

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.

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Reference

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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.

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References

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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