Furthermore, colleagues who have failed fit-testing due to their anatomy may also be faced with a similar predicament where the local trust is unable to provide a respirator hood.

Clinical activities for such colleagues will be limited to non-aerosol generating procedures. For colleagues in surgical training pathways, eg dental core training or middle-grade staff, this presents a further frustration: the specialty job application for oral surgery may ask how many surgical procedures they have carried out, and assign a score based on this. Colleagues who find themselves in the aforementioned predicaments may be disadvantaged. Should this element of the application process be revised?

*I. Rehman, Glasgow, UK*

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## PPE consistency please

Sir, with regard to protection, since the beginning of the pandemic the UK Government has changed its *Infection prevention and control* guidance 37 times.[1] This easily leads to confusion within hospitals and can often result in individuals following their personal interpretation of the guidance.

We would like to highlight the need for ongoing vigilance and consistency by all members of the team. An example within our hospital operating theatre was noted where five clinicians, including anaesthetists, oral surgeons, nurses and students all wore differing levels and styles of personal protective equipment (PPE) whilst working on the same case. Ideally, PPE recommendations for each case should be covered at the team brief at the start of a list and repeated during the WHO checklist. Clarity from the start of the case is paramount to effective safe operating and reassures all personnel that they are adequately protected with the chosen PPE.

The Royal College of Surgeons stated online that members should not put themselves at risk due to inadequate PPE whilst also stating that the guidance to be followed should be based on each individual trust protocol.[2] This also leads to discrepancies with trainees often rotating around various hospitals. It now appears likely that managing the risk of COVID-19 will be a challenge for clinicians for the foreseeable future. We believe there is a need for consistency and ongoing education regarding PPE both at a national and local level to ensure safety of all members of the clinical team and patients.

*E. Thomas, D. Cunliffe, Torbay; O. Rees-Stoner, B. Collard, Plymouth, UK*

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https://doi.org/10.1038/s41415-020-2460-3

## Failure to attend or fear to attend?

Sir, I write from a district general hospital, reflecting on the rise in patients failing to attend appointments. Could it be that with increased awareness of COVID-19, patients have again become fearful of the risks associated with attending hospitals?

Where does the line get drawn between what can wait and what is necessary? Can a symptomatic tooth be left untreated until a severe abscess or swelling develops, requiring hospital admission? Can a two-week wait appointment go missed and a lesion only be investigated at the point it is more advanced and complex to treat? As clinicians it is far simpler to answer these questions, but we cannot expect the same difficult decisions to be made by our patients who are looking to us for advice in these times.

Recently, when questioning a patient presenting with a carcinoma of the lip on why they left this un-investigated for many months, the response we have become accustomed to hearing was given, 'COVID'. We want to encourage patients to feel comfortable attending their appointments, but how do we do this in a way that doesn't disregard the rising number of cases? What we can do is offer clear advice to our patients about precautions being implemented in healthcare settings, and what the patient themselves can do before the appointment.[1] With the majority of complaints stemming from poor communication, it is important that the message we send to patients is clear, informative and consistent, and one that does not instil fear but instead inspires confidence.[2]

*L. Smith, Torbay, UK*

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# Mental health

## Compromised wellbeing

Sir, my clinical supervisor shared with us earlier today that one of her patients broke down in tears in two consecutive appointments, due to major changes in the patient's life impacted by the COVID-19 pandemic. I learnt that the negative impact of the COVID-19 pandemic on mental health can be a lot more prevalent than we all like to think.

Undoubtedly, the impact of the COVID-19 pandemic is extensive on people's lives. It is possible that every one of us knows someone that has, or we ourselves have, suffered from bereavement, financial or unemployment worries, parenting challenges, domestic conflicts, a sense of loneliness, fear of uncertainty, or any other stressors that can compromise our mental wellbeing, at some point during the outbreak.

However, signs and symptoms of compromised mental wellbeing can be difficult to pick up under social distancing measures. As dental practitioners, we have the opportunity to meet colleagues and patients for face-to-face treatments, which put us in a unique position to recognise mental health problems. But the question is, where should we signpost them to?

Before referring someone to their GP or the NHS mental health service, remember, sometimes, all the individual needs is a good listener. It is therefore important to have appropriate information on alternative resources available and signpost accordingly. Specific tips and advice on different challenges faced during the COVID-19 pandemic can be accessed at https://www.mentalhealth.org.uk; a list of NHS-recommended helplines is available at https://www.nhs.uk/conditions/stress-anxiety-depression/mental-health-helplines/; and local helplines and mental health organisations should also be explored and utilised.

I hope we all stay physically and mentally healthy in these strange times.

