The author suggests hand trimming of material does not require a dry field and AGP. There is also a mention of utilising some manufacturers, making it a potential involves gentle air drying according to however the technique of applying SEP self-etch primers (SEP) to avoid an AGP, protocol.

care may be provided following routine periapical dental pain with the absence of presence of intra-oral swelling and pulpal/≥100.0°F or subjective fever. If a patient is updated to either a measured reading of fever must be made.

being febrile ie a clinical correlation of the deferred treatment for the sole reason of recommends that a patient should not be the CDC in its guidelines for dental settings would fall under this category.

Secondly, in relation to thermal screening the CDC in its guidelines for dental settings recommends that a patient should not be deferred treatment for the sole reason of being febrile ie a clinical correlation of the fever must be made.7 The same guidelines recommend that the definition of fever be updated to either a measured reading of ≥100.0°F or subjective fever. If a patient is found to be febrile with a strongly associated diagnosis of dental origin such as the presence of intra-oral swelling and pulpal/periapical dental pain with the absence of symptoms suggestive of COVID-19, dental care may be provided following routine protocol.

Finally, in relation to orthodontic treatment this author mentions the use of self-etch primers (SEP) to avoid an AGP however the technique of applying SEP involves gentle air drying according to some manufacturers, making it a potential AGP. There is also a mention of utilising light cured resin modified GIC, but this material does not require a dry field and in fact, the surface of the enamel should be moist during bonding to ensure success.8 The author suggests hand trimming of excess composite/flash with a scalpel. An alternative to this would be to utilise either: band removing pliers (posterior teeth), hand scalpels/Mitchell’s trimmers (incisors) or adhesive removing pliers.9 Minimal remnants of residual material on the enamel surface can be lost with time as a result of toothbrushing.8

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Molecular iodine
Sir, we have read with great interest the correspondence of Challacombe et al. on the antiseptic efficacy of povidone-iodine (PVP-I) against SARS-CoV-2; we aim to demonstrate the potential prophylactic capacity of the new generation of uncomplexed molecular iodine (I1) mouthwashes.1

PVP-1 has been a gold standard antiseptic for decades with proven efficacy against the previously identified beta coronaviruses; it was one of the first candidates for the emergency trials attempting to establish an additional layer of protection for frontline healthcare workers.7 The mechanism of action of PVP-I relies primarily on the free iodine component, which is bound to a large polyvinylpyrrolidone molecule (PVP) acting as a carrier to deliver I1 to target cells. However, the viricidal activity of PVP-I is highly associated with its I1 content: the commonly used 10% PVP-I can only deliver 1–3 ppm of I1 in a compound of more than 31,600 ppm of total iodine atoms. The high percentage of bounded ‘non-active’ iodine contributes to all the undesirable toxicological and staining properties of PVP-I.3

A new generation of iodine-based antiseptics ‘super iodine’ was initiated recently to overcome the compositional side effects of PVP-I. Therefore, ioTech International (Boca Raton, FL) produced a patented aqueous solution of I1 that contains over 100 times more I1 than PVP-I and comes in various forms ready for prophylactic use including mouthwash, nasal spray, and hand cleanser. Moreover, the non-bioactive iodine content was reduced from 31,600 ppm in PVP-I to several hundred in the new formula thus accelerating its effect, increasing its shelf-life, and minimising its potential irritancy and mucosal staining.

In comparison to several antiseptic mouthwashes, the new I1 formulas showed higher viricidal efficacy against coronaviruses and took as short as 30 seconds to inactivate alpha coronaviruses (229E) completely.4 The same was observed in Rhinovirus which was totally inactivated above the cytotoxicity level after exposure to the new I1 formula for 30 seconds.4

To the best of our knowledge, there is an ongoing randomised control trial at St. Joseph’s Hospital University (Paterson, NJ) to evaluate the efficacy of I1 mouthwashes and nasal sprays in protecting frontline healthcare workers by reducing their susceptibility of getting infected by SARS-CoV-2. Therefore,