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.

Dental tourism

Eagle-eyed Swiss

Sir, a patient arrived for a check-up today who I had seen as an emergency last summer when she had lost a veneer and the tooth was sensitive. I was limited as to what I did as at that stage I could not perform any AGP or even use air or water out of a syringe, so cemented it as best I could. She reported that it lasted a few weeks but then came off in a 25 metre swimming pool whilst on holiday in Switzerland. She was unable to find the veneer but reported it to the attendant at the pool. Amazingly she got a phone call six days later informing her it had been found and she subsequently had it recemented in Switzerland. Today it was still firmly in place some 20 weeks later. I share this story in admiration of the observation powers of Swiss pool attendants.

P. Williams, Lowestoft, UK

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South East Asia

Sir, over the past decade dental tourism has become an exceedingly popular phenomenon across South East Asia, in particular in countries such as Cambodia and Thailand.[1] It was popularised by individuals looking for dental care outside of their regional healthcare systems coupled with scenic holidays. In countries such as Cambodia treatment options for procedures such as implants, ceramic crowns etc are affordable without compromising on quality.

The pandemic has brought the entire world to a standstill with international travel almost non-existent, impacting dental tourism. In the year preceding the pandemic, global medical tourism was valued at US$44.8 billion and dental tourism formed a vital component.[2] Additionally, healthcare delivery shifted to emergency procedures. The financial impact to dental tourism has been dramatic as it is still not possible to predict when patients will be able to travel normally.[3] Dental clinics that were thriving on tourists seeking treatment in countries such as Cambodia, Thailand and Vietnam have been forced to reduce their staff for the foreseeable future. The effect seems more prominent in SE Asian countries where tourism is a major contributor to the national economy.

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

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3. Karobari M I, Marya A, Venugopal A, Nalabothu P, Parveen A, Noorani T Y. The state of orthodontic practice after the outbreak of COVID-19 in Southeast Asia: the current scenario and future recommendations. *Asia Pac J Public Health* 2020; **32:** 517-518.

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Coronavirus

A problem shared

Sir, thankfully our mental health and wellbeing has been recognised as equally important as our physical health and we are all encouraged to talk more. Do we need to talk to someone about how we are feeling, about our concerns and worries? Would it help to talk to another dentist or DCP? In matters of faith and work, would it help to talk to a Christian dental colleague?

There are many good listening and counselling services out there specifically for dentists and the dental profession to be recommended. In addition, the Christian Dental Fellowship (CDF) (cdf-uk.org) has a pastoral care scheme, provided by dentists and DCPs, and whilst we are not a professional counselling and listening service, we are happy to listen to and talk with any member of the dental profession about any matter, and signpost where appropriate to other services. Prayer is optional but we believe a problem or situation shared and prayed for is a powerful thing. Enquirers don't need to be a member to access the scheme and all enquiries are welcomed, dealt with in confidence and it is free to all.

The CDF is recognised as a faith group in the recently published *Wellbeing Support for the Dental Team* document.[1]

K. Paterson, CDF Pastoral Care Scheme Coordinator, Christian Dental Fellowship, UK

References

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https://doi.org/10.1038/s41415-021-2901-7

Public health

HIV – the forgotten virus?

Sir, I write further to the letter from J. Winterburn in relation to syphilis.[1] It is important that history taking should include the possibility of sexually transmitted infections (STIs), especially in relation to oral manifestations. As a recently graduated dentist it is surprising to find that HIV testing is not routinely requested when investigating lesions such as recurrent aphthous stomatitis (RAS).

Whilst investigations are routinely carried out to assess full blood count and the serum B12 levels, a request to identify the antigen p24, which is indicative for exposure to HIV, is not routinely made. However,