PAPR may also interfere with the field of vision as a result of the downward vertical visual field being rather limited, powered PAPRs may impair the hearing ability of the wearer due to blower noise and noise created by the loose head covering during movement.[1] PAPRs also require considerable storage space, an approved staff training protocol in maintenance and disinfection, and timely battery replacement or charging to maintain optimal performance.

PAPR components exhibit significant variability across manufacturers and in their reaction to various cleaning, disinfectant methods and solutions which can cause damage or deterioration of components. They are also very specific in how they are to be used and require training to avoid contamination and infectious liability. Most manufacturers recommend the filter be discarded. CDC cautions against the use of these filters for a live virus and recommends the institution of a replacement cycle which is practical to implement till more evidence emerges.[1]

Therefore, before adopting PAPRs, practices should seriously consider various factors to decide suitability.

V. Sahni, New Delhi, India

Reference

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Dementia guidance please

Sir, our experience in a community dental service has shown that provision of domiciliary visits to care homes, including dementia patients, have come to an abrupt halt due to the increased risks associated with COVID-19 in an enclosed setting as well as the change in provision of care as we turn into an urgent dental centre.

The COVID-19 guidance and SOP document published by NHS England highlights that vulnerable patients may be seen for urgent dental care following unsuccessful implementation of remote management via advice, analgesia and antimicrobials.[1] However, there is no further guidance regarding the factors to consider during a domiciliary visit and this is left to the individual clinician to risk-assess and decide. This document has changed three times since it was first published in April 2020, and the guidance changing numerous times during this period can leave a lack of clarity and thus inconsistencies in the provision of care.

We would greatly urge that there needs to be clearer guidance for domiciliary visits in order to provide effective and safe care to the dementia patient cohort as significant risks leading to potential safeguarding issues and increased comorbidities can arise if these issues are not addressed.

Y. Lin, B. Collard, Plymouth, UK

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Two-tier dental system

Sir, the majority of dental practices in Scotland are mixed NHS-private practices. A recent survey from BDA Scotland revealed that 52% of largely/exclusively NHS practices and 86% of mixed practices predicted a relative reduction in NHS work during the next year because of the COVID-19 pandemic's impact on the provision of NHS dental services.[1] There is a possibility that dentistry in Scotland will move towards a two-tier system with reduced access for NHS patients. During question time on 12 August 2020, the First Minister of Scotland said: 'There is not, and there should not be seen to be, a two-tier system of oral healthcare. If dental practices are ready to do so, they can provide aerosol-generating procedures on patients with urgent dental problems from 17 August. We have 75 urgent dental care centres throughout Scotland, to which patients continue to be referred.'[2]

Since then, there has been a number of complaints about GDPs in Scotland who may be misinforming patients about the range of NHS services available following lockdown or coercing patients into undertaking private treatment. Some of these complaints were also sent to the Scottish government. On 14 September 2020, the Chief Dental Officer for Scotland wrote to the Directors of Dentistry with suggestions on how to deal with this type of complaint.[3]

On 12 October 2020, it was announced that NHS dental contractors in Scotland would, from 1 November 2020, be able to provide a full range of treatments to all NHS patients within dental practices.[4] The BDA has concerns that expanding the range of treatments will increase patient demand which may encourage a 'two-tier' dental system.[5]

In the interests of patient safety, only a fraction of the number of patients can be treated compared to pre-COVID levels. To avoid confusion, it is essential that the Scottish government provides regular and timely information to inform the public and dental professionals about changes to primary dental care services.

C. A. Yeung, Bothwell, UK

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Exam appreciation

Sir, we would like to take the opportunity of formally thanking our colleagues for the recent successful online delivery of the Royal College of Surgeons of England and Royal College of Physicians and Surgeons of Glasgow Bi-collegiate Specialty Membership examinations in Restorative Dentistry (the examination diet of which will be completed in November) and Orthodontics. In addition to all staff within the examinations department and all examiners, we are particularly indebted to the Faculty Board of Examiners Chairs Andrew Eder and Charlotte Eckhardt; and the Lead Examiners Paula Ng, Phil Tomson, Mark Ide, Andrew Paterson and Jadbinder Seehra for the restorative and orthodontic examinations, respectively.

The respective examination teams for both of these dental specialty assessments have worked tirelessly over the last few weeks to organise