Message From Our Outgoing President
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Dear Friends,

This is the last article I am writing as the President of our esteemed dental society. My term ends on the 31st of December. This year went by quickly and I thoroughly enjoyed serving as your President. By no means is it the end of my association with you, as I look forward to serving you in the future in a different capacity.

The year 2020 has been a challenge with the pandemic, office closures, PPE shortage, political turmoil, protests, virtual everything and devastating fires; leading to isolation and depression for many of our friends and family members. I think to a quote by our previous surgeon general, Dr. Vivek Murthy, who said, “what we need is a healing network and trusted voices.” We at OCDS have always been here as your healing network, to listen to the grievances of our members and lend support in any which way we could.

Along with all the satirical drama rather than true news on our TV, people need trusted voices they can rely on, be it a family member, your friends or your dental society. It is always a good feeling to know someone cares and looks after your true interest.

As with professional organizations, the Board of Directors changes annually, but the permanent link is our staff. I must say we have been lucky to have a very efficient and dedicated staff as our Society’s backbone. Megan Francis, as the Executive Director has proved herself worthy, in spite of her being new to the field of dentistry. In two short years she has picked up where our previous Executive Director had left off. Initially, we expected a period of uncertainty, but it was a smooth sailing from day one. I must also mention Stephanie Franklin, Shalyn Robers and Diana Alcazar who, with their vast experience with the OCDS, made the transition almost unnoticeable. Your association is in self-drive mode and in good hands and I am proud of the way it is running.

I am lucky, in addition to the efficient staff, I had a wonderful board. With their diverse expertise in different areas, we were able to keep our society one of the strongest components within CDA. We are also lucky to have two well-respected CDA Trustees, Drs. Bijan Modjtahedi and Nick Caplanis, who have the reputation of “when they talk, people listen.”

The billionaire Mr. Jack Ma of Alibaba company said, “the goal for the year 2020 is to just survive. It is not the profits, growth or entertainment, which can always be pursued if one is alive and well.”

Continued on page 6.

Ramesh Gowda, DDS
President
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continued on page 6
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**President’s Message**

We as an association are more than surviving. Thanks in part to our members; with your membership renewal our society hasn’t dwindled and remains strong. Our CE courses are going on as planned, with the exception that you are now attending virtually from the comforts of your home or office. The only thing missing is the in-person interaction and the comradery that we enjoyed in regular meetings.

As my term comes to an end, we made sure OCDS continues to be in good hands. Dr. Robert Passamano will be the 2021 OCDS President; a young and enthusiastic orthodontist who will make an excellent President. He will be supported by an equally strong Executive Committee, with Dr. David Telles as the President-Elect, Dr. Carol Daderian as the Vice President, Dr. Esther Chen as the Treasurer and Dr. Christina Do as the Secretary. I wish them all the best in their new role.

I, along with my wife Mrs. Geetha Gowda, my sons Dr. Ashwin Gowda and Dr. Chandan Gowda along with my daughter-in-law Dr. Melissa Gowda, take this opportunity to thank you all for giving me this golden opportunity to serve you on the Board all these years and to lead it as the President, which we will remember throughout our lives.

I thank our 2020 Board of Directors and our staff for all the support, encouragement and more than anything your friendship.

I love you all and wish you a wonderful time with this noble profession of dentistry.

Dr. Ramesh Gowda
President
CDA Career Center

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I write the last article of 2020 as I am at the OCDS office, with our amazing staff, handing out PPE kits. The OCDS staff has spent countless weekends putting together these kits, made from donated PPE, for our members. We know it will never be perfect (we are the largest component; securing that many donations for each and every member is almost impossible), but we are trying our best.

When people ask how we are doing, I find myself replying “we're hanging in there.” However, this society and this staff are doing more than that. We are fighters and survivors. Hanging in there give the contention that we were struggling and still are. I do not find that true for myself, OCDS staff or our members.

We navigated something that many of us never thought we'd live through and we are still taking hits.

In the past few weeks, I have run around securing donations, asking staff to take time away from families to put together kits, all the while we are still teaching our children at home, and days later some of us had to evacuate due to the fires in Orange County. I know some of our members had to evacuate and days later were still unable to go back.

The hits keep coming, but did we falter? No.

We all struggled at some point during 2020. Many of us had to ask for help in some way. To me, that's normal. Life is all about trying to find your way through the ups and downs and asking those who might have an answer for support.

