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### Improving standards of oral hygiene in intensive care

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Sir: Although the survey of oral care in European intensive care units undertaken by Rello et al. [1] was not demographically representative of those individuals participating at the European Society of Intensive Care Medicine Congress, it nevertheless reinforces the findings of previous studies. Despite data demonstrating that colonisation of the oropharynx with potentially pathogenic bacteria precedes the development of ventilator-associated pneumonia (VAP) [2], and that the latter can be reduced by oral decontamination [3], the oral cavity remains an area neglected by critical care practitioners. Too often resources are placed in elaborate approaches of reducing VAP such as subglottic aspiration ports, antimicrobial coated endotracheal tubes or automatic adjustment of endotracheal cuff pressures, instead of the simple measure of cleaning the oral cavity which may prove equally or possibly more effective.

Although Rello et al. found that oral care is given a high priority by those who perform it, this is often because it is thought to be important for patient comfort rather than an essential means of reducing

nosocomial infection. No participants from intensive care units (ICUs) in the UK were included [1], but the British Society for Disability and Oral Health recommend cleaning with toothbrushes to facilitate oral hygiene in mechanically ventilated patients [4]. Toothbrushes are routinely engaged in our own institution, although this appears to be at odds with oral care in many European ICUs, which rely largely on chlorhexidine mouthwashes [1] instead of brushing. It is unlikely that as healthy individuals we would accept oral hygiene methods that rely solely on the use of mouthwash, and yet many critical care practitioners impose this on their patients; however, the need for good oral care is even greater in mechanically ventilated patients, who have poorer baseline oral health status than healthy individuals and are rapidly colonised with potentially pathogenic organisms [5]. Although 77% of participants in Rello et al.'s survey concluded that they had adequate training on providing oral care to ICU patients, one must question whether these individuals are well qualified to make this judgement when the overall standard of oral hygiene appears to be below the desired benchmark. Even with the use of recommended "baby" toothbrushes, cleaning the oral cavity is both difficult to perform (as the endotracheal tube obscures and impedes brushing) and time-consuming.

It is common practice for modern ICUs to have their own dieticians, physiotherapists, pharmacists, psychologists and respiratory technicians. We suggest that now is the time for critical care practitioners to accept that poor oral hygiene has detrimental effects on patient morbidity and assign this task to ICU-based dental hygienists.

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