

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

Food poverty

Sir, the topic of food poverty has featured heavily in the news recently. Many families and children are facing difficulties at this time due to the effects of the COVID-19 pandemic and additional pressures over the winter period. The government's previous decision not to supply food vouchers to disadvantaged children over the October school holidays limited many families' ability to opt for healthy food options and have a balanced diet.¹

As dental professionals we see the consequences of malnutrition including the effects of an increased risk of caries. We are also seeing an increased use of antibiotics to manage these consequences. Some paediatric patients are presenting with dental abscesses and facial swelling, but are unable to tolerate dental extractions in general practice. As mentioned in a letter to the editor by Robson,² the services providing extractions under sedation or general anaesthetic are limited and have long waiting lists, meaning that many children are being prescribed multiple courses of antibiotics. Addressing food poverty in children would not only improve overall health, but would align with the government's national strategy to reduce antimicrobial resistance.³

Eddie Crouch, Chair of the BDA recently joined others in signing a letter addressed to the Secretary of State for Education and the Parliamentary Under Secretary of State for Children and Families to call for 'funding to be extended to support vulnerable children during school holidays'.⁴ On 6 November, the government announced a plan to support vulnerable families with a support package, and an intention to support families throughout 2021.⁵

I would urge all dental professionals to

remember that we are in a fortunate position where we can act and promote positive changes to support families at a local level. In the current climate it is important, now more than ever, to work with families to advise on healthy food options, explain methods to prevent dental caries, and to identify those who need additional support accessing food.

S. Halsall, Liverpool, UK

References

1. Weale S, Adams R. Marcus Rashford in 'despair' as MPs reject free school meal plan. *The Guardian* 21 October 2020. Available at: <https://www.theguardian.com/education/2020/oct/21/marcus-rashford-in-despair-as-mps-reject-free-school-meal-plan> (accessed 6 November 2020).
2. Robson J. Duty to extract. *Br Dent J* 2020; **229**: 499.
3. Global and Public Health Group. 2019. Contained and controlled: The UK's 20-year vision for antimicrobial resistance. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/773065/uk-20-year-vision-for-antimicrobial-resistance.pdf (accessed November 2020).
4. Crouch E, Crowther B, Taylor A *et al*. Letter to Gavin Williamson. 5 November 2020. Available at: <https://bda.org/news-centre/press-releases/Documents/letter-to-gavin-williamson-healthy-food-vulnerable-children.pdf> (accessed November 2020).
5. Richardson H. Marcus Rashford welcomes school holiday support climbdown. *BBC News* 8 November 2020. Available at: <https://www.bbc.co.uk/news/education-54841316> (accessed 8 November 2020).

<https://doi.org/Missing DOI>

Teledentistry safeguards

Sir, since the global pandemic started teledentistry has been encouraged by many hospital trusts and dental practices. In the standard operating procedures for urgent dental care systems, it is encouraged to risk assess, triage and manage remotely via telephone or video link. It has also been hugely beneficial for patients and clinicians shielding, significantly reducing the number of people coming into care settings lessening the risk of COVID-19 transmission.

However, with many clinicians working

from home and on personal devices it raises the question: how does our duty of confidentiality extend to protecting patient data when carrying out remote teledentistry and triaging? Undoubtedly clinicians will be aware of their duty both ethically and legally to make sure that clinical data are kept safely and securely when in a dental practice or hospital setting. Despite this, many clinicians will be unaware of how this extends to the use of personal devices, potentially leaving patient data and records vulnerable.

This leads to our second question: if patient data and records are stolen what is the clinician's liability for this and to whom would they then report this? Clear guidelines are needed on how to protect patient data and what clinicians' duties and responsibilities are regarding this matter. For example, is there a minimum level of software that our devices should have installed or should we have separate and secure devices purely for work purposes? Such guidelines are of great importance to help maintain the trust between the public and the profession, much of which stems from the duty of patient confidentiality.

P. Menhadji, K. Oberai, London, UK

Dr Len D'Cruz, Head of BDA Indemnity responds: Thank you to Drs Menhadji and Oberai for raising these important questions. The GDC together with other healthcare regulators have recently published High level principles for good practice in remote consultations and prescribing.¹

This document makes it clear that patients can expect to have effective safeguards in place to protect them when they receive advice and treatment remotely. Safeguards are necessary whether the consultation happens as part of a continuing treating relationship or in a one-off interaction between a patient and a

healthcare professional. The same obligations apply to any notes made by the clinician that explain and justify the decisions made during the consultation, regardless of it being provided face to face or remotely. At all times, there is a need to keep the patients' information secure, whether the records are held on paper or electronically.² This is already a familiar requirement of the dental practice environment that is normally facilitated by the use of commercial practice management software.

