

Department for a dental trauma review following splinting of avulsed teeth. The increasing number of dento-alveolar injuries during lockdown might be due to children spending more hours at home playing than they normally would.

Parents attending the Paediatric Department for a follow-up have complained about the lack of information available to them on managing avulsion injury.

Such a lack of easily accessible information directly impacts the prognosis of the tooth and has a significant impact on the quality of life of the child with potential cost and time required for treatment. Improvement in the delivery of services and provision for better information for the public should be a priority during the COVID-19 pandemic where access to dental care is very limited.

K. Zaheer, London, UK

<https://doi.org/10.1038/s41415-020-1721-5>

Hydroxychloroquine shortage

Sir, readers will be aware of the autoimmune disease systemic lupus erythematosus (SLE), owing to the associated oral, head and neck manifestations. The efficacy of hydroxychloroquine in reducing the risk of severe lupus flares is well documented.

Given that the emergence of a suitable vaccine against the 2019 coronavirus disease (COVID-19) may be a seemingly distant prospect, several clinical trials are underway to evaluate a potential role for existing drugs. Hydroxychloroquine is one such drug with hypothesised mechanisms of action and *in vitro* evidence supporting the inhibition of severe acute respiratory syndrome coronavirus 2.¹

However, in an almost desperate attempt to lessen the burden of the pandemic, physicians are sporadically prescribing the drug with little evidence informing whether they are appropriate for treating COVID-19.² Propagated in part by President Trump's endorsement, the sudden demand for hydroxychloroquine has created a shortage in its availability to patients requiring this medication.³ The impact of withdrawing the medication for just a fortnight can exacerbate flares and heighten disease activity in otherwise stable SLE patients.⁴ The drug is vital and unique in its ability to prevent further systemic complications and increase chance of survival.⁵

The attention drawn to the COVID-19 pandemic risks compromising the provision

of care to those with chronic conditions. The case for patients with SLE could represent one of many interruptions to treatment. Evaluating the severity of each compromise is essential. The decision to champion hydroxychloroquine so hastily raises yet more questions on the decision-making approaches, which currently show considerable disparity. Several recent clinical studies have investigated hydroxychloroquine for COVID-19 patients but these have been at high risk of bias, hence the need for large randomised placebo-controlled clinical trials to determine the potential benefits and harms before any role can be recommended. This story highlights the importance of an evidence-based approach that we increasingly recognise in the practice of dentistry.

J. Patel, Leeds, P. Coulthard, London, UK

References

1. Yao X, Ye F, Zhang M *et al*. In vitro antiviral activity and projection of optimized dosing design of hydroxychloroquine for the treatment of Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2). *Clin Infect Dis* 2020; DOI: 10.1093/cid/ciaa237.
2. Lenzer J. Covid-19: US gives emergency approval to hydroxychloroquine despite lack of evidence. *BMJ* 2020; **369**: m1335.
3. Jaffe S. Regulators split on antimalarials for COVID-19. *Lancet* 2020; **395**: 1179.
4. Canadian Hydroxychloroquine Study Group. A randomized study of the effect of withdrawing hydroxychloroquine sulfate in systemic lupus erythematosus. *N Engl J Med* 1991; **324**: 150–154.
5. Alarcón G, McGwin G, Bertoli A *et al*. Effect of hydroxychloroquine on the survival of patients with systemic lupus erythematosus: data from LUMINA, a multiethnic US cohort (LUMINA L). *Ann Rheum Dis* 2007; **66**: 1168–1172.

<https://doi.org/10.1038/s41415-020-1722-4>

Age-appropriate antibiotics

Sir, antimicrobial stewardship is as important now as before the pandemic and this includes ensuring correct doses are prescribed. Treating paediatric patients in an Urgent Dental Care Centre at Newcastle Dental Hospital, we have worryingly seen a shocking proportion of children who have been prescribed age-inappropriate, suboptimal doses of antibiotics and subsequently referred for treatment as 'unresponsive to antibiotics'. It is perhaps unsurprising to note a lack of clinical improvement in these cases. Paediatric doses for amoxicillin increased in 2014 and excellent guidance on antibiotic prescribing is available from multiple organisations such as FGDP¹ and SDCEP.² We simply wish to highlight that any child over five years of age should be prescribed an 'adult' 500 mg dose

of amoxicillin. This crucial change in practice will improve patient safety and management not only during this coronavirus crisis, but also to reduce the long-term potential for antimicrobial resistance for future generations.

O. Sumner, S. Datta, Newcastle upon Tyne, UK

References

1. Faculty of General Dental Practice. *Antimicrobial prescribing for general dental practitioners*. 2nd Edition. 2016.
2. Scottish Dental Clinical Effectiveness Programme. *Drug prescribing for dentistry*. 3rd edition 2016, updated 2017.

<https://doi.org/10.1038/s41415-020-1723-3>

Repurposing the 7Ps

Sir, as a British Army Dental Officer I was taught the 7Ps: Prior Planning and Preparation Prevents Piss Poor Performance. Being more polite, the United States Air Force changed the fifth P to 'pitifully'.¹ This is a shame as the surprise and fun of the mild expletive makes the adage memorable. Later versions sometimes substituted 'practice' for the third P.

We were also taught to be 'joined up'. The Faculty of General Dental Practice (FGDP) produced a comprehensive list of guidance, news and resources for general dental practice in the COVID-19 era.² Not surprisingly, there are inconsistencies and differing viewpoints, both within dentistry and with our medical and nursing colleagues about the new normal, particularly concerning aerosol generating procedures (AGPs). These are critical to modern dentistry, but are not unique to us.

It has been noted anaesthetists consider working in the upper airway to be an AGP but dentistry is not mentioned.³ The latest Cochrane commentary on personal protective equipment (PPE) for general dental practice states 'none of the 24 identified studies... was based in the dental environment or included members of the dental team'.⁴ The Centre for Evidence Based Medicine's commentary on PPE in primary care concerns general medical practice. It introduces a new term of aerosol generating exposures (AGE) to include AGPs and additional risks like patients coughing. Also, requiring gold plated evidence may be the enemy of good policy. We need to look at all evidence, both observational and experimental.⁵

Following the Severe Acute Respiratory Syndrome (SARS) outbreak 2002–2004, PPE for dental procedures was proposed.⁶ It did not discuss wider implications, such as