I hope during this year OCDS has brought you some of the support you were looking for.
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OCDS would like to give a big "Thank You!" to Assemblyman Phillip Chen and NewRain Healthcare for donating 5,000 KN95 masks, 250,000 surgical masks and 5,000 hand sanitizers. Their donation is greatly appreciated!

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Their donation is greatly appreciated!
Welcome New Members

The following dentists have completed the necessary requirements, paid current dues, and have been accepted as Regular Active Members.

Maria Acherman, DDS
Loma Linda University/2020
General Dentist

Rebecca Ahlers, DDS
2710 N Grand Ave
Santa Ana, CA 92705
Creighton University
Boyne Sch of Dent/2019
General Dentist

Preston Beck, DDS
Herman Ostrow School of Dentistry
of USC/2017
General Dentist

Kevin Brewer, DDS, MD
7677 Center Ave Ste 409
Huntington Beach, CA 92647-3098
Baylor College of Dentistry/2008
U of Florida Jacksonville/2014
Oral & Maxillofacial Surgeon

Po-Ting Chi, DMD
Western University of Health Sciences College of Dental Medicine/2018
General Dentist

Matthew Comfort, DDS
University of Pennsylvania/2016
General Dentist

Natalie Do, DMD
Midwestern University/2020
General Dentist

Stephen Donoghue, DDS
University of Texas
San Antonio/2020
General Dentist

Brian Goo, DDS
Herman Ostrow School of Dentistry of USC/2016
Highland General Hospital/2020
Oral & Maxillofacial Surgeon

Tai Ha, DDS
1441 Avocado Ave Ste 404
Newport Beach, CA 92660-7705
Herman Ostrow School of Dentistry of USC/2015
General Dentist

Tyler Hales, DDS
777 Corporate Dr Ste 100
Ladera Ranch, CA 92694-2138
Herman Ostrow School of Dentistry of USC/2016
General Dentist

Shou Chia Huang, DMD
Tufts University School of Dental Medicine/2018
General Dentist

Naz Khatiblou, DDS
New York University/2020
General Dentist

Crystal J. Lee, DDS
UOP Arthur A. Dugoni School of Dentistry/2018
General Dentist

Hoaihanh Nguyen, DDS
9029 Atlanta Ave
Huntington Beach, CA 92646-6332
UCSF School of Dentistry/1991
General Dentist

Jongwoo Park, DDS
University of Detroit-Mercy/2019
General Dentist

Scott Peifer, DDS
7891 Talbert Ave Ste, 101
Huntington Beach, CA 92648-8613
Indiana University/2011
Indiana University/2015
Oral & Maxillofacial Surgery

Parra Phuong, DDS
UOP Arthur A. Dugoni School of Dentistry/2020
General Dentist

Tabasom Rafi, DDS
UCSF School of Dentistry/2018
General Dentist
Maha Sadek, DDS
University of Pennsylvania/2020
General Dentist

Ruben Sandu, DDS
UOP Arthur A. Dugoni School of Dentistry/2010
Mt Sinai Hospital/2015
Pediatric Dentistry

Joshua Suk, DDS
Baylor College of Dentistry/2019
General Dentist

The following dentists have transferred as Active Members to OCDS.

Amro Albaghdadi, DDS
Herman Ostrow School of Dentistry of USC/2019
General Dentist

Soheir Azer, BDS
355 Placentia Ave Ste 105
Newport Beach, CA 92663
Univ of Alexandria/1981
General Dentist

Avni Bhula, DDS
UOP Arthur A. Dugoni School of Dentistry/2018
General Dentist

Naman Desai, DDS, MD
13132 Newport Ave Ste, 230
Tustin, CA 92780-3429
UCLA School of Dentistry/2014
USC Medical Center/2020
Oral & Maxillofacial Surgeon

Justine Hai, DDS
SUNY-Buffalo/2015
UCSF School of Dentistry/2019
Periodontist

Robert Harley, DDS
UCSF School of Dentistry/1983
General Dentist

Sheri Jones, DMD
Western University of Health Sciences College of Dental Medicine/2019
General Dentist

Rashid Kamdar, DDS
1332 E Chapman Ave
Fullerton, CA 92831
UCLA School of Dentistry/2006
University of Nevada, Las Vegas/2009
Orthodontist

Dianne Le, DDS
Univ of Medical Sciences in Ho Chi Minh City/1990
General Dentist

Dustin Le, DDS
3739 S Plaza Dr
Santa Ana, CA 92704-7463
Herman Ostrow School of Dentistry of USC/2015
General Dentist

