COMMENT

Letters to the editor

Send your letters to the Editor, *British Dental Journal*, 64 Wimpole Street, London, W1G 8YS. Email bdj@bda.org.
Priority will be given to letters less than 500 words long. Authors must sign the letter, which may be edited for reasons of space.

OMFS

Abscess or airway?

Sir, most readers of this journal appreciate the continuum from dental abscess to cervicofacial infection. In my OMFS DCT post, however, I have observed that some non-dental colleagues appear more concerned with the aetiology rather than the potential severity of the sequelae. Surprisingly, dismissive attitudes from some hospital staff have been noted when something is of odontogenic origin, resulting in a drop of their guard, lack of urgency and delays to theatre. Consequently, our department is frequently bleeped several hours post-presentation of the patient to A&E. Considering the time-sensitive nature of some cervicofacial infections, I believe this not to be best practice. In September 2021, across all emergency departments in England, only 64% of patient attendances were managed within four hours.[1] These delays can be significant for those with airway compromising swellings. We therefore must rely on our A&E colleagues to appropriately triage and involve us in cases that require surgical intervention.

Conversely, some small, isolated dental abscesses that present to A&E are being referred to us with buzzwords such as 'Ludwig's' to encourage a swifter maxillofacial input. This can create frustration amongst juniors and ultimately has the potential to harm those with actual Ludwig's angina since it is impossible to attend every referral with the same required resources.

In response, our hospital is working with ED staff to ensure suitable and timely maxillofacial triaging is carried out. There is a lot of room for improvement, but one suggestion could be a situation in which local practices, with contracted emergency dental services, have a closer working relationship with secondary care. This would facilitate efficient referrals to dental settings for cases that can be appropriately managed there. This can ease the pressure off an already stretched A&E system and allow prioritisation of urgent cases.

With the total number of dental abscess-related admissions increasing more than 3.5-fold in the last 20 years,[2] I feel strongly that our community should highlight this continuum to prevent patients with a deteriorating airway from sitting unattended in the corner of an ED waiting room. A dental abscess is best managed by a dentist. A cervicofacial abscess, even of odontogenic origin, is best managed in hospital.

D. Innes-Taylor, London, UK

References

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Paediatric dentistry

Consent congrats

Sir, regarding the recently published article by Asma Keshtgar *et al.*, entitled 'Consent and parental responsibility – the past, the present and the future' (*BDJ* 2022; **232:** 115–119), I wanted to congratulate all three authors on a very erudite and extremely helpful publication on a topic that is of great clinical importance.

I was also involved in publishing results of a national audit on the understanding of consent amongst consultant orthodontists 14 years ago and my hygienist wife and I, although now both retired, currently participate in the national COVID-19 vaccination programme and from here on, we will both be using the very succinct and user-friendly flowchart and the Parental Responsibility Form contained in this article, in order to help clarify issues of parental responsibility when they might arise, ie as and when a child is brought for vaccination by someone other than their biological mother and who is also deemed not to have Gillick competence.

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Paediatric urgent dental care

Sir, we read with great interest the recent article regarding repeat patient attendance for urgent dental care.[1] It is reasonable to postulate that the COVID-19 pandemic will have long-lasting effects in fortifying such findings.

The reduction and subsequent cessation of elective dental appointments in March 2020 resulted in the transformation of our paediatric dentistry urgent walk-in service based at St Thomas' Hospital, London to an urgent dental care centre accepting referrals via the NHS 111 pathway. Our service evaluation included 125 paediatric dental patients seen between September and October 2021 at St Thomas' Hospital. Nearly 50% of patients were under five years old, 38% of patients were 6–10 years old and 13% of patients were 11–16 years old. A quarter of patients had a significant medical condition including autism, behavioural disorders, co-morbidities such as asthma and three patients had a medical syndrome. Only 46 patients were registered with a general dental practitioner and many parents reported struggling to register their child with an NHS dental practice. Of primary diagnoses made, 13% were for dental trauma, 66% for caries and 11% presented with facial swelling. One patient required urgent admission for intravenous antibiotics. While 24% of patients required true