COMMENT

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

OHE for spread prevention

Sir, there is increasing evidence that a number of retail mouthwashes and dentifrices can inactivate the SARS-CoV-2 coronavirus. It has been suggested that these products could potentially be an adjunct to other measures which the public have been advised to adopt to reduce transmission of the virus.

Given the safety, ubiquity and high levels of use of such products by the public, there would appear to be no significant downside risk associated with pre-empting the outcome of ongoing research in this area, and advocating that those travelling on public transport, visiting high street businesses and those making bubble visits perform thorough oral hygiene procedures beforehand and as close to the time of contact with others as practical.

Given the primacy and experience of the dental profession in communicating dental health education to the public and its potential capacity to do so directly with patients, there would appear to be an argument for assessing the potential for the profession to convey government-supported advice, directly to patients, electronically.

P. V. McCrory, Stockport, UK

https://doi.org/ 10.1038/s41415-021-2605-z

Informed consent

Sir, COVID-19 has had a significant impact on the consent processes amid the current pandemic. As one of the primary care oral surgery service providers within the region, we swiftly updated our consent process for all outpatient oral surgical procedures under local anaesthesia with or without conscious sedation. The current consent process includes the 'material risk' of becoming infected with coronavirus as patients attend for treatment and possible effects on post-operative recovery. We are confident that the risk of contracting COVID-19 while attending a surgical appointment is significantly reduced by patient risk assessment, the use of personal protective equipment, meticulous infection prevention and control measures, and strict adherence to the relevant standard operating procedure. We still could not neglect the COVID-19 risk, albeit negligible. We are obliged to inform the patients about the risk of 'COVID-19 complications' based on the Montgomery ruling.

We therefore added 'COVID-19 complications' as one of the risks in our consent form. This has also given us the opportunity to re-audit our consent process within primary care oral surgery service amid the pandemic. To date, all patients assessed and treated were not averse to being informed of the possible risk of 'COVID-19 complications'; in fact, some expressed their gratitude.

J. Liew, M. Winston, Sheffield, UK

https://doi.org/10.1038/s41415-021-2614-y

Oral side effects of COVID-19 vaccine

Sir, vaccine hesitancy (VH) is an emerging public health challenge nourished by misinformation. Last year, a national cross-sectional survey-based study found out that aversion to the potential side effects of vaccines was the most frequent cause for VH among population groups in the UK.[1] The oral side effects following the administration of vaccines like polio and diphtheria were inconsistently reported with a low level of confidence; they have never been reported independently, eg they emerged typically in conjunction with other dermatologic and systemic symptoms.[2] The oral side effects of non-orally administered vaccines including influenza vaccine are extremely rare. By looking up grey literature, I have found only one study where only three participants (9%) who received the influenza vaccine got oral side effects associated with flu-like symptoms, thus implying that no statistically significant relationship could be established.[3] Owing to the mass vaccination strategies of COVID-19, dentists among other clinical specialists are supposed to provide care to the recently vaccinated patients – at this moment, Hill's criteria of causal inference and rigorous anamnestic recording should be strictly followed before jumping to irrelevant conclusions.

A. Riad, Brno, Czech Republic

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https://doi.org/10.1038/s41415-021-2615-x

MRONJ and COVID-19 caution

Sir, of late, monoclonal antibodies including tocilizumab and sarilumab have been utilised in the treatment of COVID-19. Both drugs were used in more than 3,900 COVID-19 cases in 15 countries worldwide, with encouraging results.[1] A randomised controlled trial reported a significant difference in mortality rate between the group receiving tocilizumab (28%) or sarilumab (22%) compared to those receiving standard care (35.8%).[1,2] Both act against interleukin-6 receptors and are commonly used in the treatment of rheumatoid

arthritis. There has also been some evidence to associate tocilizumab with medication-related osteonecrosis of the jaw (MRONJ).[3,4] While other monoclonal antibodies such as denosumab have been proven to be truly associated with MRONJ, we must take into account the potential effects in relation to oral health. In light of this, readers should be aware of the increased use of tocilizumab and sarilumab, as they may encounter a higher number of patients requiring dental extractions with an increased risk of MRONJ in the future. Even though further studies are required, it is worth keeping this in mind as a possible impact of the pandemic.

