

with poor venous access or medical contraindications, this is not a reasonable option.

Our introduction of IHS has allowed us to make good progress in treating these patients and reducing our GA waiting list. SDCEP recommends IHS as the preferred method of conscious sedation.<sup>1</sup> It is a safe technique with quick recovery time, and may help acclimatise patients to treatment and reduce anxiety. It also improves our consent process as it can be offered alongside local anaesthetic and GA. We are currently using this technique in both paediatric and adult cases, and have so far received excellent feedback.

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## Reference

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## Coronavirus

### SOP recovery transition

Sir, I refer to the recent publication C1461 issued by the Chief Dental Officer entitled 'Standard operating procedure: transition to recovery (a phased transition for dental practices towards the resumption of the full range of dental provision)'.<sup>1</sup>

The document advises that dichotomous division of all clinic attendees into two pathways, respiratory and non-respiratory, should be conducted prior to their management based on the initial screening for COVID-19. Introducing such additional tiers of screening and further confusion, as well as logistical issues, to an already complex problem, rather than administration of simple point of care (POC) antigen screening, is probably questionable. This is particularly the case when rapid, sensitive POC diagnostic tests for COVID-19 are already available which yield results within 60 seconds (*à la* British Airways).<sup>2</sup> These could be easily administered by the patient himself/herself prior to clinic attendance, particularly if exhibiting respiratory symptoms.

Another point of contention in the new document is the section on 'Staff at increased risk from COVID-19 and other respiratory infections' (pp 11) which

states that 'staff, including Black, Asian and Minority Ethnic (BAME) staff [...] should be risk assessed so that appropriate measures are put in place to minimise exposure to risk and support safe working.' This is a sweeping statement which is pejorative and unlikely to be evidence-based as far as the UK is concerned. Although emerging evidence suggest that the long-term consequences of COVID-19 may be severe for BAME groups, there are no data, to my knowledge, that such minority groups 'as a whole' are a higher COVID-19 infectious risk to the community than non-BAME groups.<sup>3</sup>

Perhaps these points should be noted for future editions, although the rapidly evolving dynamics of the disease, as we are currently witnessing, may render them open for further debate.

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## References

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3. Nafilyan V, Islam N, Mathur R *et al*. Ethnic differences in COVID-19 mortality during the first two waves of the Coronavirus pandemic: a nationwide cohort study of 29 million adults in England. *Eur J Epidemiol* 2021; **36**: 605–617.

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## OMFS

### Communicating communication

Sir, the risk of oro-antral communication (OAC) arising from maxillary extraction in dental practice is sufficiently remote that neither the symptoms nor signs of fluid and air passing from mouth to nose can be found in post-operative instructions routinely issued in either primary or secondary NHS dental care. However, the risk is not so vanishingly small that patients with OAC or epithelialisation leading to fistula formation (OAF) continue to be referred to dental school oral surgery departments in significant numbers.<sup>1</sup>

Notwithstanding the recognised OAC risks of advanced age, aberrant anatomy and antral proximity of roots, following lockdown, the transitional return to safe

practice carries additional risks for patients of: poor oral hygiene, chronic sinusitis and respiratory-tract infections, coupled with operator risks of skill-fade acquired from inactivity during COVID-19 closure. Undoubtedly, these increase the overall risk for OAC and OAF.

In the absence of post-operative OAC information, a telephone survey requesting post-operative advice from the 18 UK dental school oral surgery departments resulted in:

- Ten departments categorically refusing to give telephone advice (one refusal took 24 hours)
- From such refusals, one department transferred the call to an NHS medical advice line that confidently but incorrectly stated there was no communication risk from extraction
- Eight departments provided advice: four dental nurses (one male) and four female dentists delivered advice that was accurately supportive and reassured: emergency attendance if necessary
- In contrast to ten cold refusals, the sensitive, warm and empathic responses from those dental nurses and dentists taking their time (an average of eight minutes to respond) were incredibly touching, especially given their ages, range of experiences, qualifications and work pressure
- For either refusal or advice, there was no variation across the UK nations or London (with its three dental schools).

While both the significance and seriousness of OAC could engage the materiality in Montgomery, consent according to Mulholland is not an abstract exercise; it is formed within a clinical context.<sup>2</sup> However, if post-operative instructions fail to document the signs and symptoms of OAC, it may be difficult to prove consent (while actually obtained) was then effectively maintained. From these findings, during the transitional return to NHS dental practice, reliance on communication into the safety net of secondary care cannot be uniformly assured across the UK.

Regrettably, even with such communication failure, there is no regulatory disinclination from the GDC to draw adverse conclusions into the clinical conduct causing communication.