Linda Lee, DDS
Herman Ostrow School of Dentistry of USC/2017
General Dentist

Andrew Levin, DDS
UCLA School of Dentistry/2016
UOP Arthur A. Dugoni School of Dentistry/2020
Orthodontist

Irene Mokriy, DMD
3851 Katella Ave Ste 225
Los Alamitos, CA 90720-3353
Univ of Manitoba/2004
General Dentist

Jack Y. Pai, DDS
17400 Irvine Blvd Ste D
Tustin, CA 92780-3030
UOP Arthur A. Dugoni School of Dentistry/2017
General Dentist

Sepi Shafa, DDS
1122 E Lincoln Ave Ste 209
Orange, CA 92865-1909
UCSF School of Dentistry/2017
UCSF School of Dentistry/2020
Peridontist

Arie Tayani, DDS
University of Maryland
Baltimore College of Dental Surgery/2019
General Dentist

Anne Tran, DMD
Western University of Health Sciences College of Dental Medicine/2020
General Dentist
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Milestones

5 Years
Sara Akbar
Angham Al-Abdulla
Brandan Althof
Hamed Bozorgmanesh
Justin Chi
Jae Choi
Diep Dang
Christine Fortmann
Jason Kim
Hyun Yil Kim
Juliana Lee
Peter Lee
Maximilian Lin
Bijal Mehta
Maryam Meschi
Hannah Nguyen
Daniel No
Noriko Satake-Leung
Amanda Siu
Jenny Sun
Chitra Tiruveedula

10 Years
Wallis Andelin
Paul Ferraro
Jeevan Ghatnekar
Gary Hszieh
Alexander Kalmanovich
Hyun-Jung Kim
Stephen Kim
Laura Leon
Giao Ly
Ali Makhmalbaf
Christina Maldonado
Kelly Pierson
Charles Rodgers
Rose Marie Tan
Lisa Tran
Adam Vaghari

15 Years
Taher Aminikharrazi
Anthony Cao
Janice Chou
Vanessa Cruz
David Hahn
Ming-Way Lee
Khoi Nguyen
Sepehr Saeedi
Yun Song
Elmer Yoshida

20 Years
Maurice Corbett
Legiang Nguyen
Jon Orcher
Jeffrey Pene
Quynh Phan
Dave Wang
Ryan Wyn

25 Years
Robert Genc
Fred Lee
Tuan Lyk

30 Years
Michael Barnes
Bradford Lockhart
James Meeks
Eric Meyer
Jeffrey Stehly

35 Years
Milos Boskovic
John Brady
William Schluter

40 Years
Dale Baguhn
Sung Ro
William Vickerman

45 Years
Diana Canter
Gary Carlsen
Gregory Cramm
Bruce Gibson
Robert Lake

50 Years
R. May
William Guard
Terry Gundlach
Travel Policy for Offices and Staff During COVID
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As stay-at-home orders continue to relax across the country and people become more comfortable with traveling again, practice owners may be questioning the best way to maintain a safe work environment while managing employees who choose to travel.

The Centers for Disease Control and Prevention continues to warn that travel can increase the chances of getting and spreading COVID-19 virus and that staying home is the safest way for people to protect themselves and others. With travel restrictions varying by city and state and changing frequently, it may be difficult for practice owners to assess how an employee's vacation could compromise the safety of patients and other team members once that employee returns to work.

Practice owners should consider establishing a travel policy and develop a plan for how to reintegrate employees into the workplace following their travel.

Pre-travel inquiries
State laws restrict employers from regulating where employees can go on vacation, but practice owners can develop a travel policy that includes a pre-travel inquiry that could help protect patients and staff from potential exposure. The pre-travel inquiry can require employees to give advance notice to their supervisors or employer about the details of their travel plans, including their intended destinations and means of transportation. Employers should avoid asking personal details unrelated to COVID-19 and should only require information that is necessary to determine whether the employee is traveling out of state or internationally and for how long.

Travel advisories
For extra security, practice owners can incorporate a travel advisory into their policy that employees are required to sign before they start their vacation.

The advisory may ask the employee to acknowledge that if they travel to any area designated as a COVID-19 hot spot, they may be required to self-quarantine when they return. The policy should also specify whether employees who are required to self-quarantine must work remotely and, if possible, use any available paid time off to cover that period or clarify that the time off may be unpaid.

