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Knowledge, awareness and attitude towards non-aerosol procedures among dentists in Bangalore city during the COVID-19 pandemic- A Survey

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Abstract

Aim: To assess knowledge, attitude and awareness towards non-aerosol procedures during the COVID-19 pandemic among general dentists and dental specialists in Bangalore city.

Materials and Methods: A total of 100 general dentists and dental specialists practicing in Bangalore city were included in the study. An online validated questionnaire with a hyperlink was sent to them. Descriptive analysis of all the explanatory and outcome parameters was done using mean and standard deviation for quantitative variables, frequency and proportions for categorical variables. Windows Version 22.0 with SPSS was used to perform statistical analyses and the value of p<0.05 was considered statistically significant.

Results: The study revealed 97% were aware about ART, 11% were aware about Hall's technique, 12% were aware about Resin Infiltration technique. On being asked about

the methods to control aerosol practice post COVID-19, 82% stated that they were aware. Seventy six of them used N95 masks, 10 of them used FFP3, and 19 of them used 3Ply surgical masks. Air purification by HEPA filters were ideal for dental practice according to 48%. On being asked about treating a patient who was COVID positive 2 months ago or has come in a contact with a COVID positive patient, 78% answered they would treat the patient using a fully equipped PPE followed by fumigation. (P<0.001)

Conclusion: General dentists showed satisfactory knowledge regarding aerosol control, disinfection protocol and non aerosol alternatives, but lacked knowledge about clinically implementing them.

Keywords: COVID-19, Non aerosol procedures, general dentists, Bangalore city.

Introduction

By the end of 2019, a pneumonia outbreak with unknown etiology occurred in Wuhan, China. The pathogen was identified and named as 2019 novel coronavirus (2019-nCoV), and the disease was named corona virus disease 2019 (COVID-19). The possible routes of nCoV transmission are mainly direct contact and droplet transmission. Aerosol transmission is also a possible route of transmission when there is an exposure to high concentrations of aerosols in a relatively closed environment.[1] Dental aerosol have a mean particle size of $\leq 5 \mu m.[2]$

According to a report by The New York Times [3], dentistry is one of the most exposed professions to the COVID-19 contagion. It is necessary to establish a clinical protocol to be applied in the working environment to avoid new infections and progressive virus spread. In daily clinical practice, the patient's oral fluids, material contamination, and dental unit surfaces can act as sources of contagion both for the dentist and the assistant, and for the patient themselves. Saliva and blood droplets that are deposited on the surfaces or aerosol inhalation generated by rotating instruments and ultrasound handpieces constitute a risk for those who occupy those environments. Therefore, the use of disinfectants and personal protective equipment (PPE) remain essential for the protection of the dental professional.[4]

The dentist should focus on limiting aerosol procedures to the minimal and resort to non-aerosol procedures. The sudden spread of SARS-CoV-2 has determined the need to modify both preventive and therapeutic protocols in dental practice.

Materials and Methods

The study was conducted for a period of 3 months through an online survey. A sample size of 100 was estimated, with margin of error at 0.10. The ethical approval of the study was obtained from the Institutional ethical committee and review board (IEC:109). The eligibility criteria were doctors with a BDS degree and exclusion criteria were subjects without a BDS degree. An online questionnaire with a hyperlink was sent to them.

The validated online questionnaire consisted of 32 questions excluding personnel information. The questionnaire covered questions regarding dental practice pre-COVID 19, aerosol control and disinfection, knowledge about non aerosol procedures and clinical practice post COVID-19.

Descriptive analysis of all the demographic and KAP variables was done using mean and standard deviation for quantitative variables, frequency and proportions for categorical variables. Windows Version 22.0 with SPSS was used to perform statistical analyses and the value of p<0.05 was considered statistically significant.

Results

The questionnaire was answered by a total of 105 dentists out of which 85 were General dentists, 13 PG students and

7 specialists. Practice was resumed by 23 of them in September 2020, 20 of them by June, 18 of them by August, 10 of them by October, 8 of them by July, 6 of them by June, 4 of them by November, and 15 of them didn't resume practices even by december 2020.

Non aerosol procedures pre-COVID 19: The study revealed that 97.1% were aware about ART, 10.5% were aware about Hall's technique, 11.4% were aware about Resin Infiltration technique and 10.5% were aware about Silver Diamine Flouride (SDF)/Nano Silver Flouride (NSF). (P<0.001) [Figure 1]

Methods to control aerosol post COVID 19: Majority of the dentists (82%) stated that they were aware of methods to control aerosol practice post COVID-19. Average diameter of an aerosol was correctly answered by 57%, and 40% said aerosols remain suspended in the air for less than an hour. According to 59% the easiest way to control aerosol was to use slow speed micro motor without water spray, keeping window and doors open.

