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.

Medical emergencies

Paediatric BLS

Sir, I am writing to you to stress the significance of child Basic Life Support (BLS). Throughout my undergraduate training, I felt a lot of emphasis was placed on adult BLS; however, childhood BLS was often rushed and not given the same importance. Although a cardiac arrest is less likely to occur in a child, it is still a critical, life-threatening event and dental professionals have a duty of care to ultimately save a life. I hope this letter outlines the key differences in delivering CPR to a child,¹ as opposed to an adult:

1. Shout for help. Call 999
2. Airway: head tilt, chin lift
3. Breathing: look, listen and feel for abnormal breathing. This is a vital sign of life so must be done for ten seconds
4. If the child is not breathing, deliver five initial rescue breaths. If available, use a bag-mask device or pocket mask
 - a. Infant: take a breath and cover the mouth and nose of the infant with your mouth to ensure you have a good seal. Blow into their mouth and nose over one second. You should see the chest rise
 - b. Child over one year: pinch the soft part of the nose closed with your index finger. Open the mouth a little, take a breath and place your lips around their mouth to ensure you have a good seal. Blow into their mouth over one second. You should see the chest rise
5. If there are still no signs of life, start chest compressions
 - a. Rate of 100–120/min
 - b. Compression to breaths ratio is 15:2 (unlike an adult which is 30:2)
 - c. Infant: use a two-finger technique. Compress the lower sternum with the tips of your two fingers by one-third of the depth of the infant's chest
 - d. Child over one year: use the heel of

one hand. Lift your fingers to avoid excess pressure to the child's ribs.

I would like to use this platform to be able to share my appreciation of anyone who has conducted BLS. Together, we can save lives.

S. H. Thakkar, London, UK

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<https://doi.org/10.1038/s41415-021-3332-1>

Special care dentistry

Vaccinating the vulnerable

Sir, in England, 3.7 million people have been identified as being clinically extremely vulnerable (CEV) to severe illness from the coronavirus (COVID-19): 96% of CEV people have had at least one dose of the vaccine (12% have had one dose and 84% have had both doses).¹

In May 2021, it was announced that Janssen's single-dose COVID-19 vaccine had been authorised by the Medicines and Healthcare products Regulatory Agency (MHRA) for use in the UK and that this vaccine would become available later this year. This vaccine has been shown to be 85% effective in preventing severe disease or hospitalisation and 67% effective overall in preventing COVID-19 infection.² This compares to the 52% (Pfizer),³ 70% (AstraZeneca)⁴ and 80% (Moderna)⁵ effectiveness after the first dose of other available vaccines.

Many of those who are CEV may be unable to tolerate vaccination whilst conscious due to complex behavioural needs. This raises the question as to whether NHS trusts should consider use of the Janssen single-dose vaccine for those who are CEV and unable to cooperate with vaccination whilst undergoing general anaesthetic procedures for other problems

(eg comprehensive dental care in special care dental patients). This would ensure that those who are most CEV receive protection against COVID-19 when they would otherwise be unable to do so and also avoids the need for administration of a second dose.

R. Sen, R. Kaur, London, UK

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<https://doi.org/10.1038/s41415-021-3337-9>

Dental radiography

An appreciation

Sir, I was very sad to read about the passing of Laetitia Brocklebank. We first met at Guy's Dental Hospital where she was a Registrar in Dental Radiology and I was a Lecturer in Oral Surgery. I remember Laetitia and her senior colleague Brian Beeching as being unfailingly helpful and courteous with the questions we brought to them.

We next crossed one another's path when she was Senior Lecturer at Glasgow Dental Hospital and I was a Consultant Orthodontist

in Ayrshire. I had recently lost my sister-in-law to ovarian cancer and I had become very suspicious of anything on dental radiographs which I could not positively identify. There are significant diagnoses to be made in orthodontic practice and I had recently identified a patient with Wegener's granulomatosis and another who had an osteochondroma of the mandibular condyle. For several months, she graciously and gently spent time with me discussing the films I had suspicions about until, with the passing of time, my acute anxieties subsided. It was a very kind, understanding and supportive thing to do and I was very grateful to her.

