

of all restorative specialists participating in head and neck multidisciplinary teams, and cooperation for future projects beyond that, looks like a real possibility after all.

S. Schunemann, Plymouth, UK

References

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<https://doi.org/10.1038/s41415-021-3036-6>

Paediatric dentistry

Odontopaste contraindications

Sir, I write further to the letter *Ledermix in children*.¹ The authors write that Odontopaste shows no contraindication for use in children, however, the manufacturer does state that the product should not be utilised for patients with an allergy to clindamycin or lincomycin. It should also not be used for patients who are undergoing erythromycin therapy since the two drugs have been noted to demonstrate antagonism *in vitro*. Additionally, its use is not advised in patients presenting with a history of gastrointestinal illness, particularly that of colitis.² These contraindications/precautions all pertain to conditions and therapies in the paediatric population and dentists must be aware of these before incorporating this preparation into their practices.

V. Sahni, New Delhi, India

H. Al-Saffar and D. Dadnam respond:
Thank you for your response. To reiterate, the purpose of the letter was to highlight age as a contraindication to the use of Ledermix. Owing to the tetracycline component of the formulation, in accordance with British National Formulary and manufacturer recommendations, the use of Ledermix in paediatric patients, in line with UK national guidelines, would be unlicensed.

Our letter informs clinicians that Odontopaste provides a suitable alternative with no restrictions for use based on a patient's age. There are other contraindications for both Odontopaste and Ledermix, some of which you have stipulated in this response, however quoting all contraindications wasn't the remit of the original letter. We

would also recommend that every clinician consult manufacturer guidance for any contraindications before using any product.

References

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<https://doi.org/10.1038/s41415-021-3037-5>

Treatment planning

Temperature screening

Sir, temperature screening of patients (as well as staff) in dental settings was made part of the triaging process during the COVID-19 pandemic with variable outcomes. However, the use of thermometers to aid decision making and treatment planning in dentistry goes beyond COVID-19. The use of thermometers is recommended within SDCEP guidelines when assessing the systemic involvement of dental infections.¹ There is no reference to the type of thermometer that should be used within the SDCEP document, but there is plenty of literature on the accuracy of different types available. Tympanic infrared thermometers provide greater accuracy than non-contact types. Other types of thermometer that are more reliable are more invasive in nature and harder to disinfect, providing a difficult balance between accuracy and suitability within dentistry.

I hope this leads to those with thermometers for clinical use to review if they are fit for purpose, and to become familiar with the manufacturer guidelines to maximise accuracy for their purchased thermometers.

R. Botrugno, Cardiff, UK

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<https://doi.org/10.1038/s41415-021-3038-4>

Primary care

Suicide prevention training

Sir, I read the recent letters with real interest.^{1,2} As a general practitioner (GP), I concur that suicide prevention training is important for my dental colleagues, and equally important for my GP and other primary care colleagues. There is

unfortunately, presently a scarcity of well evaluated training programmes for GDPs and GPs to access, and this is concerning.

As clinicians on the frontline in primary care, the number of patients presenting to GDPs and GPs with mental health concerns and suicidal behaviours, particularly as a result of the psychosocial impact of COVID-19 on the public, may increase. There have been documented rises in suicidal thinking in young people early in COVID-19, which is worrying.³ Rates of self-harm recorded in primary care have, however, not exceeded expected annual levels through COVID-19 thus far, but there may be an unmet need which could soon show itself, particularly as we near some type of normality.⁴

There is an opportunity for early self-harm identification and intervention by GDPs and GPs which can prevent repeat self-harm and reduce suicide risk. This is crucial in the primary care response to suicide prevention. To achieve this, we urgently need to develop the suicide prevention evidence-base in both dental and general practice settings. Primary care networks have an important responsibility to incorporate community dental teams and prioritise evidence-informed suicide prevention training for GDPs and GPs, which if done alongside each other and perhaps remotely, would improve access, knowledge transfer, and shared learning.

F. Mughal, Keele, UK

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<https://doi.org/10.1038/s41415-021-3039-3>

Ethics

Hand to mouth?

Sir, I write with interest about the use of non-edible products that may indirectly influence the consumption of fizzy drinks or sugary sweets by psychologically making people think of them. Recently, I came across a 'Fizzy cola' flavoured handwash (Cien Kids Fizzy Cola Anti-Bacterial Handwash) which