A. Hasan, Birmingham, S. Alraisi, London, UK

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https://doi.org/10.1038/s41415-021-2616-9

Public vaccine distrust

Sir, I am surprised and concerned that, according to a report on the behavioural aspects of vaccine update and misinformation, published by the British Academy and Royal Society, around 36% of the UK population are either uncertain or unlikely to be vaccinated against COVID-19.[1]

Vaccinations are one of the most successful public health measures in history, preventing multiple diseases, hence saving millions of lives and also bringing about large-scale societal and economic benefits. For this to be successful, a community-level vaccine coverage of 80%+ for COVID-19 will be required.[1] Misinformation regarding the vaccine is driven by five key factors: distrust of science and selective use of expert authority, distrust in pharmaceutical companies and government, simplistic explanations, use of emotion and anecdotes to impact rational decision-making, and development of information bubbles and echo chambers. Behavioural factors include complacency (perception of risk, severity of disease), trust and confidence (efficacy, safety), convenience (barriers, access), sources of information and socio-demographic characteristics (eg education, sex, ethnicity, religion, post-vaccination behaviour).[2]

As healthcare professionals, our patients may come to us with questions regarding this new vaccine, and we must equip ourselves with the knowledge to answer these queries and put their minds at ease. We are trained to interpret scientific information, follow evidence-based research, and portray this information in an accessible and comprehensible way. Directing patients to reliable sources of information, such as the WHO website, which provides a 'mythbusters' page collating the main misinformation coronavirus messages, could be useful.[2] While personal opinion and choices cannot be overlooked, collectively, we can work towards dismantling misinformation and protecting public health.

E. Elleray, London, UK

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https://doi.org/10.1038/s41415-021-2617-8

Nominations sought

Sir, since last March, I know that so many dentists are stepping up and doing truly extraordinary things to ensure our patients receive the best possible care, and the profession is represented and supported during this COVID-19 pandemic. Over the last few months, I have also seen colleagues working long hours to give consistent evidence-based advice at this time of uncertainty, so we can protect our patients, staff, families and ourselves. These are truly unprecedented times for dentistry. In my long career, I have never seen our profession put under such unrelenting pressure for such a sustained period of time. I am proud of how brilliantly our profession has responded.

The BDA would like to ensure those dentists who are going above and beyond are recognised by their peers and by our Association, so I urge you to consider if you know of anyone, through your Branch or Section, your LDC or another professional group, to please nominate them for our BDA Honours and Awards this year.

The deadline for this year's round is 28 May. We are also keen to ensure younger dentists are recognised and our Joy Harrild Award seeks nominations for dentists up to ten years post-qualified; the deadline for this is 30 April. Details of how to nominate are on our website at bda.org/honours-awards. Please note that self-nominations are not accepted. I would like to thank all those who have worked so hard during these difficult times and also to let you know we are there to support you if you need us – find out how we can help at bda.org/stress.

R. McMullan, Chair, BDA Honours and Awards Committee, UK

https://doi.org/10.1038/s41415-021-2618-7

DHSC is not listening

Sir, on 8 June 2020, practices in the UK reopened after the lockdown precipitated by the pandemic. Since then, dentists have rejigged their practices at some expense to maintain full cross-infection control and social distancing in line with a series of standard operating procedure guidelines issued by the Department of Health and Social Care (DHSC). In time, output ramped up so that most practices are currently working at what they consider to be a safe speed commensurate with a safe environment, something around 20% of pre-COVID levels.

The profession was dismayed to learn in December 2020 that, as of 1 January 2021 and with only a few days' notice, the DHSC was demanding that output was to be increased to 45%. This figure would be accompanied by a return to the invidious UDA as a measure of output along with a complex set of bands which determined levels of clawback if targets were not reached.

Regrettably, the Department has not listened to and, in reality, has completely ignored the arguments of the GDPC that this target was untenable for a number of reasons, these being:

- Practices are currently working to capacity, taking into account high levels