is undoubtedly complex, involving salivary defence molecules, oral mucosa barrier affinity/penetrability and immune response. Further investigations should, thus, focus on targeting specific viral strains and selected antimicrobial agents.

As the oxidative agents might not be available now, due to the global shortage of disinfectants and prioritization given to hospitals, dental practitioners would like to know what sort of additional measures might be utilized to minimize the exposure to risk. How about using, for example, chlorhexidine in higher concentrations, or other antiseptic agents, such as octenidine, cetilpiridine? Overall, taking into consideration the pH-dependent mechanism of host entry, the antiviral effectiveness of common antimicrobials seems to be associated with solution acidity. We are aware that we could get more common mouthwashes widely available, such as Peroxyl (Colgate), Crest 3D White (Crest) with a hydrogen peroxide ingredient, however, their range of standard 1–1.5% H_2O_2 concentration might be too low to be efficient towards a specific virus strain, including SARS-CoV-2. There is always an alternative option to use hydrogen peroxide mouthwash, with a right concentration arranged by a local pharmacy as per the BNP formulary. As dental practitioners, we urgently need more research-based information on how mouthwashes alter the balance of oral micro-organisms in the face of the recent COVID-19 outbreak, to protect our patients and staff.

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COVID-19: a momentary pause to dental core training

We are writing to share our concerns regarding the impact of the COVID-19 pandemic on UK Dental Core Trainees (DCTs). We are currently facing much uncertainty regarding progression of training, recruitment and potential redeployment.

Following suspension of all non-urgent elective procedures and limitation of aerosol generating procedures, training has come to a pause. This has halted development of clinical skills in our chosen specialty. Many DCTs, particularly those based in Dental Hospitals, will be unable to complete mandatory clinical competencies usually necessary for satisfactory completion of core training. There is no assurance that we will be able to complete the final 6 months within these training posts, further decreasing our ability to develop skills which would be expected of us to continue into the next stage of our career. Not to mention the loss of several opportunities for portfolio development, including face-to-face teaching and presentations at a national or international level.

Currently, national recruitment has been postponed and existing posts are due to finish in September. Undeniably, there are concerns regarding availability of upcoming training posts as well as opportunities within primary care. Lack of job security come September is undoubtedly an additional source of stress and anxiety during these already testing times.

DCTs across the nation are being redeployed to clinical areas, ranging from A&E to maternity units and ICU. This opportunity, which has been likened to a 'war-time' effort has, for the most part, been welcomed by the profession with open arms. Redeployment offers trainees an exciting opportunity to develop new skills in areas outside of the usual working environment. It is inevitable, however, that finding ourselves in such unfounded territory may put a strain on, not only our mental, but also our physical well-being.

Despite this, there is a wealth of pastoral support for DCTs. Individual deaneries are focused on the wellbeing of their current trainees, especially those who have been redeployed. Health Education England is also working on a solution to national recruitment, with cancellation of all face-to-face interviews, in what are extremely difficult circumstances. Undoubtedly, COVID-19 has affected all members of the dental profession to a certain extent, but the question remains, what does this mean for the future of dental core training?

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CPD ANSWERS March 2020

1. D	**6.** C
2. A	**7.** D
3. D	**8.** C
4. C	**9.** B
5. A	**10.** B