Security in the practice might involve encryption or password protection for documents stored on or sent from a computer. Remote consultations conducted from a dentist's normal practice allows the clinician to securely update the patient's record at the time of the consultation. Working from a remote location might require the clinician to make written notes which are subsequently transferred to the patient's electronic record held on the practice server. Unless remote access to the practice server has been organised, any written notes will require safe storage and/or anonymisation until they can be transferred manually at a later date.

The variety of available practice management software in use and the design of surgery networks as well as choices for cloud storage, means that practice owners should take professional advice from commercial providers to review the systems employed in running their business to ensure that they meet the principles adopted by the GDC for good practice in remote consultations and prescribing.

The use of teledentistry and remote working has been accelerated by the current pandemic and is likely to have a role in the future provision of dental services. By embracing the modifications adopted to stop the spread of disease, we also help to future-proof the business of dentistry since it is unlikely that COVID-19 will be the last pandemic we will experience.

References

1. General Dental Council. High level principles for good practice in remote consultations and prescribing. Available at: <https://www.gdc-uk.org/docs/default-source/guidance-documents/high-level-principles-remote-consultations-and-prescribing.pdf> (accessed November 2020).
2. General Dental Council. Standards for the dental team (4.5). 30 September 2013. Available at: <https://standards.gdc-uk.org/Assets/pdf/Standards%20for%20the%20Dental%20Team.pdf> (accessed November 2020).

<https://doi.org/10.1038/s41415-020-2414-9>

A radiological conundrum



Fig. 1 Post-operative posterior-anterior (PA) mandible radiograph – nine months following bi-maxillary osteotomy and advancement genioplasty

Sir, a 19-year-old male patient was reviewed in our maxillofacial outpatient clinic nine months following a bi-maxillary osteotomy with advancement genioplasty. His only complaint was a clicking sensation below his nose, ongoing for one month. No abnormalities were found on clinical examination, along with a good result for facial profile and occlusion of teeth.

Although post-operative dental panoramic tomogram (DPT) and posterior-anterior mandible (PA mandible) radiographs had been taken the day after surgery, a repeat DPT and PA mandible were taken to assess the maxillofacial plating and bone to ensure fixation had remained adequate. As can be seen in Figure 1, a horizontal radiopaque line was detected in the Le Fort I osteotomy surgical site, traversing the mid-face titanium mini-plates. This abnormality was not

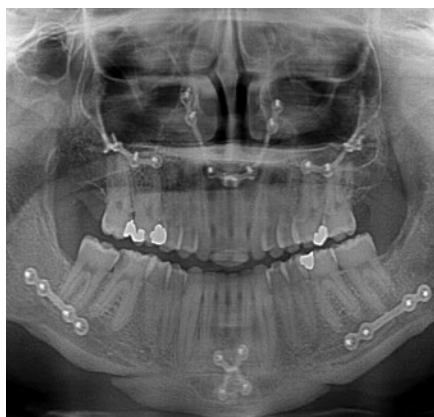


Fig. 2 Post-operative dental panoramic tomogram (DPT) – nine months following bi-maxillary osteotomy and advancement genioplasty

present in the DPT radiograph (Fig. 2), nor was it present in the initial post-operative DPT and PA mandible radiographs nine months before.

Initial differential diagnoses were:

- a) Retained 'Raytec X-ray detectable swab' in Le Fort I osteotomy site
- b) Orthodontic wire.

After due consideration, the attending clinician had an epiphany. It was confirmed that at this clinic appointment, when the patient attended the radiology department, he had been wearing a fluid resistant surgical face mask in an effort to adhere to hospital trust infection control policy, during the current COVID-19 pandemic. This face mask was worn for the PA mandible but not for the OPG radiograph. Figure 3 demonstrates the aluminium wire within the face mask, which allows adaptation around the nose and mid-face for better fit and seal. The artefact seen on the PA mandible (Fig. 1) was indeed this metal wire.



Fig. 3 Fluid resistant surgical face mask – demonstrating the aluminium metal wire extruded from its superior horizontal margin

I hope my letter raises awareness to colleagues regarding this radiographical COVID-19 conundrum so that they might prevent its recurrence by advising patients to remove their face mask before facial radiographs.

M. Watts, Exeter, UK

<https://doi.org/10.1038/s41415-020-2415-8>