Ninety of them answered that pre-procedural mouth rinse, rubber dam, high volume evacuation can be used to reduce the viral load, out of which 79% of them use pre procedural mouth rinse in their practice, and 45.7% of 39% them use povidine-iodine, of them use Chlorhexidine, 15.2% use hydrogen peroxide. (P<0.001) [Figure 2]

Practice on wearing protective masks during clinical procedures: Seventy-six of them use N95 masks, 10 of them use FFP3, and 19 of them use 3Ply surgical masks. When asked about the re-use of N95 masks - 53.8% of them use it by specific time space re-use, 16.3% of them use it only once, 14.4% of them use after disinfection and 13.5% of them use it after autoclaving and 2% of them after UV/Ozone disinfection. [Figure 3]

Awareness on PPE and Sanitizers: Majority of the participants, 83.8% answered disposable fluid resistant

PPE's were most effective in preventing contamination, whereas 11.4% answered cotton gowns and 4.8% weren't sure. Seventy of them answered doffing the PPE gowns plays a role in cross contamination, and 35 answered maybe. When questioned about what percentage of alcohol santitizer was most effective, 85 answered >70%, 20 answered <70%. This was statistically significant at a P value of 0.001. [Table 1]

Practice on air purification in their dental practice: Fourty-eight of them answered they weren't sure whether air purification by HEPA filters were ideal for dental practice, 14 of them answered that air purification by HEPA filters werent ideal for dental practice, and 43 of them answered air purification by HEPA filters were ideal for dental practice. Only 21 of them correctly answered about how much can a HEPA filter ideally would capture particles and 93 of them said efficacy of UV germicidal irradiation depends on both intensity and duration of light. (P<0.001) [Table 2]

Disinfection and Fumigation in dental practice: Ninetytwo of them fumigate their clinic of which 69 said hydrogen peroxide is the best choice for fumigation. Seventy one of them disinfect of which 92% of them said sodium hypochlorite is the best choice for disinfection. This was statistically significant at a P value of <0.001.

Post COVID-19 dental practice: Eighty-seven of them limit dental aerosol procedures post COVID 19. Ninety five of them use a PPE, along with mask, face shield and headcap; 6 of them only use a mask and face shield and 4 of them only use a mask. The PPE kit is changed at the end of the day by 31 of them, 52 of them change it after every patient who have undergone an aerosol procedure, 17 of them change it after every patient, and 5 of them do not use a PPE kit at all [Table 3]. When asked about what precautions the dental assistant takes, 48 of them said the assistant only uses a mask and no face shield, 49 of answered they use a mask and face shield and 8 of them said the assistant doesn't take any precautions. (P<0.001) **Non aerosol procedures post COVID-19:** Seventy-nine percentage of them use ART post COVID to treat lesions extending into the enamel and not dentin. Only 31.4% of them knew resin infiltration technique was used to treat white spot lesions and implemeted it in their practice [Figure 4(a)]. Fifty-nine percentage of them were aware that Hall's technique is used in relation to SSC crowns, and 20% of them use it in their practice. Sixty-six percentage of them were aware that SDF/NSF is used to arrest caries and 29.5% of them implement it in their practice post COVID. This was statistically significant at a P value of 0.001. [Figure 4(b)]

Special precautions followed while treating high risk patient during COVID-19: Thirty-seven percentage of them answered they would treat a patient with a history of fever, cold and cough using a fully equipped PPE followed by fumigation, 5.7% of them would use only a PPE followed by no fumigation and 57.1% of them wouldn't treat the patient.

On being asked about a patient who was COVID positive 2 months ago or has come in a contact with a COVID positive patient, 74.3% of them answered they would treat the patient using a fully equipped PPE followed by fumigation, 2.9% of them would only use a PPE and no fumigation, and 22.9% of them wouldn't treat the patient. (P<0.001) [Figure 5]

Discussion

The current study was conducted during the later stages of the COVID-19 outbreak and the knowledge about non aerosol procedures among general dentists along with their knowledge in aerosol control, disinfection in their clinical practice post COVID-19 was evaluated.