*K. Chan, Belfast, UK*

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## Mental health training

Sir, the awareness of the importance of our mental health within the dental profession has increased recently, which is amazing and vital but this alone is not enough. We know dentistry is a stressful career and a challenging university course, and our mental health can be significantly affected. Also, being healthcare professionals, we have a duty of care to patients who could have a range of mental health diagnoses or who could present in a crisis – for example having suicidal thoughts.

This leads to the question: why aren't we undertaking regular mental health and suicide training? Mental Health First Aid courses are available which should be compulsory to complete alongside physical first aid and medical emergencies training.[1] *Zero Suicide Alliance* offers a free 20-minute training course on suicide awareness which highlights three key aspects: SEEing the signs of suicide; SAYing, speaking about suicide and whether someone has suicidal thoughts; and SIGNPOSTing people to the correct services, eg GP, Samaritans.[2]

If a colleague or patient is struggling with their mental health, we need to talk openly about suicide and whether they are having or have had suicidal thoughts. This can be difficult to do but is imperative to their safety and wellbeing. It does not 'put the idea into their head', but instead protects them and allows people to tell you how they feel.[3]

We need to urgently integrate this training into both the student curriculum and professional CPD cycles. Not only mental health training, but also thorough interactive equality and diversity training (eg by E&D UK),[4] since discrimination has a huge impact on mental health and is so prevalent in our society.

As we normalise talking about suicide, we should be using the correct terminology. For example, 'committed suicide' is a term that should be avoided as it implies it is a crime and adds to the stigma. Instead we can say 'died by suicide' or 'took their own life'.[5]

We must also question: why is there a barrier to dental professionals seeking help for their mental health? More attention is needed on mental health within the profession to save lives. If you need someone to talk to or are experiencing suicidal thoughts, call Samaritans on 116 123, who are available 24/7.

*K. Benson, Newcastle, UK*

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# Medical emergencies

## Three things

Sir, I write further to an article published in the *BDJ* on 25 September entitled *Management of odontogenic infections and sepsis: an update*.[1]

Firstly, while recommending incision placement, the authors mention making the same on healthy skin or mucosa. It would be important to include here that skin incisions must be made as aesthetically as possible, keeping them parallel to (or in) existing skin tension lines.[2] This would not only serve the purpose of the procedure but also enhance cosmetic outcomes.

The dimensions of the incision must allow for adequate access of the haemostat. An adequately sized incision enhances irrigation and avoids excessive build-up of pressure within the abscess cavity.[2]

Secondly, the authors recommend opening the haemostat 'at the depth of penetration'; a more specific way to ascertain this is to insert the haemostat till the resistance of healthy tissue is felt.[2] Apart from a microbiological swab, a syringe can also be utilised to obtain a sample of the drainage. This should ideally be sent for culture sensitivity testing (CST). The article describes dentists being guardians against antibiotic resistance, especially due to the fallout from the pandemic. This makes recommending CST even more important in cases where the abscess has clinically worsened in follow up appointments and antibiotic treatment is necessitated.

Thirdly, the authors have also mentioned wrong antibiotic choice and/or dosage as a cause for treatment failure. Utilising CST would help to circumvent this and move away from protracted empirical regimens and their associated issues.

Finally, the authors make the correct suggestion of never closing a haemostat while it is inside the wound. It would be informative for readers to know that the reason behind this is to avoid damaging any vital structures in the vicinity. Knowing the reason and its gravity would serve to underscore such a suggestion.

*V. Sahni, New Delhi, India*

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## Sepsis and COPD

Sir, I write further to the excellent poster: *Medical emergencies in the dental practice*.[1]

With medical emergencies the risk of mortality multiplies with co-morbidities, especially so in managing sepsis, when organ dysfunction follows the deregulated response to infection.[2] Undoubtedly in patients with both sepsis and COPD (chronic obstructive pulmonary disease) time management is critical.

Such patients demonstrate greater risks of acute exacerbation, pneumonia and mortality compared to those with one condition.[3] While a single Red Flag Sign triggers blue light transfer, one sign: *Needs oxygen to keep Sp $O_2$ 92% (88% in COPD)* is noteworthy when managing the patient at risk of sepsis, but who has COPD. Discussion with the authors revealed the following:

1. The Sepsis Trust Screening Tool follows NICE Guideline NG51 (1.4.2): high sepsis risk follows the need to maintain oxygen saturations more than 92% or more than 88% where COPD is known.[4] This guideline is followed for medical but not dental practices, where $SpO_2$ is to be kept at specific saturation levels[1]
2. With sepsis and COPD, pragmatic rather than dogmatic approaches are vital, the oxygen dissociation curve shifts left, partial oxygen pressure decreases and haemoglobin's oxygen binding increases.