would like to describe our approaches to modify

postgraduate periodontal training at the University of Texas Health Science Center at Houston (Houston, TX, USA) in response to substantial interruptions in didactic and clinical training.

First, we identified our immediate goals:

1. To evaluate the existing curricula and reorganise them by adopting the Commission on Dental Accreditation (CODA) compliance protocols on the interruption of education and distance education to allow for a continuation of the PGRs' hands-on and didactic learning
2. To calibrate all full- and part-time periodontal faculty
3. To transition the residents through their respective clinical curricula
4. To provide feedback on the residents' surgical skills.

Once these goals were met, we aimed to implement the following sessions to allow for the transition of PGRs through the updated curricula:

1. Case-based classroom videos from the American Academy of Periodontology (AAP) and webinars allowed residents to enhance their didactic knowledge on clinical techniques
2. Clinical case presentations through online sessions allowed continued PGRs' feedback to enhance their presentation and treatment planning skills as well as surgical techniques
3. Sessions with invited speakers allowed PGRs to learn clinical management with the experts in the field and receive constructive feedback

4. Collaborative seminars in surgical, prosthetic and restorative dentistry with the Department of Periodontics at the University of Illinois at Chicago allowed PGRs to get exposed to world-class periodontists and dental implantologists and ask one-on-one questions
5. Suturing training modules allowed PGRs to practise suturing at home and learn indications of various techniques
6. Virtual sedation cases were utilised to accomplish PGRs' sedation competencies
7. Mock periodontal oral board sessions allowed PGRs to prepare for the AAP specialty board examination and fulfil temporary CODA requirements in certain competencies
8. As laboratory research activities were suspended, PGRs were asked to work towards their Master's thesis writing and analysis of the existing data.

Despite facing changes in a teaching format, especially in clinical training, our approaches, including the use of online portals and modules, maintained and enhanced PGRs' hands-on and didactic experiences. We expect to implement these new teaching approaches in future curricula.

K. Parsegian, N. Angelov, S. Ayilavarapu, Houston, Texas, USA

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Oral research

Scientific rigour

Sir, I read with interest the paper by Sampson *et al.*¹ regarding a possible link between the severity of SARS-CoV-2 infections and oral hygiene. Their call for excellent oral hygiene as a strategy to potentially aid the prevention of bacterial superinfections in patients with SARS-CoV-2 infections is not in question here.

However, I draw attention to the interpretation of research findings by the authors, and would caution against reporting associations between COVID-19 symptoms and oral bacteria without the support of adequate data.

Of greatest concern, Sampson *et al.*¹ report that sequencing data indicate high reads for *Prevotella*, *Staphylococcus* and *Fusobacterium* in patients severely infected with SARS-CoV-2. The supporting data come from a letter by Chakraborty.² It is unclear in which publication this letter appears or whether it has been through a peer review process. In the letter, metagenomic sequencing data from five patients are presented.² No methods, including no source for the samples is given. This, along with a lack of data from healthy subjects, makes it impossible to draw any conclusions about the number of sequencing reads relating to these genera and any association with SARS-CoV-2 infection. These data can therefore not be used to associate

oral bacteria with severity of COVID-19 symptoms. Indeed, bacteria from the genus *Staphylococcus* and *Fusobacterium* dominate the nasopharyngeal microbiome of healthy individuals,³ and *Prevotella* and *Fusobacterium* dominate oropharyngeal communities.⁴

The authors also refer to Nagaoka *et al.*⁵ as evidence for a relationship between *Prevotella intermedia* and severe pneumonia. This is an *in vivo* study examining the effect of a bacterial supernatant on experimentally induced pneumonia in mice, and not an observed relationship in human subjects.

A global health crisis such as we are experiencing places huge pressure on health professionals and the research community in the rapid search for knowledge. Whilst