Comment on: Frequency of face touching with and without a mask in pediatric hematology/oncology health care professionals: For application to the COVID-19 pandemic

We thank the authors for their contribution to literature regarding face touching (FT) associated with mask use. The ongoing COVID-19 (SARS-CoV-2) pandemic provides an important context, given the global cultural landscape of use of masks by the general population.

The UK mandate for masks on public transport and shops has been recently published: mask wearing poses unique risks if not done properly. Our response to this article attempts to highlight some of these concerns.

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The UK mandate for masks on public transport and shops has been recently published: mask wearing poses unique risks if not done properly. Our response to this article attempts to highlight some of these concerns. The study observed a total of 330 person-minutes. It was found that face touching was lower with masks (5 FT/h compared to 20 FT/h without) in a health care setting. It took place in health care professionals (HCP), who would have had access to and use of masks throughout training and practice. It can therefore be inferred that they would be habituated in good mask practice.

In public populations lacking training, there is the potential that the mask changing process can pose risk of infection. This would have particular relevance to the doffing process, where potentially infected internal surfaces can be touched, and people can touch their face with infected hands.

A study in 10 individuals performing isolated office work without masks found that hand-to-face contact rate was 15.7 FT/h. This is comparable to the 20 FT/h found in the study under discussion. It should be noted that this study was observed in a student population, and none of the participants was noted to be a HCP. There is no evidence that decreased face touches while wearing masks can be applied to public populations.

Particularly in mask users who wear glasses, the combination of the flexible nose strip of a mask with the bridge of a pair of glasses may cause discomfort. This coupled with glasses’ inclination to gather condensation might cause increased adjustments to the mask during wear. This may be mitigated by training; initial wear in a naive general public may cause discomfort and lead to improper use.

We again offer our gratitude to the authors of the study for their work. Further studies should be completed, allowing for more person-minutes of investigation, improving the robustness of any conclusions drawn.

The aforementioned UK mandate for face coverings in public provides an interesting potential adjunct, whereby the study could be repeated in UK populations. There also exists the possibility of a similar study in nonhealth care settings, as shown by Nicas and Best in a nonhealth care professional study of similar objectives. This would then account for the earlier point regarding training in proper mask use during medical school/health care practice.

Further to this, public health campaigns regarding correct mask protocol and avoiding face touching can be evaluated for efficacy; this could involve randomising groups to receive training and then observing mask use. Should this be done in a large enough sample size, the true benefit of public health information regarding masks could be assessed.

With the COVID-19 pandemic remaining pervasive in many countries across the world, limiting infection risk through hand-to-face contact will be paramount in public health maintenance.

CONFLICT OF INTEREST
The authors declare that they have no relationships, financial or otherwise, with any organisation that might benefit from this piece.

Lauren Elizabeth Church
Gurnoor Nagi
Faculty of Life Sciences & Medicine, King’s College London, London, UK

Correspondence
Lauren Elizabeth Church, Centre for Human and Applied Physiological Sciences, Shepherd’s House, Guy’s Campus, London SE1 9RT, UK
Email: lauren.church@kcl.ac.uk

ORCID
Lauren Elizabeth Church https://orcid.org/0000-0001-9404-2401

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