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Subscription Information

Full UK £137 | Digital Subscription £110
Retired GDP £93
Student UK Full £51 | Foundation Year £95
11 issues per year
Single copies £24 (NON UK £35)
Subscriptions cannot be refunded.

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Mark Allen Group, Unit A 1–5, Dinton Business Park, Catherine Ford Road, Dinton, Salisbury SP3 5HZ
FREEPHONE: 0800 137201
Main telephone (inc. overseas): 01722 716997
E: subscriptions@markallengroup.com

Managing Director: Stuart Thompson
Design/Production: Lisa Dunbar
Design Creative: Georgia Critoph-Evans

Dental Update is published by: George Warman Publications (UK) Ltd, which is part of the Mark Allen Group.

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GEORGE WARMAN PUBLICATIONS (UK) LTD
Unit 2, Riverview Business Park, Walnut Tree Close, Guildford, Surrey GU1 4UX
Tel: 01483 304944, Fax: 01483 303191
email: **angela.stroud@markallengroup.com**
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DU ISSN 0305-5000

Trevor Burke

Is prevention more important now than ever?

Discussion on how to achieve a preventive mindset among clinicians has been taking place for, it seems, decades. It is the ultimate in minimally invasive dentistry, which has been much talked about/written about since the COVID-19 crisis caused a rethink on dental operative procedures. Why, you may ask, do dental schools have vast areas set aside for restorative dentistry, when there is nothing resembling a total preventive clinic? Hume, in 1992, described this phenomenon as a 'restorative tiger' that needed 'taming and turning'.[1] And, I am sure that, had GV Black (probably best known for his principles of cavity preparation) been alive today, he would have agreed with such comments, given his statement in 1896 'the day is surely coming when we will be practising preventive rather than *reparative* dentistry'.

At a time when there has been much head-scratching regarding aerosol production (well discussed in the last issue in the paper by Prof Samaranayake[2]), the alternative approach, already proposed by me and my co-authors two issues back[3] (seems like a lifetime!), is to utilize procedures which don't involve an aerosol, but the alternative proposal, which is to concentrate even more on prevention. Have all our patients been taught an effective method of plaque control? Orthodontists, I know, will not proceed with treatment until their prospective patient undertakes a session of Oral Health Instruction. Why should patients undergoing operative treatment for caries be different? They should have the same instruction.

A problem, as I see it, relates to the question – who will pay? This is not only a UK problem, but one which has not been addressed by governments worldwide. The majority remain hooked on the principle of not paying for what they cannot see. And, hence, if prevention works, then the patient and clinician see – nothing! – no demineralization, no cavity, nothing but sound enamel. When we have sorted out a way to pay, then prevention will be supreme. Capitation, as a method of payment, works for motivated patients, because they take the preventive message on board. Keeping the patient off the traditional chain of events when restorative treatment is first carried out is important, fuelled, as Elderton stated, by the repeat restoration cycle being driven by a culture of drill-related dentistry.[4] The dental restoration is treatment but, unfortunately, a preventive session is not seen as treatment by some. It is time for this to change and for UK Governments to start valuing prevention as a means of stopping the drill philosophy in the long term. In that regard, I hope that readers will enjoy the very relevant article by Timms and colleagues on Silver Diamine Fluoride, which is fast becoming 'flavour of the month'.

I have already quoted Richard Elderton. While researching an Editorial

on minimal cavity preparation, I came across an article by him describing minimal cavity designs for Class II cavities.[5] This was from an occasional series called 'Dentistry in the year 2000'. The follow up, published in 1986, was entitled 'Prospects for the future'. I felt that there was much in this article that could be applied to dentistry today, so I sent it to the Restorative members of the Editorial Board, asking if they felt that it was worthy of being re-published in its original form. Unanimously, they agreed that it was. Only once, to my knowledge, has a dental article been re-published (p623–628) in its original form 30 years after first being published. That was by de Van, whose famous 1952 article on impression-taking was re-published *verbatim* in 2005.[6,7] I hope that readers will enjoy reading the reproduced article and will be able to embrace its philosophy, and also rejuvenate their preventive principles.

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Unhelpful advice

One would hope that advice would generally be given with a view to helping a given situation but, in my view, the recent interim guidance from the World Health Organization (WHO) regarding the current provision of essential oral health services[1] falls short of that hope. Its purpose is 'to address specific needs and considerations for essential oral health services in the context of COVID-19, with the guidance being intended for public health authorities, chief dental officers and oral health care personnel working in private and public health sectors'.

It starts, rightly, by stating that effective prevention of oral problems should remain a high priority, with patients being given advice through remote consultation or social media channels. The document then suggests screening of patients before appointments or triage done on arrival, again something that readers would, I feel, agree with. So far, so good! It then adds that 'only patients requiring urgent or emergency (care) – (that word seems to have been omitted in the document) receive treatment and that they have no symptoms suggestive of COVID-19 infection'. This was reported in the UK press on 11 August, as 'people should not go to non-urgent dentist appointments until COVID-19 risk is better understood'. Not helpful.

Unfortunately, this, to me, seems (i) unrealistic and (ii) appears to indicate that the 15 authors of the document are a long way distanced (excuse me using this word) from the real world of general dentistry. I analysed the authorship, many being distinguished researchers, epidemiologists and public health dentists and, while I could not find one member via Google, I could only identify three who appeared to presently be carrying out clinical dentistry. While there are many good recommendations in the document (hand hygiene, ventilation, de-cluttering of work surfaces, avoiding the use of a spittoon, etc) which are well worth reading, the document would have been massively more useful if it had suggested practical ways by which general dentists, worldwide, could return to work using, wherever possible, non-AGP procedures, as I have already suggested.[2] The WHO document concurs with this suggestion, stating that 'minimally invasive procedures using hand instruments should be prioritized'. The British Dental Association (BDA) has also spoken out and warned against misinterpretation of the advice.

I am not the only critic! The Canadian Dental Association and the American Dental Association (ADA) stated that they respectfully but strongly disagreed with the WHO guidance that routine, non-essential oral health care be delayed, with the ADA President, Dr Chad Gehani, stating that 'Oral health is integral to overall health – dentistry is essential health care', adding that 'millions of patients have safely visited their dentists in the past few months for the full range of dental services', and, 'with appropriate PPE, dental care should be considered to be delivered during global pandemics or other disaster situations'.

Where does that leave us? I am sure that some readers will have had to explain the unhelpful Press statement to their patients on 12 August, always a difficult task, given that some patients will have totally believed what they read. My recommendation to readers would be to read the WHO document, take the good advice offered in some sections, but ignore the recommendation on not carrying out routine care. In some ways, my recommendation is pragmatic, given that it is essential that UK dental practices follow those in other parts of the world in negotiating a way to continue to carry out the routine dentistry that our patients need. I hope that these comments are helpful.

PS. I had already written the Comment for this issue prior to reading the WHO document. Hence two Comments from me for the first time ever! Double value or a double whammy, depending on your point of view!

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