Tips for employees when traveling
Practice owners can include the following recommendations in the travel policy to help employees minimize their risk of exposure while on vacation:

- Continue to follow all the CDC-recommended COVID-19 practices, such as washing hands, staying home if sick, wearing cloth masks, practicing social distancing and avoiding large groups of people.
- Before traveling, consider if and where you will be permitted to stop and plan ahead. Evaluate the risk of exposure in the area and take enhanced safety measures such as using additional PPE, disinfectant and hand sanitizer.
As stay-at-home orders continue to relax across the country and people become more comfortable with traveling again, practice owners may be questioning the best way to maintain a safe work environment while managing employees who choose to travel. The Centers for Disease Control and Prevention continues to warn that travel can increase the chances of getting and spreading COVID-19 virus and that staying home is the safest way for people to protect themselves and others. With travel restrictions varying by city and state and changing frequently, it may be difficult for practice owners to assess how an employee’s vacation could compromise the safety of patients and other team members once that employee returns to work.

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- Before traveling, consider if and where you will be permitted to stop and plan ahead. Evaluate the risk of exposure in the area and take enhanced safety measures such as using additional PPE, disinfectant and hand sanitizer.
- If traveling domestically, evaluate whether the location you are visiting will permit entry with or without self-quarantine and whether your home state will permit you to return with or without self-quarantine.
- If traveling by bus, train or airplane, anticipate a greater risk of exposure and take enhanced measures to protect yourself.
- If traveling internationally, thoroughly review the travel bans and restrictions related to the country you plan to visit and whether you will be permitted to return to the U.S. after your trip.

Practice owners should clearly communicate any new policy to employees in advance and specify that the goal of the policy is to maintain a healthy workplace. Employers should also obtain a signed acknowledgment of the new policy from each employee.

Additionally, employers should be prepared to revise policies as changes occur. Practice owners should ensure they follow the policy consistently and enforce the policy universally for all team members to avoid a discrimination claim. A travel template is available in the CDA Back to Practice Center along with additional practice management resources.
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“ Been with Silverstein & Associates for over 15-years. Neil and his staff handle our personal & business finances and we could not be happier. They are a pleasant and professional group. Would certainly recommend. ”
Calendar 2020 - 2021

November
13  2020 Virtual CDA House of Delegates
26-27 Thanksgiving - OCDS Closed

December
24-31 Christmas - OCDS Closed

January 2021
1   New Years - OCDS Closed
19  CE Webinar: “Infection Control” with Leslie Canham, CDA, RDA
20  CE Webinar: “California Dental Practice Act” with Leslie Canham, CDA, RDA

Effective January 2020

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# PPE Recommendations for Dental Practices

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<th>Eye Protection &amp; Side Shield</th>
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</thead>
<tbody>
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<td>Administrative</td>
<td>Level 1</td>
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*Recommended* | *Optional* | *Not Recommended*  

While it is understood that aerosols are produced in various ways, both organically by the patient and through various dental procedures, it is still unknown how exactly the virus is transmitted. Based on current studies and guidelines, these recommendations reflect what levels of adequate PPE will protect patients and dental team members.

*During PPE shortage, surgical masks should be prioritized for dental team members providing direct patient care and may be an acceptable alternative in addition to a full-face shield when N95/KN95 or higher masks are not available. The use of a Level 3 mask instead of an N95/KN95 mask may carry a higher risk for transmission due to the lack of a respirator seal, which limits the mask’s protection primarily to splatter and droplets.*

**If consistent with office uniform policy, dental team members should change out of street clothes into clinical attire upon arrival to the office. Although clinical attire is not considered PPE under the dental practice act, lab coats worn as the outermost garment that provide adequate protection for the employee may be considered PPE. A gown may be a more appropriate choice of protective attire for most dental procedures.

- Alternatives to a face shield may include the installation of a sneeze guard or the mandate that patients wear masks in the reception area. If such a policy is implemented, dental practices should consider providing Level 1 masks to patients who arrive without a mask.

^ PPE in these scenarios should be changed between patients when visibly wet or soiled.

# PPE, including gowns, should be changed between patients. Follow CDC guidelines for mask extended use, reuse, and decontamination.

+ For staff performing in-office laundering duties, it is recommended that a Level 1 or 2 surgical mask, face shield or eye protection, gloves, clinical attire, and gown are worn. Follow established protocols for donning and doffing for cleaning patient care areas.

