Orthodontic brackets for dental trauma

Sir, we wish to highlight the recommendations from the Royal College of Surgeons of England regarding the management of dental trauma during the COVID-19 pandemic.[1] The usage of orthodontic brackets and modules in the management of dental trauma have previously been proven to be effective.[2] The usage of brackets and wire splints by clinicians may eliminate the need for an AGP as brackets can be removed without the usage of a high speed handpiece.[1,2]

As the capacity of AGPs carried out generally in both primary and secondary care have been greatly reduced, there is also a build-up of patients awaiting treatment in primary care leading to difficulties in accessing primary care. As such, patients often end up in the emergency department (ED) of a hospital, are seen by oral and maxillofacial senior house officers and require follow-up appointments for splint/bracket removal to reduce the risk of ankylosis of the traumatised dentition. With limited access to a clinical assistant and the facilities found in the dental department, it can be a challenging procedure to perform and therefore the competence of the clinician is key.

Whilst such patients commonly present to an ED they may also be readily managed in primary care. For these reasons it may be beneficial for general dental practitioners to attend CPD or refresher courses where appropriate. Ideally, the undergraduate curriculum should also be tailored to ensure this specific clinical skill is being appropriately taught. Students can practise these procedural skills in a suitable facility, as a minimum to ensure confidence and competence upon graduation. With the current surge in COVID-19 and the emergence of a new phase in dentistry, we must ensure the next generation of dentists are well equipped with the change in times.

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Dental education

What matters to you?

Sir, I read with interest Apelian *et al.*'s recently published article *Is the dental profession ready for person-centred care?*[1] Their qualitative study of 11 dentists practising in Quebec Province, Canada found that most of the sample, regardless of their years in practice (3–21 years' service) expressed difficulty with eliciting patient stories, as well as a lack of interest in or an uncomfortableness with the rich narrative data being shared with them. The 'messy' lives of their patients were framed as an 'inconvenience' for dentists who merely wanted to fix their teeth.

These findings confirm the worst about dental education, the persistence of the biomedical approach and the prioritising of technical proficiencies and clinical competencies at the expense of advocating for a model of oral health that is socially determined and where oral care is interactional, dialogical and holistic. While the authors acknowledge the shortcomings of this model and its negative legacy on patient-dentist relationships and the profession, they throw down the gauntlet to dental education to rectify this predicament.

Social and behavioural scientists, like myself, working in dental education feel both the responsibility of such a task as well as the impossibility of it. From our interactions with students to timetable schedulers and curriculum designers we encounter individual and institutional resistance in the guise of a 'hidden curriculum' about the behavioural and social sciences as applied to dentistry.[2] Here in the UK, the GDC acknowledges the role played by the behavioural and social sciences in the undergraduate curriculum.[3] Nevertheless, we are still waiting for the trickle-down effect to take hold and transform dental education at an institutional level.

In answer to both these dilemmas, 'how can dentists be more patient centred?' and 'how can dental education be more holistic?' – I offer the same four words – 'what matters to you?'

When asked of patients, research confirms that this open question facilitates a dialogue between patient and dentist where mutual respect and understanding about the needs, preferences, expectations and values of each party can emerge and grow.[4] When asked of dental educators and dental schools, the question 'what matters to you?' forces us to contemplate what is dental education for? Whom does it serve? Where is the patient in all our deliberations? Clarifying our curricular priorities in such a way can help us begin the process of paradigm shift and curricular transformation.

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Endodontics

Tips for odontogenic infections

Sir, we write further to the paper on the management of odontogenic infections and sepsis.[1] We totally agree that early recognition and prompt management of sepsis improves outcomes. As mentioned in the paper, there is a strong belief that once the abscess is formed, surgical drainage is mandatory to achieve resolution. We would like to draw attention to a few additional considerations in managing such situations, which are as follows:

1. Regarding elimination of the source of the infection, if the cause of infection is odontogenic and there is a possibility of saving the tooth, initiation of root canal treatment (RCT) with drainage of the abscess through the canal using copious amount of saline irrigation should be used before incision and drainage is attempted
2. If drainage of the abscess through the root canal is difficult, a sterile #10 or #15 K file can be used for slight over instrumentation beyond the apical constriction. This helps in achieving

apical patency which aids in drainage of the abscess through the canal.[2] A considerable amount of time should be given for this procedure. Once the abscess is drained, root canal therapy can be continued or if time is a constraint, a closed dressing should be given, and the patient recalled after 24 hours for review and continuation of the RCT

3. Thorough root canal debridement during the first session is vital for minimising the possibility for spread of infection in addition to incision and drainage of the abscess.[3]

In our clinical experience of over ten years in managing odontogenic infection and sepsis, initiation of RCT with drainage through the canal is effective in reducing patients' pain, swelling and minimising the risk of spread of infection to tissue spaces.

