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Letter to the editor

COVID-19 and its implications in the management of resource infrastructure



To the Editor:

Following the outbreak of the coronavirus disease-2019 (COVID-19), Guo et al.¹ reported a reduction in the non-urgent dental care cases to three-tenths of its original volume and a concurrent thirty-eight percent reduction in the emergency dental patient volume in Beijing, China. These findings suggest the need to re-evaluate resource distribution in dental practice both during and after the COVID-19 pandemic.

In Taiwan, our current approach to limiting virus transmissions involves temperature taking followed by a questionnaire to screen patients with potential COVID-19 infection. The questionnaire records patients' travel history, occupation, contact history, clusters history, and whether they have displayed symptoms of possible infection. However, the highlighted risk of virus transmission through asymptomatic patients in their incubation periods has also caused an escalation of the pandemic worldwide. Moreover, while airborne particles vested with COVID-19 viruses might be the route of disease transmission, contact with human fluids and contaminated surfaces also put dental professionals and patients at an increased risk.

The infeasibility to screen out all infected patients and the rapid transmission rate of the virus has led routine dental practice to be suspended in several countries in hopes to limit nosocomial COVID-19 infections. The redistribution of dental cases in Beijing shows that even without suspension of service, the general population is conscious about the risk of infections through dental services and responds by reducing the demand for non-urgent services. Thus, countries across the globe should suspend all non-emergency dental practices in order to help contain the spreading pandemic. In their place, online consultations can be used to filter patients who do not need immediate treatment and to curtail patient anxiety from delayed dental visits.²

Past literature has illustrated pulpal and periapical diseases, gingival and periodontal diseases and oral soft tissue

infections to be the top three diagnoses in emergency dental visits.^{3,4} Similar findings can be seen in the COVID-19 emergency dental services in Beijing,¹ which are reiterated by Coulthard's⁵ concern of potentially having an increased number of patients suffering from acute life-threatening infections with reduced dental service availability. Redistribution of resources freed from service suspensions to managing infection-related diseases based on statistical analysis of emergency dental visits will allow the maximization of our assets in this time of crisis. Perhaps equally importantly, however, hospitals and clinics should be prepared for the increased volume of patients when the pandemic is over. In terms of both the keeping stock of equipment and of planning longer and more frequent shifts will likely be needed to respond to the increase in regular dental visits that might occur then. These distributions of resources both during and after the pandemic need to be carefully calibrated in order to ensure the quality of care and the well-being of dental professionals.

Declaration of Competing Interest

The authors have no conflicts of interest relevant to this article.

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