Laetitia Brocklebank is a loss to our profession and I shall miss her. I offer my condolences to her partner and her relatives, her friends and her colleagues.

R. Pilley, Ayr, UK

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Vocational training

A shot in the dark

Sir, as the 2020/21 national recruitment cycle ends and the 2021/22 cycle begins, we would like to discuss some key observations as to how the process could be improved.

For those unfamiliar with the current recruitment process, applicants sit a situational judgement test and, for dental core training (DCT) posts, an interview. They are then ranked off their score in both. This rank

determines the allocation of their training post against their preferences.^{1,2} The process of ranking these posts is long and tedious, with incoming foundation dentists having to rank over 900 individual training practices. Minimal information is given about the training practices, with many only providing a practice name, location and patient-facing website. Some posts provide a small summary as to what can be expected. For DCT, an average summary of each post consisted of 'OMFS post 12 months with/without on-call'. There is minimal description of what each post involves, what shift patterns are like and other trainees' thoughts on the post, making the ranking process feel like a shot in the dark at times. While Facebook groups exist to connect young professionals, such as 'Deciduous', it is not possible to ask about every available post. A practice website is patient-facing and not targeted towards trainees – you cannot tell what a place is like to work at from a CQC rating and list of available treatments. This makes it difficult to choose between posts.

To combat this, we suggest a review system completed by trainees that could be made visible to potential applicants, as well as a more detailed summary of each post including what to expect from the role, any special interests of the Educational Supervisor and other associates, as well as facilities within the practice. Trainees must already fill out an end of year survey about their year, so

adding questions as to whether they would recommend their practice and making their answers publishable would be a good way to ensure trainees are well informed as they are applying. This may help good rural units recruit more trainees and provide poorer-performing posts with feedback on what to improve. While new training practices will not have reviews provided by previous trainees, a detailed description of what to expect from the practice should aim to fill the gap so trainees are well informed about the practice.

Having the extra information available during the ranking process would help trainees make a more informed decision around their rankings. If a trainee did not get their first choice of post, having the extra information available to them would again allow them to be better informed during the upgrade process. It is a daunting process to sign up to a job in an unfamiliar environment based on a sentence and a person specification.

A. Mace, Foundation Dentist, M. Joll, Educational Supervisor, County Durham, UK

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CASE REPORT

Mouth cancer

Peri-implant squamous cell carcinoma

Sir, an asymptomatic 81-year-old woman was referred to our department (oral surgery) for assessment of a somewhat unusual radiographic pattern of peri-implantitis of the left mandible. On clinical examination, there was a significant increase of probing depth around the implants of the left mandible, with no other findings in the oral cavity or the neck. Panoramic radiograph revealed advanced bone resorption around three implants (Fig. 1). All mandibular implants had been placed 15 years ago. Ten years thereafter, the patient underwent surgery and adjuvant radiation therapy for squamous

cell carcinoma (SCC) of the left tongue. Since then, she had no recurrence and neither any complication with the implants (Fig. 2). A biopsy revealed SCC around the implants and the patient underwent segmental resection of the left mandible.

Malignancy in the vicinity of dental implants is a rare occurrence first described in 1996.¹ We now know that most patients

Fig. 1 Radiolucency seen around implants in the left mandible at the time of initial clinical examination

have been middle-aged or older, with a 2:1 ratio for men.² Roughly two-thirds have a previous history of malignancy.² Amongst published cases, there is a strong pattern of doctors' delay in terms of accurately diagnosing the malignancy, which is mainly due to the misleading radiographic

Fig. 2 Panoramic radiograph with no obvious findings that would raise any concern. Taken by the patient's GDP three years prior to the examination at our department