According to news reports, all of the contiguous 48 states are allowing dentists to resume performing elective procedures with various caveats, except Maine.

Since recommendations vary from state to state, as well as the language in the announcements, I would like to make some observations about what have been suggested as “best practices” and also add some comments based on a daily study of the information available from the CDC, ADA, OSHA, various state dental societies, infectious disease “experts,” webinars, and many discussions with fellow practitioners.

1) PPE- this alone is preventing many practitioners I know from opening. The recommendations call for N95 respirators which need to be fitted to prevent leakage. But the more pressing issue is availability. N95s are almost impossible to find in many locations. First, they are being prioritized for front line health care workers, first responders, police, and fire fighters. Second, they need to be certified by the nationally recognized testing authorities NIOSH and the FDA. (ADA Return to Work Interim Guidance Toolkit). Goggles (non-vented and face shields, medical gowns, booties, and head coverings are also recommended for aerosol producing procedures. Patients should use hand sanitizer before entering operatory and before leaving. {Comment: Not providing proper PPE for staff when doing aerosol producing procedures appears to be an OSHA violation which should give all of us pause before returning to using high speed
handpieces and ultrasonic cleaners without having all the proper equipment for all of our at-risk employees.

2) Daily temperature of all staff at beginning, middle, and end of day and all patients in car before entering office. {COMMENT: How can we be sure that staff and/or patients are not taking anti-pyretics, perhaps for a condition not pertaining to a fever? This question needs to be asked!}

3) Pre-screening patients on phone before appointment {COMMENT: Patients can be asymptomatic and still transmit the virus or convert to positive in the time span between screening and appointment. Make sure to ask if anything has changed since we spoke to you last while patients are in the parking lot. If you do not reach the patient prior to the appointment, ask the screening questions while patient in parking lot. If teenagers who can drive and come alone, be sure that they are of legal age to answer screening questions and check with parent or guardian if anything not absolutely clear}.

4) Have staff in beginning of day and patients rinse for 1 minute (two 30 second rinses) with 1.5% hydrogen peroxide. {No scientific evidence that this has any effect}

5) Barrier wrap x-ray, light handles, chair switches, etc. Change aseptically between patients) {Good idea!}

6) Test oxygen saturation If less than 93% refer to physician for C-19 evaluation. {Good idea!}

7) Put all patients on oxygen using nasal hood to minimize exhaled air from nasopharynx where there may be a high viral load if patient is positive and is asymptomatic

8) Use rubber dam on all restorative patients. Place dam up under nasal hood. Use of the RD will minimize suctioning or exhalation of oropharynx droplets which may contain a high viral load {IDEA: To decrease likelihood of leakage from sides of rubber dam punch 4 holes in each corner of rubber dam, loop one length of 1/4” elastic through the holes on one side and tie the two ends together. Next, slip another length of elastic through the two holes on the other side. Then tie the elastic loops behind the patient’s head with Velcro so the dam is snug against the patient’s face. Be sure to use latex free rubber dam}

9) Use of portable, high volume suction units in each operatory {COMMENT: New and not thoroughly tested technology as far as significantly deceasing viral; load- awaiting more testing and evaluation}

10) Installing negative pressure equipment in at least two operatories as used in hospital operating rooms which would allow for isolation, 12 air exchanges/hour, HEPA filtration of the air, and reduced pressure from corridor. {COMMENT: Not at all practical. See Expedient Patient Isolation Rooms & Expedient Methods for Surge Airborne Isolation within Healthcare Settings during Response to a Natural or Manmade Epidemic for extensive discussion of these issues}

11) A similar situation might be able to be created as in Scenario described in (10) above by venting each operatory and use an exhaust fan sized appropriately for the operatory which would exhaust any aerosol up through the ceiling into the parking area above.

