

Letters to the Editor

Behaviour management in children during COVID-19

I wish to highlight how the current COVID-19 pandemic has affected the effective behaviour management of children. Children with anxiety issues related to dentistry are usually referred to community dental services where dentists are able to spend extra time and effort acclimatizing them to dental treatment. However, owing to current changes in surgery fallow time and the fear of children being asymptomatic carriers, this has made current efforts all the more difficult.

Children tend to pick up on non-verbal communication and body language that provides reassurance and the impression of a child-friendly environment.¹ However, this is very difficult to accomplish due to enhanced PPE protocols, which may seem very strange and alien-like to children.² Voice control, which relies on the change in one's intonation to influence a child's behaviour, is also much more difficult to implement because this is easily muffled with the use of a visor and FFP3 mask.¹

The lack of social interaction due to the recent lockdowns that have restricted school attendance, meeting up with peers outside their household, as well as the encouragement to be socially distant, can have a negative impact on a child's psychological and mental wellbeing.³ This can lead to a general feeling of mistrust and wariness when meeting strangers, thus making it much more difficult for the dentist to obtain a child's trust in complying with dental treatment.

It is important that dentists adopt a calm and proactive approach and involve the child during their interactions. Empathy and support should be provided to establish some form of trust during a child's visit to the dental surgery.³ Where possible, it may be beneficial to don one's PPE while the child is watching and provide a simple explanation, as this will work as a form of systematic desensitization.²

References

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management guideline: clinical guidelines in paediatric dentistry. 2011. Available at: www.bspd.co.uk/Portals/0/Public/Files/Guidelines/Non-pharmacological%20behaviour%20management%20.pdf (accessed February 2021).

2. Al-Halabi M, Salami A, Alnuaimi E *et al*. Assessment of paediatric dental guidelines and caries management alternatives in the post Covid-19 period. A critical review and clinical recommendations. *Eur Arch Paediatr Dent*. 2020; **21**: 543–556. <https://doi.org/10.1007/s40368-020-00547-5>.
3. Acharya S, Mohanty S, Singh B *et al*. The impact of Covid-19 pandemic on children behaviour in pediatric dental clinics. *J Ment Health Psychiatr Dis* 2020; **101**: 1–6.

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A new artefact source

I would like to draw the attention of readers to a new artefact source that may start to be seen more regularly. In the current era of the COVID-19 pandemic, the uptake of wearing masks has dramatically increased, and in certain places, it is compulsory to wear one unless there is an exemption.¹

Here we see the artefact of the metal wire in a surgical mask on an orthopantomogram (OPG) in a male in his 20s who presented to A&E with bilateral mandibular angle fractures (Figure 1).

This artefact has the potential to cause confusion to the interpreter of the radiograph. With homemade and fashion masks also being available to patients, different artefact patterns may be observed by your readers. Here, I aim to highlight this as a potential artefact source.

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Reference

1. Department of Health and Social Care. Face coverings: when to wear one, exemptions and how to make your own. 2020. Available at: <https://tinyurl.com/28wyr6jp> (accessed March 2021).

In defence of the cowhorns

Responding to Adrian Curtis' interesting letter in the February issue of DU just a few things about my beloved cowhorns that I do not think I have ever used intentionally to split a tooth. Although I would consider the separation of roots of multi-rooted teeth prior to individual removal, to be the least



Figure 1. An orthopantomogram (OPG) showing a surgical mask wire artefact in a male with bilateral mandibular angle fractures.

