

EDITORIAL

COVID is here to stay

I do not think I need to say too much about the effect of COVID but want to use this editorial to briefly look back and ahead. COVID has had a devastating effect across the globe. Thankfully, it would appear that although the infectivity of each mutation is increasing, the mortality rate is decreasing. My sincere condolences go out to all those affected by COVID. This editorial is in no way making light of the impact on these families. I also need to say that the opinions expressed are mine and do not represent anyone else.

There has been a huge impact on dentistry with Victoria arguably the worst affected. Similar to the United States, where the American Dental Association surveyed a range of practitioners, we went to emergency treatment only, reopening with reduced patient numbers and “allowed” procedures then back to full capacity. In 2020, the prevalence of dentists in this survey testing positive was 2.6%, increasing from March to November. However, transmission during patient treatment was unclear, and most were thought to be already positive contacts (American Dental Association website accessed 12 May). This appears to be similar to what we experienced. In the United Kingdom, COVID led to a backlog of patients and changes in dental service design (General Dental Council website accessed 12 May), again with a similar situation here. To complicate matters, there was a lack of evidence-based guidelines leading to confusion and uncertainty, mainly due to the fact we did not know what we were dealing with. Certainly, increased PPE seemed to reduce the prevalence. In the impact of infection with SARS-Cov-2 on dental disease, especially periodontal disease, is a subject of debate and unclear. For periodontal disease, it would appear that the lack of regular maintenance or inability to start treatment led to deterioration rather than infection with SARS-Cov-2.

SARS-Cov-2 has been detected in the saliva of patients including the asymptomatic (JADA Nov 2021) resulting in the cessation and/or minimization of aerosol-generating procedures. However, preprocedural rinses can effectively reduce the viral load for 45 min. This study used 0.12% chlorhexidine, 1% peroxide, and povidone iodine as well as saline. However, research from Melbourne has suggested CHX is the least effective, and essential oils can also be considered (ADA VB website accessed 12 May). In addition, we know that high volume suction and rubber dam are effective and recommended by the Australian Dental Association. Of interest is that the American Environmental Protection Agency has clearly stated in April that this year “By themselves, portable air cleaners and HVAC filters are not enough to protect people from the virus that causes COVID-19. When used along with other best practices recommended by CDC and others, filtration can be part of a plan to protect people indoors” (<https://www.epa.gov/coronavirus/air-cleaners-hvac-filters-and-coronavirus-covid-19>, accessed 12 May).

We are at the stage of becoming complacent. Restrictions are highly unlikely to come back. The risk of infection is still there, although vaccination reduces the severity of symptoms. Risk mitigation is now the focus. This looks at what points during a patient’s visit we are able to reduce risk. On the ADAVB website (<https://adavb.org/resources/for-dental-professionals/covid-19>), there is a great image of the Swiss cheese model developed by Reason in 1990 showing how we can prevent the holes from lining up and reducing the risk of infection. All practices are required to have a COVID safe plan. Dentistry has always had very good infection control, but increased PPE and more stringent cleaning between patients are here to stay. I think many of us have been using preprocedural

rinsing prior to the outbreak and this will continue as routine practice prior to aerosol-generating procedures. However, rinsing out every 45 min is unrealistic, especially during surgical procedures or requiring the removal of a rubber dam. The rubber dam is already widely used and recognized as a good method to reduce “infected” aerosol. Increased airflow and ventilation are here to stay, but with the appropriate filters for air purifiers. There are now very clear guidelines (<https://adavb.org/resources/for-dental-professionals/covid-19>) that are comprehensive and up-to-date. Well done to the ADA with the latest ADAVB update on 9 May at the time of writing. For the next few months, symptomatic staff will be required to go home and/or stay at home and test immediately using rapid antigen tests and PCR. We are currently having to isolate for 7 days or until symptoms have resolved. So there are and will be ongoing issues with staffing and patient cancellation in the short term. Anecdotally, we all seem to be busier, short of dental assistants and booked further ahead than normal. Reappointment will present issues and unhappy patients. However, I suspect that isolation will be ruled out altogether and we will have a full complement of staff. Face masks in the waiting room will not be required. Many people assume that they will get infected and we may end up treating it the same way as a head cold. For many currently, these are the symptoms they are reporting. SARS-Cov-2 will continue to mutate, similar to the flu, and mandatory annual boosters are likely to be introduced with employees required to provide evidence to their employer, in line with a flu vaccination. RATs have well-known issues and are best used repeatedly over a few days rather than once. I suspect we will be using them less and less and then only on the really sick, especially if we are treating COVID like a head cold. So maybe in 12 months, we will be back to “normal”? I feel we also have forgotten that other respiratory diseases exist and they are/will make a comeback. So I ask if we really can treat all people with a cough, runny nose, and sore throat as if they have COVID.

SARS-Cov-2 is here to stay. We have weathered the storm and now have to deal with the aftermath. Dentistry as a whole is going a great job.

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