In general, the knowledge about non-aerosol procedures were satisfactory. The study revealed that 83% were

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aware about ART (Atraumatic Restorative Treatment) but the knowledge level on Hall's technique, Silver Diamine Flouride (SDF) was 62% and 70% respectively, and not many were implementing these techniques in their practice. This was in accordance to the study done by Ahmad Aldhafeeri et al [5], Altaf Hussain Shah [6] and Jasmine Rayapudi et al [7]. Knowledge on Resin Infiltration Technique was 33% which indicated unsatisfactory knowledge as in accordance with the study by Abdullah Fozan A. Alhammad et al.[8]

The knowledge level on methods to control aerosol was satisfactory in agreement with the previous studies[9], however the results showed some gaps do exist on basic knowledge on aerosols. Fourty percent of them answered aerosols remain suspended in the air for less than hour. The average diameter of a dental aerosol $\leq 5 \mu m^2$ and aerosols can remain suspended for several hours (depending on local air movement) and can travel for 1-3m from their source[10]. The easiest way to control aerosol is it to use a mouth rinse before dental procedures, using rubber dam, high volume saliva ejectors and reducing the use of high speed handpieces, using slow speed micromotor without water spray [11]. Preprocedural mouth rinses play a key role in reducing viral load. In a recent study done by Jin Gu Yoon et al[12] he concluded Chlorhexidine mouthwash was effective in reducing the SARS-CoV-2 viral load in saliva for a shortterm period.

N95 respirators, named for their ability to filter 95% or more of tiny 0.3-µm particles, are the mainstay of protection against airborne pathogens [13]. N95 masks are made in several layers. The middle filtering layers are made of polypropylene fibres with an embedded electrostatic charge. Filtering efficiency is achieved by both the mechanical structure of the polypropylene filter layer and the electrostatic charge [14]. In the present study

72% of the practitioners used n95 masks which has been proved most effective against respiratory pathogens. The re-use of N95 masks can de done by different methods:

1) Using 3–4 masks, numbered on the outside as 1–4, for each day. They can be used each day in numerical order. All SARS-CoV-2 viruses on the mask will be dead in 3 days.¹⁵ Masks should be kept at room temperature (21–23 $^{\circ}$ C [70–73 $^{\circ}$ F]) and 40% humidity. There will be no change in the mask's properties[14].

2) Heating at 70° C (158° F) for 60 Minutes – this will retain 98.5% of the filtering efficiency.

3) N95 Masks Can be Boiled for 5 Minutes without immersing the elastic bands or stirring the water - this retains 92.4% of filtering efficiency[15].

4) Ultraviolet irradiation and fumigation: This method places two towers, each containing eight ultraviolet C(UVC) bulbs, in a room with walls coated with reflective paint. Testing shows that 15 min of UVC radiation is enough to kill the virus [16].These 4 methods are most commonly used. Filtering Face piece – 3 (FFP3) was used by 9% that is almost as competent as N95's and 3 ply surgical masks were used by 18% which is not deemed fit for aerosol generating procedures however high quality standard surgical masks (type II/IIR according to European Norm EN 14683) were as effective as FFP2 masks [17].

The World Health Organization (WHO) defines an alcohol-based hand rub as: "An alcohol-containing preparation (liquid, gel or foam) designed for application to the hands to inactivate microorganisms and/or temporarily suppress their growth. Such preparations may contain one or more types of alcohol, other active ingredients with excipients, and humectants." The recommended alcohol ranges permit the alcohol to interact with functional proteins thus inactivating them. The lower range (60–75%) readily denatures proteins while higher

levels (>95%) cause coagulation of membrane proteins hence preventing the alcohol from entering the cell. So ideally formulations having 70% alcohol content is to be used [18].

High Efficiency Particulate Air filters have been discussed an adjunctive means for decontamination of SARS-Co V-2 aerosols in health care settings. HEPA filters are usually manufactured by pleating microfiber glass or other fibrous media made with multiple layers of randomly arranged fibers, with diameters ranging from 2 to 500 nm [19]. As air flows through the filter and in between the fibers, airborne particles—such as respiratory and aerosol droplets—will be trapped by 1 of 3 mechanisms: Impaction, Interception, and Diffusion. HEPA filters have at least 99.97% efficiency for removing all particles, with even higher efficiencies for particles both larger and smaller than 0.15 mm. The aerosols that may be produced by human cough are <1 μ m, and the SARS-CoV-2 virion is reported to be 60 to 140 nm (0.06-0.14 μ m) [20].

A spray of respiratory droplets from an infected individual may also land on surfaces where the virus could remain viable and can serve as a source of transmission [21] and therefore disinfection and fumigation are of utmost importance. The degree of effectiveness of all the surface disinfects is dependent on their concentration and exposure time. Ethanol 62–71%, Hydrogen peroxide 0.5%, or 0.1% Sodium hypochlorite are most commonly used. It is imperative to clean the surface with soap and water before applying any surface disinfectant. Fumigants have been traditionally employed for a long time for their germicidal tendencies [22]. Recently a study used hydrogen peroxide as a fumigant to disinfect N95 masks [23].

