

and deliver robust and fair revised-format diets for these two cohorts of specialty trainees. In line with the recent General Dental Council statement relating to dental specialty training,¹ the mode of delivery for these examinations has been successfully adapted to an entirely remote format. This has meant that career progression has not been significantly delayed for these trainees, but they have been able to undertake their formal assessments in a safe and responsible manner in relation to the needs of maintaining appropriate social distancing during a period of increasing COVID-19 spread within the United Kingdom population.

M. Cobourne, M. Garrett, London; N. Cross, A. I. Edwards, Glasgow, UK

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Postgraduate periodontal education

Sir, the pandemic has forced dental institutions to change approaches to teaching undergraduate dental students and postgraduate residents (PGR). With great interest we have read recent letters and publications in the *BDJ*^{1,2} and elsewhere that outline the approaches our European colleagues have taken. In this letter, we would like to describe our approaches to modify

postgraduate periodontal training at the University of Texas Health Science Center at Houston (Houston, TX, USA) in response to substantial interruptions in didactic and clinical training.

First, we identified our immediate goals:

1. To evaluate the existing curricula and reorganise them by adopting the Commission on Dental Accreditation (CODA) compliance protocols on the interruption of education and distance education to allow for a continuation of the PGRs' hands-on and didactic learning
2. To calibrate all full- and part-time periodontal faculty
3. To transition the residents through their respective clinical curricula
4. To provide feedback on the residents' surgical skills.

Once these goals were met, we aimed to implement the following sessions to allow for the transition of PGRs through the updated curricula:

1. Case-based classroom videos from the American Academy of Periodontology (AAP) and webinars allowed residents to enhance their didactic knowledge on clinical techniques
2. Clinical case presentations through online sessions allowed continued PGRs' feedback to enhance their presentation and treatment planning skills as well as surgical techniques
3. Sessions with invited speakers allowed PGRs to learn clinical management with the experts in the field and receive constructive feedback

4. Collaborative seminars in surgical, prosthetic and restorative dentistry with the Department of Periodontics at the University of Illinois at Chicago allowed PGRs to get exposed to world-class periodontists and dental implantologists and ask one-on-one questions
5. Suturing training modules allowed PGRs to practise suturing at home and learn indications of various techniques
6. Virtual sedation cases were utilised to accomplish PGRs' sedation competencies
7. Mock periodontal oral board sessions allowed PGRs to prepare for the AAP specialty board examination and fulfil temporary CODA requirements in certain competencies
8. As laboratory research activities were suspended, PGRs were asked to work towards their Master's thesis writing and analysis of the existing data.

Despite facing changes in a teaching format, especially in clinical training, our approaches, including the use of online portals and modules, maintained and enhanced PGRs' hands-on and didactic experiences. We expect to implement these new teaching approaches in future curricula.

K. Parsegian, N. Angelov, S. Ayilavarapu, Houston, Texas, USA

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Oral research

Scientific rigour

Sir, I read with interest the paper by Sampson *et al.*¹ regarding a possible link between the severity of SARS-CoV-2 infections and oral hygiene. Their call for excellent oral hygiene as a strategy to potentially aid the prevention of bacterial superinfections in patients with SARS-CoV-2 infections is not in question here.

However, I draw attention to the interpretation of research findings by the authors, and would caution against reporting associations between COVID-19 symptoms and oral bacteria without the support of adequate data.

Of greatest concern, Sampson *et al.*¹ report that sequencing data indicate high reads for *Prevotella*, *Staphylococcus* and *Fusobacterium* in patients severely infected with SARS-CoV-2. The supporting data come from a letter by Chakraborty.² It is unclear in which publication this letter appears or whether it has been through a peer review process. In the letter, metagenomic sequencing data from five patients are presented.² No methods, including no source for the samples is given. This, along with a lack of data from healthy subjects, makes it impossible to draw any conclusions about the number of sequencing reads relating to these genera and any association with SARS-CoV-2 infection. These data can therefore not be used to associate

oral bacteria with severity of COVID-19 symptoms. Indeed, bacteria from the genus *Staphylococcus* and *Fusobacterium* dominate the nasopharyngeal microbiome of healthy individuals,³ and *Prevotella* and *Fusobacterium* dominate oropharyngeal communities.⁴

The authors also refer to Nagaoka *et al.*⁵ as evidence for a relationship between *Prevotella intermedia* and severe pneumonia. This is an *in vivo* study examining the effect of a bacterial supernatant on experimentally induced pneumonia in mice, and not an observed relationship in human subjects.