## Resources

- NIOSH-Approved N95 Manufacturers
- Authorized Imported Non-NIOSH Approved Respirator Manufacturers
- CDC Recommended Guidance for Extended Use and Limited Reuse of N95 Masks
- CDC Crisis Standards of Care Decontamination Recommendations for Respirators
- CDC Strategies for Optimizing PPE Supply

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Symptoms/Positive Test for COVID-19
Regulatory Reporting Requirements

**PATIENT REPORTS SYMPTOMS WITHIN 2 DAYS FOLLOWING VISIT**

**RECORD:**
- Date of reporting and date pt last seen
- Information provided by pt, including if testing has been done

**EMPLOYEE REPORTS SYMPTOMS**

**RECORD DATE OF REPORT AND SYMPTOMS**

**EMPLOYEE REPORTS EXPOSURE TO SYMPTOMATIC OR COVID-19 POSITIVE INDIVIDUAL ANYWHERE**

**OBTAIN DETAILS OF EXPOSURE AND ASSESS RISK:**
- Date of exposure
- Was there “close contact”?

**NEGATIVE DIAGNOSIS**

**SUSPECTED OR POSITIVE**
- Refer for medical consult if appropriate
- Assess employee “close contact” exposure; follow chart at far right

**YES**
Instruct employee to return home immediately, if not already home, to self-monitor for 14 days, to contact their medical care provider and notify employer of results.

**NO**
Employee can continue to work and should actively self-monitor for 14 days.

**NEGATIVE DIAGNOSIS**
See below for information on CDC guidance for employees returning to work.

**SUSPECTED OR POSITIVE**
- Report to the LHD and follow instructions
- Send identified employee home with direction to contact healthcare provider and to inform dental practice of results.

**Glossary of terms:**
- **Close contact** – Within 6 feet of an infected or symptomatic person or within operating area; 15 min exposure without wearing PPE that is NIOSH or CDC approved (i.e. not cloth masks).

- **Screening and symptoms guidance** – Employee Screening Form

- **Contact tracing** – Identifying patients and employees in the office in close contact with the infected or symptomatic patient or employee. Advise person to seek medical evaluation.

- **LHD** – local public health department
Additional information if you have an employee diagnosed with COVID-19:

Employees who are not close contacts of the employee with COVID-19 may remain working as long as they have no symptoms of the virus. Whether the dental practice remains open depends on whether it can continue to operate without the employees who are sent home.

Employers must report outbreaks to the local health department. An outbreak is when a worksite has three or more COVID-19-positive employees within a 14-day period.

Contact your workers comp carrier if employee reports positive diagnosis for COVID-19, and believes they contracted COVID-19 at work.

California employers must report to the nearest Cal/OSHA office any serious illness or injury, or death of an employee that occurred at work or in connection with work within eight hours of when they knew or should have known of the illness, injury or death. This includes a COVID-19 illness if it meets the definition of serious illness. “Serious injury or illness” is defined in Title 8 Section 330(h) and includes inpatient hospitalization for a reason other than medical observation or diagnostic testing.

Eligible employees who have been advised by their health care provider to self-quarantine related to COVID-19 or are experiencing symptoms and seeking a diagnosis may be eligible for up to two weeks (80 hours, or a part-time two-week equivalent) of emergency paid sick leave under Families First Coronavirus Response Act (FFCRA). Please refer to the required notice provided by the Department of Labor for more detailed information on qualifying reasons for leave. Further, any additional COVID-19 employee policies you may wish to implement in your office should be developed in consultation with an HR professional.

Following is the CDC’s guidance on when an employee suspected or having COVID-19 may return to work:

Employers should not require sick employee to provide a negative COVID-19 test result or healthcare provider’s note to return to work. Employees with COVID-19 who have stayed home can stop home isolation and return to work when they have met the following criteria:

- At least 10 days have passed since symptom onset (except for individuals who had severe illness and who should be isolated for an additional 10 days)
- At least 24 hours have passed since resolution of fever without the use of fever-reducing medications, and
- Other symptoms have improved

Additionally, CDPH provides COVID-19 Workplace Outbreak Employer Guidance that includes notification and reporting requirements.

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On September 19th, the Center for Disease Control belatedly acknowledged the role of aerosols, airborne transmission, and the importance of ventilation for COVID-19. The CDC website now warns that factors that contributed to documented airborne transmission of COVID-19 were enclosed spaces, prolonged exposure to respiratory droplets, inadequate ventilation, or air handling that allowed a buildup of suspended small respiratory droplets or particles.

