professional lives being investigated by the General Dental Council.

May I draw your readers' attention to the network of support groups available to dentists with addiction in the UK:

- British Doctors & Dentists Group: www.bddg.org; Tel. 07850 125119
- British Doctors & Dentists Group – London: www.bddg-london.org; Tel. 07557 961512
- Dentists' Health Support Programme: www.dentistshealthsupporttrust.org; Tel. 020 7224 4671
- Sick Doctors Trust: www.sick-doctors-trust.co.uk; Tel. 0370 444 5163
- NHS Practitioner Health Support Programme: <https://www.practitionerhealth.nhs.uk>; Tel. 0300 0303 300.

Other groups can be found in the 'Other Organisation & Resources' section of www.bddg.org and www.bddg-london.org.

Help is available!

H. J. Breen, Great Dunmow, Essex

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<https://doi.org/10.1038/s41415-021-2672-1>

Deaneries' responsibilities

Sir, many dental core trainees have moved away from friends and family and often live on their own or with new people. I wonder whether deaneries should bear some responsibility for making sure that their trainees are coping and signposting them towards any help that is available. The deaneries are fully aware of the national recruitment element of jobs and that

some live miles from home as well as deal with the rest of life's stresses. I am incredibly grateful to be in a stable job, until September at least, but I think the deaneries need to consider the health and wellbeing of their trainees as part of their overall responsibilities.

L. Crowder, Glasgow, UK

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PVP-I in practice

Sir, I wish to report on the experience of the routine use of 0.5% povidone iodine (PVP-I) mouthwashes and nasal sprays in 6,000 consecutive dental patients, all of whom were notified of the need to use a mouthwash and nasal spray before dental treatment and of possible exclusions on the grounds of a history of allergy to iodine. Three patients were excluded.

The mouthwash was taken in the prescribed manner; held and moved round the mouth for 60 seconds and spat out into a plastic beaker. All patients consented to use of the mouthwash. There were no complaints of taste or procedure and no reports of any adverse reactions. All staff felt more relaxed about providing dental treatment with patients using such an effective antiviral mouthwash. We understand that research is being undertaken to determine the duration of the virucidal activity in the mouth, with preliminary indications that this might be up to two hours. If safety rather than effectiveness is the reason that august UK bodies have not yet enthusiastically endorsed the use of pre-operative mouthwashes, we hope that information from practice may help.

P. Davis, Tavistock, UK

<https://doi.org/10.1038/s41415-021-2674-z>

Suicide prevention

Sir, I have found an increase in patients disclosing to me how COVID-19 has affected their lives, hearing many harrowing tales of loss of husbands, jobs and houses. Further to this, an article recently published in the *BMJ* reported the potential increase of suicide rates from 1% to 145%, due to the surrounding effects of COVID-19.¹

As a newly qualified dentist in foundation training, I felt that not enough emphasis has been put on suicide prevention. As dental professionals, we need to be acutely aware of early warning signs and risks of suicide. As we create a rapport with our patients and see some patients regularly, it may be easier for us to note changes in patterns of behaviour. Now more than ever, this knowledge on suicide prevention could be invaluable to us and our communities.

Due to the unique current circumstances, we may be the only source of human interaction that some patients have, possibly being the only medical professionals they have seen face-to-face for some time. I suggest that all dentists during this time should undertake additional CPD on suicide prevention. Knowing what signs to look for and how to manage the situation effectively will better equip us to protect our patients' mental and physical wellbeing. Understanding suicide and its risk factors could potentially save a life.

A. Osman, London, UK

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<https://doi.org/10.1038/s41415-021-2675-y>

Antibiotic resistance

Dental antimicrobial stewardship

Sir, I am delighted to see the launch of the white paper, *The essential role of the dental team in reducing antibiotic resistance*, by the FDI World Dental Federation during the World Antimicrobial Awareness Week in November 2020. This white paper is supported by an online library of resources and accompanied by a massive open online course.¹

Concurrently, the Belgian Health Care Knowledge Centre also published *Guideline on the prudent prescription of antibiotics in the dental office*. This clinical practice guideline

provides evidence-based recommendations for the prudent use of antibiotics in 12 situations frequently encountered in the dental surgery. The main objective of this guideline is to reduce the non-prudent prescription of antibiotics by dentists (and to a lesser extent by general practitioners) and ultimately to reduce antibacterial resistance. Another objective of this guideline is to reduce the variability in clinical practice and to improve the communication between care providers and patients (eg to explain why antibiotics are not indicated in certain situations).²

In 2019, amoxicillin and phenoxymethylpenicillin (penicillin V)

accounted for 68% and 0.4% of antibiotics prescribed in primary dental care, respectively, in Scotland.³ Penicillin V has a narrower spectrum of antimicrobial activity than amoxicillin, but has equivalent efficacy and clinical outcomes in acute dento-alveolar infections. Limiting unintended consequences of antimicrobial use is a key principle of antimicrobial stewardship, and since amoxicillin has a broader spectrum of activity than penicillin V, it has a greater impact on selection of resistance in the host micro-flora. Following an extensive period of research and consultation, the Scottish Antimicrobial Prescribing Group and its dental subgroup have

advised that, when antibiotics are unavoidable, then penicillin V should be recommended as first line in acute dento-alveolar infections.