A global health crisis such as we are experiencing places huge pressure on health professionals and the research community in the rapid search for knowledge. Whilst

improving oral hygiene is unlikely to be detrimental, it has never been more important to uphold scientific rigour in the interpretation and reporting of research findings to help build our collective understanding of the aetiology and prevention of disease.

S. Byrne, Melbourne, Australia

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<https://doi.org/10.1038/s41415-020-2362-4>

Emergency dentistry

Surviving on call

Sir, having completed a year as an OMFS DCT in a major trauma unit, I thought it would be useful for fellow colleagues to have some know-how of how to survive on a call:

- If in doubt, ask: senior colleagues will know you haven't done the job before. They have experience of training DCTs and will be more than happy to assist you
- Get to know the paperwork. As laborious as it may be, paperwork is extremely important, and the more you are aware of what needs to be filled in, the smoother the process will be
- Prioritise your jobs. You will have calls coming from multiple different places at the same time, so you need to know which jobs need to be finished urgently, and which jobs can be completed later
- Keep a logbook – preferably electronic but if it is in paper form, make sure there is no patient information which will make them identifiable, and make sure to get it verified by your consultant
- Practise suturing at home. I know it sounds simple, but practising a little can go a long way! You will come across as more confident in front of the patient and will feel less fazed
- Watch videos on how to cannulate – once again, it will be unlikely you will have

done many cannulations, so it can be useful to know the exact process of how to place a cannula successfully

- Know the basics about bloods. Having a basic knowledge about what all the blood results mean will be useful when handing information over to senior colleagues, and will help you to know what to look out for
- Get the information – sometimes when you get a bleep from A&E, they may not have completed all the tasks required from them at the time of referral. For example, if there is a mention of head injury, make sure they have assessed and cleared the patient of any head injuries otherwise you will have to sort this out, and it can be daunting
- Know what needs to be on the consent form – you will be admitting and clerking in many patients, so if you know exactly what needs to be on the consent form, it will speed up the process
- When handing over use SBAR – Situation, Background, Assessment, Recommendation. This will make handovers concise and easy to follow
- Make sure to rest properly in your spare time – the job can be demanding so this is vital to stay alert.

And lastly, enjoy this time! You will see extremely interesting cases through to the weird and wonderful; you have an amazing opportunity to learn new things in a supported environment so take advantage of it!

A. Kazmi, Liverpool, UK

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Dental regulation

Keeping up the fight

Sir, thank you for publishing Martin Kelleher's article (*BDJ* 2020; **229**: 225-229). Martin has long been highly respected as an excellent teacher and communicator, and a voice of reason in our profession.

The first part is a truly appalling account of just one problem at the GDC. The second is an excellent reminder that we must not let lawyers overrule common sense in the way we practise. The profession needs a regulator (note not plural) with an understanding of what comprises good dental practice. In the meantime we look to the BDA and its esteemed Journal to continue the fight on behalf of our profession.

P. S. Nayler, Brighton, UK

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Pharmaceuticals

Directions for use

Sir, I write further to the letter of Kalsi *et al.*¹ in which they described that the product Alvogyl (Septodont, Cedex, France) used in the management of acute fibrinolytic alveolar osteitis had been superseded by a chemically different product Alveogyl (Septodont) with potentially significant clinical ramifications.

These colleagues make a very valuable and important point in that the formulations of not only pharmaceuticals but also dental materials and biomaterials may be changed by manufacturers surreptitiously. This may be necessary due to product development, regulatory demands and ongoing product safety. Whilst this is both laudable and proper, the clinician should be mindful of potential changes in product formulation as this may have a significant bearing on how the product is mixed and/or handled clinically. It therefore follows that the failure of the dental team to fastidiously use the material as intended may result in inferior clinical performance.

One way of ensuring best practice would be that the directions for use of each new batch of product are read carefully and then stored in a centrally placed file in the clinic, easily accessible to all members of the dental team. A ring binder folder containing punched pockets is ideal and the responsibility of keeping the file contemporaneous should lie with the member of staff responsible for stock management.² Furthermore, dissemination of any change in handling protocol etc should also be communicated to all appropriate clinical staff. Such a measure will ensure that all products intended for clinical use are used correctly to ensure the best outcome for the patient.

S. J. Bonsor, Aberdeen, UK

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<https://doi.org/10.1038/s41415-020-2365-1>

Dermatology

Skin care doubts

Sir, there is an increasing number of dentists who have started to provide specialist skin care. May I emphasise, I do not mean facial aesthetics courses (botulinum toxin and fillers). This is after they have gone to a