

I make no apology for not giving clear clinical instructions, because this is a discussion paper not a manual.

If he sees the paper as an attack on the re-organised approach, he is mistaken. In our paper, he will see that we encourage all dentists to pursue the sort of training that his and other academically based organisations provide. However, I would be interested to know if he feels that not following the guidelines that he gives will always give a poor result for the patient. Our starting point was the assumption that it probably does not, which may be upsetting for those of us who can find and record his RAP or our CR [ophs!].

If this non-orthodox re-organised approach is currently being adopted by some dentists when restoring the worn dentition, then I hope that our paper will encourage them to keep a very close eye on how the patient's articulatory, dental and periodontal systems are reacting to the occlusions that they are providing.

I am grateful for his observation that a dentist, who cannot find the jaw relationship of which we speak, is going to struggle to make a stabilisation splint and mount the models to do a mock equilibration. He is absolutely right. Maybe this will be the stimulus for that dentist to seek some help. Not ideal, but better than the dentist being unaware of the need, because the patient was not being carefully monitored.

I hesitate to contradict the President of such an esteemed society, but I think his last paragraph describes the re-organised approach by a specific means.

His comments are most welcome to the discussion that we hoped would arise.

<https://doi.org/10.1038/s41415-021-3532-8>

Coronavirus

COVID-19 and consent

Sir, the results of a local completed audit cycle in our oral and maxillofacial surgery (OMFS) department have raised some interesting points for discussion that I wish to share with the wider dental community.

Outpatient elective activity has gradually resumed since April 2020¹ and continues to take place in line with the latest Royal College of Surgeons COVID-19 safety guidelines.^{2,3} These guidelines state that the decision to bring vulnerable patients into a hospital or dental clinic environment during the COVID-19 recovery phase should be decided after careful consideration and discussion of the risks and benefits as part of informed consent.

In line with the Montgomery v Lanarkshire ruling,⁴ it is the opinion of the authors that the significant risk of contracting COVID-19 by attending hospital during the pandemic should be communicated to patients undergoing surgery.

A two-cycle departmental audit was conducted to identify if this risk was being communicated and documented by clinicians for patients undergoing OMFS procedures. The results of the first cycle and an education session were presented at a local clinical governance meeting. The audit was then repeated to assess any changes to practice.

The results showed an improvement for the inclusion of COVID-19 risk on written consent forms from 20% to 44%. The audit concluded that there is still scope for improvement in the department for consenting for COVID-19 infection and a further cycle will be considered for the new cohort of DCTs.

Presenting the audit revealed substantial differences in clinician opinion and raised questions on whether COVID-19 is indeed a material risk that should be included in the formal written consent process. Those who objected to including coronavirus as a

CASE REPORT

Emergency dentistry

Ingested not inhaled

Sir, a three-year-old boy presented to the Accident and Emergency Department with his mother. He had hit his face after colliding with another child in a fall that was witnessed by his parents. There was no loss of consciousness. Examination revealed traumatic dental injuries including an avulsed upper primary incisor (62) which was unaccounted for. In line with international guidelines,¹ a chest radiograph was requested and Figure 1 shows a radiopaque object projecting adjacent to the left aspect of the L4 vertebral body, crucially



Fig.1 A chest radiograph showing the avulsed 62 clearly visible to the left of the L4 vertebral body

indicating that the avulsed tooth had been ingested rather than inhaled.

We would like to emphasise that both the child and his parents were not aware, or perhaps in the case of the child, did not communicate that the tooth was swallowed during the sudden collision. This tooth could well have been inhaled. When considering that inhalation of foreign bodies in children has a 'lack of clinical manifestation' and is therefore often not diagnosed immediately, ensuring that the child has a chest radiograph undertaken is important.² A lack of intervention when a foreign body has been inhaled can have serious consequences.³ We appreciate, especially when based in primary care, that having this imaging undertaken via the local hospital can be a time-consuming process, but we urge colleagues to consider if this is clinically necessary for some patients presenting with traumatic dental injuries.

P. Radford, K. Corsar, Wakefield, UK

References

1. Day P F, Flores M T, O'Connell A C *et al*. International Association of Dental Traumatology guidelines for the management of traumatic dental injuries: 3. Injuries in the primary dentition. *Dent Traumatol* 2020; **36**: 343–359.
2. Singh H, Parakh A. Tracheobronchial foreign body aspiration in children. *Clin Pediatr* 2014; **53**: 415–419.
3. Holan G, Ram D. Aspiration of an avulsed primary incisor. A case report. *Int J Paediatr Dent* 2000; **10**: 150–152.

<https://doi.org/10.1038/s41415-021-3534-6>