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Hypochlorite injuries

Sir, a 50-year-old female presented on 29 November 2019 complaining of tenderness in her right cheek area, reduced sensation at the right corner of her lips and a dent in her cheek. It transpired that during second stage root canal treatment at 14 on 12 December 2018 a hypochlorite injury occurred. The notes of the treating dentist report that a radiograph revealed the working length to be too short and length was increased, and that on the final irrigation with hypochlorite the patient complained of pain. The procedure was stopped, the patient was asked to rinse with distilled water and the root canals were flushed with distilled water. The patient was informed of the incident and advised to take ibuprofen. When she left the surgery she was not in any pain. A radiograph did not show any evidence of lateral perforation or excessive apical preparation.

The patient contacted the practice later that day to say that the swelling had increased, she had called 111 and been advised to attend hospital whereupon she was given antibiotics and an appointment with an oral and maxillofacial surgeon who prescribed further antibiotics, and later, prednisolone. The patient was having difficulty with drooling due to reduced sensation, had a hard lump adjacent to 14 and an area of fat atrophy.

The soft tissue defect and area of reduced sensation one year following the hypochlorite injury are shown in Figure 1. The patient is considering surgery of fillers for the soft tissue defect.

Suggested strategies to reduce the damage of hypochlorite injuries include:[1,2]

- Immediate and copious irrigation with saline or water for 15 minutes
- Ice pack compression for 24 hours followed by warm compress for 24 hours
- Analgesics to manage pain
- Antibiotics to prevent secondary infection
- Consideration of steroid therapy for severe injuries (with referral as required).

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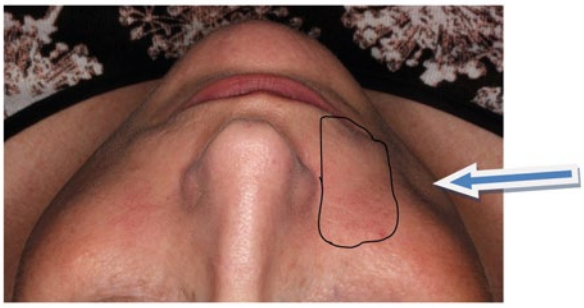

Fig. 1 The soft tissue defect and area of reduced sensation one year following hypochlorite injury

OMFS

East Grinstead and Whanau

Sir, East Grinstead remains synonymous with one of New Zealand's most famous sons, Sir Archibald McIndoe: the father of plastic and reconstructive jaw surgery. A statue commemorating his pioneering work that surgically, psychologically then socially rehabilitated his patients stands at the end of a high street in the town that did not stare at those profoundly disfigured by their injuries.

That was another conflict and today much has been written about the sacrifices made then and those being made now on the frontline of the pandemic. Nevertheless, from McIndoe's time till today, men and women still stand on another frontline. Sgt Matt Ratana of the Metropolitan Police was on that front line and a few weeks short of retirement, following a long and illustrious career, he fell in the line of duty, serving and protecting all of us. He was also the head coach at East Grinstead, mentoring youngsters away from harmful influences guiding them towards their full potentials through rugby.

It was a fitting and poignant tribute that Matt Ratana from New Zealand should receive an air salute with a fly past over East Grinstead. An aircraft trailing an unbroken line of blue smoke flew over the rugby pitches then ascended to draw a white heart in the same blue sky that McIndoe's patients flew, fought and secured our freedoms in all those years ago.

The East Grinstead Rugby Club and Metropolitan Police are establishing foundations perpetuating his legacy of *Whanau* (pronounced far-now) – the Maori word for: family, health and connection – to guide youngsters, so they don't become lost and to build successful futures using sport in general and rugby in particular. Many youngsters attend at their dentists, requesting gum shields for sport and there are three things we may consider apposite in these circumstances:

1. Family: taking an interest in the young patient, making a note in their dental records of their aspirations and achievements, thus ensuring an approach to care that is holistic
2. Health: providing gum shields at a cost so profit is not a barrier to providing protection
3. Connection: consideration towards making a donation from each gum shield to the Matt Ratana foundation; a small