As we continue to refine our best practices for caring for patients during the pandemic, I have compiled some research papers that have direct application to our profession and could help us make clinical choices. Currently, there is a lack of studies that show how many viral particles are needed to transmit COVID-19, although it is believed to be a small number of viral particles. For this reason, I will focus on the best current studies that address concerns about viral aerosol transmission and airflow, and conclude with three studies on how we might address the virus risk in our office.

1) In the article "Coronavirus Disease 2019 Patients in Earlier Stages Exhaled Millions of Severe Acute Respiratory Syndrome Coronavirus 2 Per Hour" by Ma, et al., in the August 2020 issue of Clinical Infectious Diseases, researchers in China studied exhaled breath samples, air samples and surface samples from 10 countries and found COVID-19 RNA much more prevalent in exhaled breath samples than on surface samples.

They tested 49 COVID-19 patients from 10 countries, 26 air samples and 242 surface swabs from quarantine hotels, hospitals, and personal belongings. Of the exhaled breath samples, 26.9% were positive for COVID-19 RNA, but only 3.8% of air samples and 5.4% of surface swabs tested positive. The viral RNA breath emission rate was highest in the first stages of disease.

Breath samples from two patients were positive for coronavirus RNA, but surface swabs of their cell phones, hands, and toilets were negative. Among the 242 surface swabs, viral RNA was found most often on toilet bowls (16.7%); floors (12.5%); patient hands, pillowcases, mobile phones, and computer keyboards (4.0%); and surfaces that healthcare staff touched (2.6%). But only 2 of 22 mobile phone surface samples tested positive for viral RNA, and all object handles were negative.

The authors said that the viral RNA breath emission rate appears to vary based on factors such as patient activity level and disease stage and may be affected by age. Viral RNA emission was sporadic in at least one patient, whose samples generated different test results on different days.

Why this is significant: The findings support previous studies and case reports that concluded that COVID-19 is most likely spread by aerosols rather than large respiratory droplets or contaminated surfaces.

Research on COVID-19 and Aerosols That May Modify Our Clinical Practice in Dentistry
Steven A. Miyamoto, DDS
Oral and Maxillofacial Surgery
Fullerton, CA
continued on page 29

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Nuance Medical
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3) In the article “Aerosol and Surface Stability of SARS-CoV-2 as Compared with SARS-CoV-1” by Doremalen, et al. which appeared in the March 2020 issue of The New England Journal of Medicine, the researchers found that aerosol and particle transmission of COVID-19 is plausible, since the virus can remain viable and infectious in aerosols for hours and on surfaces up to days. They found the virus was viable in aerosols throughout the 3 hours of the experiment, and was viable for 72 hours on plastic, 48 hours on stainless steel, and 24 hours on cardboard. Under these laboratory conditions, the aerosols were only measured for three hours before the experiment was stopped, although they could have been airborne for longer than 3 hours. Why this is significant: This was one of the first studies that showed how the virus can remain a potential threat through aerosols for many hours and long after the patient has left the office, if there is poor ventilation. A recent study “Prolonged infectivity of SARS-CoV-2 in Fomites” which appeared in the September 2020 issue of Emerging Infectious Diseases also showed that the fomites (virus infecting particles) which were surrounded by proteins like in respiratory droplets, could be infectious and survive for long periods of time.

4) In the article “Aerosol and surface contamination of SARS-CoV-2 observed in quarantine and isolation care” by Santarpia, et al., which appeared in the July 2020 issue of Scientific Reports, air collectors positioned more than 6 feet from infected COVID-19 patients were found to have samples that tested positive for viral RNA, as did air samplers placed outside of patient rooms. In addition, personal air samplers worn by the testers were found to also have viral RNA even though the patients were not coughing when the testers were present. The highest airborne viral concentrations were found when a patient was receiving oxygen on a nasal canula. Why is this significant: This was the first study that demonstrated that the virus can be spread airborne farther than 6 feet and outside of the room and into hallways of infected patients. Other studies are consistent in reporting that the virus can spread much farther than 6 feet. Yet, the current CDC recommendations for social distancing of 6 feet and hand washing to reduce the spread of COVID-19 are based on studies of respiratory droplets carried out in the 1930s. When these studies were conducted, the technology did not exist for detecting submicron aerosols. Measurements now show that intense coughs and sneezes that propel larger droplets more than 20 feet can also create thousands of aerosols that can travel even further. Increasing evidence for COVID-19 suggests the 6 feet CDC recommendation is likely not enough under many indoor conditions, where aerosols can remain airborne for hours, accumulate over time, and follow airflows over distances further than 6 feet. This also suggests that we need to prevent the accumulation of aerosols and clean other areas in our offices as well as the operatories where aerosols are generated.