There is also no evidence to suggest that addition of a second antibiotic, such as metronidazole, improves clinical outcome.⁴

C. A. Yeung, Bothwell, UK

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<https://doi.org/10.1038/s41415-021-2676-x>

Community healthcare

Training with pharmacists

Sir, having recently met a community pharmacy colleague who had asked advice regarding dental trauma a customer had experienced, it made me consider: how much of a relationship exists between community pharmacists and dentists?

Pharmacy staff are well trained, with a wide variety of professional development; however, speaking to this colleague, it seems their knowledge of dealing with dental trauma is very limited. With the easy (and affordable) access to pharmacies, especially considering current restrictions, it would surely be beneficial to us all to engage in some sort of training together. It would allow pharmacy staff to confidently provide accurate advice, which would only serve to help dentists in their treatment and follow-up of these cases.

This particular colleague is a very experienced pharmacist, but revealed much of her dental knowledge is based on her own experience as a parent dealing with dental issues.

Both pharmacies and dentists play a key role in community healthcare; is it time we learn to sing from the same hymn sheet?

C. Murphy, Cork, Ireland

<https://doi.org/10.1038/s41415-021-2680-1>

Paediatric dentistry

Lip-tie

Sir, I write further to the letter 'Tongue-tied' published on 27 November 2020¹ and point out that tongue-tie corrections are performed not only in neonates but across all age groups.²

There does, however, seem to be some debate on the term 'lip-tie' (which refers to the maxillary frenum) and how this may affect breastfeeding among other problems.³ Classification systems of maxillary frenum attachment rely more on anatomy rather than function, whereas rendering treatment seems to revolve more around the symptoms such as improper 'latch' of the newborn on to the breast, dental caries, diastema, interference with maintenance of oral hygiene, failure of trauma to the area to heal and situations wherein the lip may get caught between the upper central incisors.²

It is acknowledged that performing an upper lip-tie 'correction' without addressing the tongue-tie would be treating the symptom rather than the cause in certain cases.³ With there being no NICE guidelines on upper lip-ties or the association of tongue-tie, practitioners acknowledge the role of dentists as being the go-to professionals as far as opinions on upper lip-ties are concerned.³ It would hence be relevant for dental practitioners to realise the importance of their role in diagnosing, advising and managing such conditions and even taking the lead in advising the public on such matters.

V. Sahni, New Delhi, India

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Boarding school 'guardians'

Sir, I write to increase awareness within the dental community of the guardianship service for international students at UK boarding schools, and the challenges this can present to clinicians in gaining consent for emergency and elective dental treatment.

Prior to the pandemic, I had an interesting and novel situation present during my foundation training year in a Somerset general dental practice. Two international students at a local boarding school presented to the surgery

accompanied by their 'guardian.' One of the students required extensive dental treatment to the primary dentition and I was unsure regarding the legal status of the guardianship service, and therefore endeavoured to learn more about their role.

Guardians are registered individuals or families who provide 24-hour emergency assistance for students, arrange safe travel within the UK and host students during shorter term breaks and exeat.¹ The Association for the Education and Guardianship of International Students (AEGIS) provided me with a commonly included clause in an example contract between parents and guardians relating to emergency medical and dental care which states that, where parents cannot be contacted, they consent to emergency treatment under local or general anaesthetic for their child if deemed necessary by a qualified doctor for the child's safety and wellbeing under the National Health Service or privately if necessary.²

I contacted my indemnity organisation regarding the case and was still advised to seek parental consent for treatment in alternative formats which I was able to obtain over the phone and via email correspondence (albeit difficult due to differing time zones).

G. Hallett, Bath, UK

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<https://doi.org/10.1038/s41415-021-2682-z>

Newton's lore

Sir, I am writing to share a valuable trick I learned from Professor Tim Newton (with permission) on the management of administering anaesthetic to paediatric patients. He shared his technique of 'showing the child the needle.' This thought surely

Fig. 1 Elephant and chicken glove animals