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.

## CORONAVIRUS

### Testing the limits of UDCs

Sir, a 77-year-old male attended the Emergency Dental Clinic at the University Dental Hospital of Manchester (UDHM). The main complaint was an ongoing, non-specific facial pain of the right face following extraction of the 16 two months previously.

History revealed that the 17 had been removed four months prior to presentation due to similarly vague symptoms. The pain failed to settle so the 16 was subsequently removed. The patient reported both teeth to have become mobile prior to extraction. Ten days after the extraction of the 16 he presented at UDHM with ongoing persistent symptoms. He had already begun a course of antibiotics and was using chlorhexidine mouth rinses prescribed remotely via an urgent dental centre (UDC). Radiographs ruled out any retained root fragments but clinical examination revealed an area of exposed bone. Conservative management advice was reiterated and two weeks later, the patient was seen for a review. The pain had reduced but there was still discomfort in the area and the patient reported it to feel sharp on his tongue. The socket had epithelialised but a small fragment of bone was present and this was removed under local anaesthetic. He was advised to return to his GDP for review.

The patient contacted UDHM six weeks later with ongoing pain and a face-to-face review was arranged. In that time he had not been offered a face-to-face review but rather been given a further two courses of antibiotics after remote UDC consultations. He presented with moderate discomfort, radiating around the right side of his face which he was able to manage with simple analgesia. He had no extra-oral swelling, temperature sensitivity or tenderness to chew. He reported no history of swellings. Examination revealed friable red and white speckled tissue fungating from the socket with adjacent ulceration extending around the 15 mesially and 17 region distally. There was an area of indurated tissue extending 1 cm into the hard palate with rolled borders.

He had no risk factors in his medical or social history. A provisional diagnosis was made of squamous cell carcinoma and an urgent biopsy was taken. Histopathology confirmed moderately differentiated SCC and he has been referred via an urgent pathway to maxillofacial services.

Reflecting back over this patient's history and clinical encounters there were signs that may have pointed towards a non-odontogenic diagnosis. Certainly, it would appear there was no indication for repeated courses of antibiotics. The picture is further complicated by the number of clinical and remote contacts with different clinicians. We hope this may serve as a timely reminder of the limitations of remote consultations and the possible consequences of a lack of continuity of care in any one setting.

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### Teaching remote consultation

Sir, the *BDJ* has recently published articles describing the use of remote consultations in dentistry during the COVID-19 pandemic.[1,2,3] I would like to draw attention to considerations for teaching undergraduate students and trainees this new type of communication skill.

While demonstrating their value, remote consultations also have limitations, for example being unable to carry out a full soft tissue examination,[2] and may increase the risk of missing a serious diagnosis or misdiagnosing. This has also been noted by the medical profession, particularly around telephone consultation, where clinician experience and skill are deemed to reduce risk.[4]

From my experience working in hospital oral surgery and oral medicine services during the pandemic, a multitude of factors inform a risk assessment that influences whether a patient is seen remotely or face-to-face, including: patient complaints/concerns about their oral health, NHS trust policy, patient wishes, type of oral disease/problem (confirmed or suspected), patient's accessibility to a device for a remote consultation, distance a patient would travel to our clinic, prevalence of COVID-19, patient's general health and vulnerability to COVID-19. Furthermore, remote consultation requires a different communication approach and arguably more thorough history taking to triage those that require a face-to-face appointment.

It seems inevitable that remote consultation will become a permanent and useful element of dentistry owing to the potential for improved efficiency and accessibility. With the start of the academic year upon us, as dental hospitals and schools, we will need to consider how to teach this new skill set to our students and trainees. This could involve utilisation of observation, role play and peer review to develop both remote communication skills and competencies in facilitating a joint decision with patients about the most appropriate consultation mode.

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## Bio-fuel from PPE

Sir, I concur with your correspondent R. Dean[1] on the unprecedented usage of PPE (personal protective equipment) leading to the other PPE (polluting Planet Earth). One good alternative to protect Mother Nature in this situation is the conversion of plastic waste material into a liquid biofuel. Pyrolysis is the procedure of conversion of any material at very high temperatures. All PPEs which at present are disposed in landfills, oceans, etc, which impose negatively on aquatic animals, can be transferred to an incinerator and then pyrolysis can be done to break down the propylene chains to form a liquid. The liquid obtained can be used as a biofuel. We are very much in need of fuel for the operation of various mechanical devices. This biofuel can be further reused thus protecting our planet. Due to the increasing population and their demand for energy consumption, this would serve as a healthy alternative and also preserve our nature.[2]

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# Pharmaceuticals

## Dexamethasone caution

Sir, were Dexamethasone to be included in the Dental Formulary, practitioners need to be aware of common and important physical and psychiatric side effects of this potent glucocorticoid (steroid), prior to prescribing for the control of pain related to root canal treatment.

It is widely recognised that steroids can cause or worsen hyperglycaemia, and national guidelines recommend monitoring glucose levels in those with and at risk of diabetes.[1] Although much of the evidence concerns long term steroid use, hyperglycaemia has been frequently reported after short courses, for example in oncology practice.[2]

Glucose levels can rise within hours of high dose steroids, with a disproportionate effect on afternoon and evening levels.[3,4] Patients with or at risk of diabetes therefore need to be counselled to monitor their glucose levels after taking dexamethasone and may need to make short term adjustments of their diabetes therapy.

Even short courses of Dexamethasone in the peri-operative period may have an impact on wound healing,[5] which would be relevant to the proposed use in endodontics.

Another established side effect of Dexamethasone is that it can cause steroid induced psychiatric reactions, including psychosis, mood changes, behavioural disturbance and cognitive dysfunction. These symptoms can develop within days of a 5 mg single dose even in those who have no psychiatric history.[6,7,8,9] The incidence of a psychiatric episode to steroids has been recorded at being between 13% and 62%.[8] Many of these are mild reactions such as euphoria and increased irritability and may not impact on functioning, but patients need to be warned about the severe reactions in up to 5–6% of patients,[8,10] such as mania and suicidal thoughts. Severe and persistent symptoms will require treatment which is beyond the remit of the dentist.

Whilst Dexamethasone may reduce pain related to endodontic procedures[11,12] it is not a drug to be used when other safer treatment options may be available. We would be opposed to it being more widely available.

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## Co-codamol okay

Sir, I was surprised to read an article (*BDJ* 2020; **229:** 15-18) reporting that dentists cannot prescribe co-codamol. I have been prescribing it for years on a private prescription in different practices and never had an issue with it, as well as other drugs that are not on the dental practitioners section of the BNF.

After seeing the article, I checked the GDC website where it states: 'A dentist can prescribe any medicine from the British National Formulary (BNF) on a private prescription; however you must only prescribe medicines to meet the identified dental needs of your patients'. As for myself, I believe that many colleagues that deal with surgical procedures are prescribing it as it would be very counterproductive and difficult to seek medical advice every time you have procedures that are bound to cause moderate to severe pain. In that same light I believe that we may prescribe any medications that we judge to be beneficial and justifiable for the patient's dental condition.

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