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Why this is significant: The previous study from the University of Hong Kong found that the public areas did not have much viral RNA, except for the bathrooms. There are studies that show the viral load is greater in feces than in the respiratory tract in some patients. Closing the lid and flushing is a simple solution to help control the spread of the disease through toilet plumes. Additionally, the restrooms in our offices are a potential source of infection and need to be cleaned with the same protocol as our operatories.

In the article “Far-UVC light (222 nm) efficiently and safely inactivates airborne human coronaviruses” by Buonanno, et al., which appeared in the June 2020 issue of Scientific Reports and posted on the FDA website, the researchers found that UVC radiation can destroy the outer protein of the SARS-Coronavirus. Although this strain tested is different than the COVID-19 virus, this paper and other research suggests that UVC should also be effective against airborne human coronaviruses. However, at this time, there is limited published data about the wavelength, dose, and duration of UVC radiation required to inactivate the COVID-19 virus.

Why this is significant: This study is consistent with other studies that UVC light should be effective in inactivating an aerosolized COVID-19. In our office, we use a standalone mobile UVC light sterilizer immediately after the patient leaves the room, in conjunction with our other modalities to address any aerosolized virus, and to address harder to reach areas from fomites. We currently close the door and block the windows of a used surgery room when cleaning because of the harmful effects of direct contact with UVC light, which include the risk of skin cancer and eye damage. The Far-UVC light described in this article does not present the same risk to humans when in direct contact, but they are not currently widely available for sale at this time. Also, as there is an absence of studies on the optimum methodology of UVC, we use UVC as an adjunct for cleaning a room, but do not depend on this method.
committee on emerging infectious diseases, researchers found high concentrations of virus in the rooms where health care workers removed PPE. This was more than the levels of virus concentrations in most public areas of the health center. The authors concluded that one of the sources of infection was from a virus-laden aerosol resuspended by the changing of PPE, cleaning floors or movement of the staff. They also suggested that while it may be difficult to resuspend a virus particle of a respirable size, these particles may be transmitted to hands, mouth, nose, or eyes without requiring direct respiration to the lungs.

Why this is significant: The virus appears to be re-launched by removing PPE, cleaning the floors, or the movement of the staff. The authors recommended care to be taken with the PPE before removal. In one large hospital system in Orange County, it is protocol that no one except the anesthesiologist is allowed in the room on intubating and extubating, and no one is allowed to enter for 20 minutes after, so the virus particles can settle.

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8) In the article “Reducing transmission of SARS-CoV-2” by Prather, et al., which appeared in the June 2020 issue of Science, the Duke University researchers developed an online calculator (http://covid-exposure-modeler-data-devils.cloud.duke.edu/) that helps teachers and students assess their COVID-19 risk based on the physical dimensions of a classroom, the number of students, the number of in-person sessions and other variables. The model calculates the likely concentration of infectious airborne particles. The most significant factor that decreases risk is air purification. A filter in the classroom, according to the calculator results, can reduce the chance of infection to about 1 percent from 13 percent to 14 percent in a classroom without air filtration.

Why this is significant: This shows us the importance of air purification in decreasing the risk of aerosols. Along with most other dentists, I have set up UV/HEPA filters around the office to clean the air. I have also added high speed air evacuators with filtration in the operators. Depending on the output capacity of the HVAC system in your office (measured by cfm), and the airflow as it passes from outside the office through the office and back out again, solutions to address this issue may vary. If you merely put a much higher level of filtration air filter (measured by MERV), but the HVAC system cfm is not strong enough, you could create a more dangerous positive pressure situation where air does not evacuate and turn over quickly. Most commercial air conditioning units cannot tolerate a high enough MERV rating to filter out 0.1-micron particles. To address the unique situation in each office, companies are offering increased UV/HEPA filtration units that are connected to the HVAC or mounted independently in the office ceiling.

9) In the article “Hypochlorous Acid: A Review” by Block and Rowan which appeared in the September 2020 issue of the Journal of Oral and Maxillofacial Surgery, the authors reviewed this inexpensive, available, nontoxic and practical disinfectant that is effective against COVID-19. The US Environmental Protection Agency has recommended hypochlorous acid (HOCl) as an approved disinfectant, and it has been used safely for a long time in various fields including agriculture.

