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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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

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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

brings shivers to many practitioners. However, with a pair of gloves and a simple trick, it can help alleviate nerves, desensitise young patients and has improved my success rate in administering local anaesthesia in children.

Firstly, the child chooses whether they would prefer a chicken or an elephant. Both animals are made by inflating a glove, with the air spray, and tying the end (Fig. 1). If the child chooses an elephant, the index and middle finger and the ring finger and little finger of the inflated glove should be tied together. This forms two pairs of legs and a thumb as a trunk (pictured). A quick line and a dot (with a bit of imagination) represent a mouth and an eye!

The child should then be asked: 'if I place this [syringe] into the chicken or elephant, what do you think will happen?' Usually they will answer with 'it will pop!' If the needle is inserted gently, it slides in and nothing happens. When it is removed, a tiny hole appears, which is not noticeable. This unexpected result allays the child's fear and helps reduce catastrophisation.

The use of topical anaesthetic prior to insertion of the needle removes the initial 'pinch'; in addition, anaesthetic delivered slowly reduces tearing of tissues and painful stimuli. I liken the liquid to Queen Elsa's magic powers or Frozone's ice powers from Disney's *Frozen* and *The Incredibles* movies. This allows the child to relate to the procedure and accept that it will be painless. I hope readers will give it a try!

I. George, Bristol, UK

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Teledentistry

Further safeguards

Sir, I write in response to the letter 'Teledentistry safeguards'.¹ On searching for established guidelines for the same, it was seen that very few regulatory bodies had addressed this issue. The Royal College of Dental Surgeons of Ontario has laid down some guidelines on their COVID-19-dedicated page that would be particularly useful if implemented by regulatory bodies; these include:²

- If the need arises to prescribe medication, then audio-video technology must be used to accumulate adequate information before any medicines are prescribed
- Patients' personal health information must be secured and confidential by using

technology compliant with the Personal Health Information Protection Act, 2004

- The technology in use must ensure that only the dentists and the patients have access to their individual health-related information. If possible, the dentist must ensure that the service provider complies with the privacy requirements
- Teledentistry appointments must be conducted in private chambers to ensure that the patient information remains secure
- Records of virtual appointments must be maintained following similar guidelines set by the college for physical records
- Virtual appointments must be monitored and evaluated on a regular basis to ensure that these are conducted according to the laid-down professional regulations.

A. Marya, A. Venugopal,
Phnom Penh, Cambodia

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Dental radiography

Making the grade

Sir, since 2001 and the publication of *Guidance notes for dental practitioners on the safe use of x-ray equipment*¹ by the National Radiological Protection Board (NRPB), the recommended method for assessing quality of radiographic imaging has been via a three-grade NRPB system: grade 1 – 'excellent', grade 2 – 'diagnostically acceptable' and grade 3 – 'unacceptable'. This guidance was recently withdrawn in October 2020 and replaced with an updated second edition which is free

to view and download from the Faculty of General Dental Practice (FGDP) website.²

The chief aim of dental radiography is to produce an image of adequate quality for diagnostic purposes, while minimising patient dose as far as reasonably possible.³ Measuring the quality of radiographs compared with NRPB guidelines is a common clinical audit performed across primary and secondary care, and is a useful tool to help improve personal practice or check if the required standard is being met.³ Public Health England (PHE) previously recommend certain targets; eg >70% grade 1 and <10% grade 3.³

A move away from traditional film-based imaging towards digital imaging systems has removed the need for chemical processing, a major source of reduced image quality.² As such, the FGDP and PHE now recommend a two-point grading scale, where images are recorded as either 'diagnostically acceptable' ('A') or 'not acceptable' ('NA') (Table 1).²

An important point to note is the allowance for differentiation between digital and film imaging in the recommended targets when performing clinical audit. The new guidance details clearly defined elements of image quality analysis, quality assurance audits and image quality rating, of which all practitioners should be aware going forward.

R. Bird, Newcastle, C. Donnell, Sheffield, UK

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Table 1 Subjective image quality ratings of dental radiographs and CBCT images²

Quality rating	Basis	Target	
		Digital imaging	Film imaging
Diagnostically acceptable ('A')	No errors or minimal errors in either patient preparation, exposure, positioning, image (receptor) processing or image reconstruction and of sufficient image quality to answer the clinical question	Not less than 95%	Not less than 90%
Diagnostically <u>not</u> acceptable ('NA')	Errors in either patient preparation, exposure, positioning, image (receptor) processing or image reconstruction which render the image diagnostically unacceptable	Not greater than 5%	Not greater than 10%