Care is to be observed while providing treatment to the patient to avoid spread of nosocomial infection of the disease. Dental personnel should use disposable face

masks, sterile gloves, head cap, gown and eye wear while assessing patients with a flu-like or other respiratory illness. The personal protective barriers should be worn once and discarded. Elective dental procedures should be avoided until the patient is no longer contagious with the airborne transmitted disease. Emergency dental treatment for patients with severe tooth pain, diffuse oral swelling, tooth fractures, pericoronitis & uncontrolled bleeding should be treated [24]. According to the British Medical Journal, use of Ibuprofen is prohibited due to its interference with immune function. Acetaminophen is a drug of choice for analgesia in treating COVID-19 infected patients. World Health Organization (WHO) endorsed this recommendation on March 18, 2020.[25]

Conclusion

General dentists showed satisfactory knowledge about non-aerosol techniques but lacked finesse about implementing them clinically. Knowledge regarding disinfection and aerosol control was also satisfactory. However, there is still scope for recommendations to improve the knowledge level amongst dental staff. It is also recommended to increase the dentists' access to materials provided by dental health care authorities and to specify the best and safest approaches when dealing with COVID-19 patients during and after the outbreak.

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Legend Tables and Figure

Table 1: Comparison of distribution of responses towards awareness on protective gown and sanitizer using Chi SquareGoodness of Fit Test

Question	Responses	n	%	c^2 Value	P-Value
Most appropriate gown in preventing	Cotton gowns	12	11.4%		
contaminated fluid transfer?	Disposable fluid resistant gowns	88	83.8%	121.086	< 0.001*
	Not sure	5	4.8%		
What percentage of alcohol sanitizer is	< 50% Alcohol content	0	0.0%		
effective?	<70% Alcohol content	20	19.0%	40.238	< 0.001*
	>70% Alcohol content	85	81.0%		
Ways of doffing the gowns plays a role	Yes	70	66.7%		
in cross contamination?	No	0	0.0%	11.667	< 0.001*
	Maybe	35	33.3%		

* - Statistically Significant

Table 2: Comparison of distribution of responses towards practice on air purification in dental practice using Chi								
Square Goodness of Fit Test								
Question	Responses	n	%	χ^2 Value	P-Value			
Do you think air purification by	Yes	43	41.0%					
HEPA filters are ideal for dental	No, Too much aerosol production in			10 257	<0.001*			
practice?	very less time	14	13.3%	19.237	<0.001			
	May be	48	45.7%					
How much can a HEPA filter	0.001-0.1 microns	21	23.3%					
capture?	0.3 microns	51	56.7%	22.200	< 0.001*			
	Not sure	18	20.0%					
Efficacy of ultraviolet germicidal	Intensity of Light	6	5.7%					
irradiation depends on?	Duration of Light	6	5.7%	144.171	<0.001*			
	Both	93	88.6%					

* - Statistically Significant

Table 3: Comparison of distribution of respo	onses towards post-COVID denta	al practi	ce using C	hi Square G	oodness of
Fit Test					
Question	Responses	n	%	χ^2 Value	P-Value
Do you limit aerosol generating procedures	Yes	87	82.9%	45.343	<0.001*
post COVID19?	No	18	17.1%		
How would you perform an aerosol	Only mask, no face shield	4	3.8%	154.343 <0.001*	<0.001*
generating procedure?	Mask and face shield	6	5.7%		
	Mask, face shield and heal				
	cap along with PPE	95	90.5%		
Do you use a PPE kit and how often do you	After every patient	17	16.2%	_	
change it?	After patients who undergone				
	aerosol procedure	52	49.5%	46 581	<0.001*
	At the end of the day after			10.501	<0.001
	treating all patients	31	29.5%		
	Do not use PPE Kit	5	4.8%]	

Statistically Significant



Fig. 1: Distribution of responses to different procedures done before COVID lockdown.



Fig. 2: Distribution of responses towards awareness on ways to reduce viral load.



Fig. 3: Distribution of responses towards practice on wearing protective mask.



Fig. 4(a) :Distribution of responses towards specific Rx procedures in post COVID-19 dental practice



Fig. 4(b): Distribution of responses towards specific Rx procedures in post COVID-19 dental practice



Fig. 5: Responses towards special precautions followed during treating the high risk patients.