Why this is significant: The HOCl can be sprayed on contaminated areas directly or sprayed in a fogger to disinfect the air or a wide area in a short amount of time. Using a commercial HOCl maker, an effective amount could be made with a few grams of salt and a teaspoon of vinegar in minutes. The ability of a fogger or sprayer to make smaller particles may help a solution’s molecules to be suspended in the air for a longer period because of their low settling velocity rate. This may increase the odds of the solution to come into contact with virus particles. As the byproduct after the disinfection is water, this usually does not need to be wiped off.

Some dentists are also using HOCl in a humidifier. A peer reviewed study in the August 2020 issue of Transboundary and Emerging Diseases from the University of Sydney (Australia) and the Fudan University School of Public Health in Shanghai estimated that for every 1 percent decrease in relative humidity, COVID-19 cases can increase by 7 percent to 8 percent. A 10 percent drop in relative humidity could double COVID-19 infections. Therefore, the greater the humidity, the decreased risk of disease transmission.

In conclusion, we must consider the importance of aerosols, airflow, and ventilation as key factors as we search for the best ways to protect our patients and ourselves from the virus. Depending on the airflow and HVAC conditions in the office, each office will have a different solution to address the risk. UV light, air filters, and Hypochlorous Acid can be used as adjuncts to decrease the risk of infection. Additional studies are needed to give more precise guidance on how to practice safely in the age of the pandemic.
8) In the article "Reducing transmission of SARS-CoV-2" by Prather, et al., which appeared in the June 2020 issue of Science, the Duke University researchers developed an online calculator (http://covid-exposure-modeler-data-dev.000cloud.com/) that helps teachers and students assess their COVID-19 risk based on the physical dimensions of a classroom, the number of students, the number of in-person sessions and other variables. The model calculates the likely concentration of infectious airborne particles. The most significant factor that decreases risk is air purification. A filter in the classroom, according to the calculator results, can reduce the chance of infection to about 1 percent from 13 percent to 14 percent in a classroom without air filtration.

Why this is significant: This shows us the importance of air purification in decreasing the risk of aerosols. Along with most other dentists, I have set up UV/HEPA filters around the office to clean the air. I have also added high-speed air evacuators with filtration in the operatories. Depending on the output capacity of the HVAC system in your office (measured by cfm), and the airflow as it passes from outside the office through the office and back out again, solutions to address this issue may vary. If you merely put a much higher level of filtration air filter (measured by MERV), but the HVAC system cfm is not strong enough, you could create a more dangerous positive pressure situation where air does not evacuate and turn over quickly. Most commercial air conditioning units cannot tolerate a high enough MERV rating to filter out 0.1-micron particles. To address the unique situation in each office, companies are offering increased UV/HEPA filtration units that are connected to the HVAC or mounted independently in the office ceiling.

9) In the article "Hypochlorous Acid: A Review" by Block and Rowan which appeared in the September 2020 issue of the Journal of Oral and Maxillofacial Surgery, the authors reviewed this inexpensive, available, nontoxic and practical disinfectant that is effective against COVID-19. The US Environmental Protection Agency has recommended hypochlorous acid (HOCl) as an approved disinfectant, and it has been used safely for a long time in various fields including agriculture.

Why this is significant: The HOCl can be sprayed on contaminated areas directly or sprayed in a fogger to disinfect the air or a wide area in a short amount of time. Using a commercial HOCl maker, an effective amount could be made with a few grams of salt and a teaspoon of vinegar in minutes. The ability of a fogger or sprayer to make smaller particles may help a solution's molecules to be suspended in the air for a longer period because of their low settling velocity rate. This may increase the odds of the solution to come into contact with virus particles. As the byproduct after the disinfection is water, this usually does not need to be wiped off.

Some dentists are also using HOCl in a humidifier. A peer-reviewed study in the August 2020 issue of Transboundary and Emerging Diseases from the University of Sydney (Australia) and the Fudan University School of Public Health in Shanghai estimated that for every 1 percent decrease in relative humidity, COVID-19 cases can increase by 7 percent to 8 percent. A 10 percent drop in relative humidity could double COVID-19 infections. Therefore, the greater the humidity, the decreased risk of disease transmission.

In conclusion, we must consider the importance of aerosols, airflow, and ventilation as key factors as we search for the best ways to protect our patients and ourselves from the virus. Depending on the airflow and HVAC conditions in the office, each office will have a different solution to address the risk. UV light, air filters, and Hypochlorous Acid can be used as adjuncts to decrease the risk of infection. Additional studies are needed to give more precise guidance on how to practice safely in the age of the pandemic.
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