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12) Use electric handpieces and the thickest non splatter prophy paste available or make our paste thicker AND use high speed suction with a FUNNEL attachment to eliminate splatter when doing a prophy. {COMMENT: This needs to be tested (which I have not done) to see if high torque electric handpieces will decrease splatter and that the handpiece and prophy angle can be autoclaved.}

13) Consider using silver diamine fluoride (SDF) on floss BEFORE regular fluoride to help prevent interproximal carries. First test for staining between two most posterior teeth. {Since we are trying to minimize aerosolization, if interproximal caries can be prevented or incipient caries remineralized, aerosolization from high speed rotary instrumentation can be prevented, minimized, or postponed.}

14) Remove all hard build up with appropriate scalers. Order new curettes and sharpen half of the scalers monthly (or more or less often as required) followed by the other half after 1st half returned. Work out a volume discount with sharpening company. Less wear and tear on hygienists’ wrists if curettes are sharp and better, quicker scaling and root planning. Clean ortho wires with ortho brush and coarse prophy paste. When necessary, ask orthodontist to remove arch wire for better access for cleaning.

15) To decrease time in the chair and office and therefore decrease chances of exposure to any virus load in the office (a) switch to digital x-rays if have not done so and (b) Hire assistants for the hygienists who will do an especially detailed cleanup between patients allowing office to turn over chairs more expeditiously, insure a thorough cleanup, and decrease patients’ potential exposure time in the office.

16) Instead of high speed and water spray, use low speed electric handpiece dry (with high torque) and a NEW 556 cross cut fissure burr to “prep” the teeth for sealants. After prep, use pumice and a sharp explorer to clean out the grooves of the molars. {I have not tried this technique-- needs to be tested first before adopted. If not going to explore pits and fissures with a fissurotomy burr to rule out occlusal caries, need to secure optimal BW x-rays to try to rule out occlusal caries.}

17) If you feel that using a high-speed handpiece is safe for the dental team, but wish to limit aerosolization in your office, you might want to consider the following approach. (a) Try to postpone restoring enamel caries in appropriate patients; (b) use SDF when indicated, and (c) consider doing operative on the last 2 patients of the day at opposite ends of the office and creating a non-porous floor to ceiling barrier between the ends of the office with a secure door or sliding door. When the patient leaves, use exhaust fan to exhaust air out of the office. Patients need to wear goggles and some type of disposable drape and chair needs to be covered with plastic as well as head rest, x-ray switch, chair switch, etc. Ideally patient should be on oxygen to minimize viral load from
nasopharynx and RD used as described in (9) above. Patient should be wearing mask into the treatment area and after rubber dam removed. Recommend nitrous oxide and oxygen if patient has problem with RD and/or nasal hood. Otherwise, just oxygen to decrease viral load from nasopharynx.

18) Settle all financial issues, insurance, scheduling, etc. before the procedure, preferably over the phone as much as possible so patient may exit office ASAP after procedure completed, preferably through a dedicated exit. Then “deep clean” operatories, including mopping the floor with appropriate germicide since virus laden droplets will fall to the floor and other hard surfaces due to gravity. {Although no scientific data on efficiency of UV light in killing C-19, many practices are using them for overnight sanitizing (at least 1 hour). There are portable units with timers which can be used overnight. Size of unit and exposure time would have to be determined according to manufacturer’s recommendations. Deep clean and mop floor before first patient in morning}.

19) Some practitioners are “resting” treatment rooms for 1 hour before the next patient is seated after a procedure that required aerosolization. The idea is to thoroughly clean the room, seal the room, ventilate the room, and return in one hour and repeat the cleaning, since potentially virus laden particulate matter and droplets should drop onto the floor and other hard surfaces due to gravity. This would also be the rationale for mobbing the floor with an appropriate disinfectant and wearing booties. {No studies available to substantiate this approach, but in theory sounds like a good idea and should do no harm as long as proper PPE is worn by person doing the cleaning and proper ventilation during this “deep cleaning” is provided}

*Before making decisions about the scope of your practice, I would recommend reading the final attachment written by Professor Erin Bromage ([https://www.erinbromage.com/post/the-risks-know-them-avoid-them](https://www.erinbromage.com/post/the-risks-know-them-avoid-them)), a comparative immunologist who provides an excellent overview of what we know about COVID-19.*