traumatic form of extraction. I do still have my 1976 undergraduate copy of Geoffrey Howe's *Minor Oral Surgery*,¹ which contains much still of value, but in common with all 20th century texts, it has one very important chapter missing, and that is the chapter on 'Closed and atraumatic extraction techniques'. The conventional use of a cowhorn is a closed technique, in the sense that a soft tissue flap is not used, but it is traumatic in the sense that crushing, fracture or removal of bone can occur, in common with almost all extraction techniques! Closed techniques using forceps, elevators and luxators, are important worldwide because the majority of tooth extractions are performed when the luxury of a surgical hand piece is not available (my opinion). On school patrols in Papua New Guinea, the commonest tooth I was asked to take out was probably the grossly carious lower first permanent molar. I would have had a surgical handpiece with me, but if used, I would have needed to wait an hour for it to go through the pressure cooker before the next use. Cowhorns often came to the rescue. Back in the UK, operating day bed lists, it was not unusual to be performing clearances on young adults (methadone mouth). Interesting when sugar-free medication appeared, the drug-induced xerostomia and insatiable thirst for fizzy drinks still caused havoc with the dentition. To take out up to 28 teeth in less than an hour would rely on rapid closed extraction techniques. Cowhorns to the rescue. Also this century, we have seen the arrival of the physics and power forceps, both drawing on the concept of guiding a beak along the periodontal space (like the cowhorns), but also introducing the reciprocal bumper. These 'Beak & Bumper' forceps in the hands of the experienced clinician perform a rapid, albeit traumatic, closed extraction. This century has seen pleas from implantologists to preserve bone, and also the spectre of bisphosphonates and now, COVID, good reasons not to raise a flap in anger. Most recently we have seen the 'sprocket pullers' appear in the form of the Benex and others. The only technique to my knowledge claiming to be closed and atraumatic!

We all use procedures that we are familiar and confident with to the exclusion of others (I have no experience of using the eagle beak), but maybe our patients should be informed of what else is out there, and why we are doing what we do.

Thank you cowhorns, long may you live.

References

1. Howe G. *Minor Oral Surgery*. 3rd edn. London: J Wright & Sons, 1985

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In defence of modern oral surgery

It would seem that this technique tip¹ has started some debate, and I thank Dr Malden for his reply to my letter.² I note in his reply that Dr Malden refers to Geoffrey Howe's *Minor Oral Surgery*.³ I have the 1988 reprint of the third edition. It sits in my office and is still a useful guide on technique, although my Registrars regularly remind me it was written before they were born!

Dr Malden points out that the use of cowhorns is a 'traumatic technique'. While back in the day, it may have been acceptable to undertake 28 serial traumatic extractions in an hour with his beloved cowhorns, this is no longer the case, nor is it required. Modern oral surgery departments and practices in the UK are all equipped with surgical handpieces when required. Closed atraumatic techniques, using luxators and periostomes, are much less traumatic to the tissues and, more importantly, to the patient. The use of the surgical handpiece, when required, can supplement these techniques, negating the need for archaic instruments such as cowhorns, and minimizing the crush injuries he talks about.

COVID should not be used as an excuse for not raising a flap and using the drill. We all have enhanced PPE (Figure 2), air circulation, vaccination and other mitigations.

Dr Malden and I will probably always disagree on the use of cowhorns; however, I suspect he and I would agree on a lot of things regarding other aspects of practical oral surgery. I suspect he is only about 10 years ahead of me professionally, and I am therefore very envious of his title 'Retired Oral Surgeon'. A title I would hope to use by the end of the decade!

References

1. Rehal S, Shoker P. Technique tips. The battle of the lower molar extraction forceps: cowhorn versus eagle beak. *Dent Update* 2020; **47**: 972–973.



Figure 2. The author dressed for action!

2. Curtis A. Monsters versus aliens. *Dent Update* 2021; **48**: 162.
3. Howe G. *Minor Oral Surgery*. 3rd edn. London: J Wright & Sons, 1985.

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Addressing misconceptions in relation to fasting and oral health during Ramadan

As a dentist who worked in practice, I became aware of a situation that requires addressing in the dental community. With Ramadan approaching, there are certain misconceptions that exist that need discussion in relation to oral health and fasting.

Ramadan is a holy month in the Muslim calendar in which healthy and medically fit Muslims fast from dawn to dusk meaning no fluid, food or medication during sunlight hours. Some Muslims misinterpret this as not brushing their teeth due to the fear of swallowing/tasting the toothpaste, resulting in invalidation of the fast.

We must educate our patients that they are able to maintain excellent oral hygiene even during fasting periods, because they ultimately spit out the toothpaste (and even blood from gingival bleeding), they do not swallow it.

We can ensure to offer different forms of oral hygiene habits, whether this is using toothpaste with a toothbrush, or even using the miswak. A miswak is a teeth cleaning twig made from the *Salvadora persica* tree and is predominant in Muslim-inhabited