Consultation 29/11/21 – Graeme Christie, Dentist

Dear Sir/Madam

We appreciate the opportunity to comment on the Supplementary risk management principles for oral health during the COVID-19 pandemic.

Our 2 practices have provided care throughout the entire COVID periods in Auckland (Mt Albert and New Lynn). They are located in community medical buildings. We have been providing emergency and urgent care as required. This has been to resolve dental pain or accidents. Toothaches mainly.

It has been and continues to be hard to cater for all the dental care needs of people phoning in. Let alone catering to the need of our own client base. Level 4 is particularly hard work as most dental practices close, but the populations need for care persists.

From the point of view of risk to staff in the dental practice, it seems to me that the main risk is encountering asymptomatic carriers of COVID 19.

Reference 2 below puts this risk at 20% of community case numbers.

Reference 1 then is informed by this meta-analysis and provides the following table as it applies to dental practice.

Estimated number of asymptomatic patients at different case prevalence rates

Average No. cases per 100,000	Estimated number of asymptomatic patients		Risk Description[4]
	per 100,000	Equates to:	
5	1	One patient in 100,000	Minimal/ Very Low
10	2	One patient in 50,000	Very Low
50	10	One patient in 10,000	Very Low/Low
100	20	One patient in 5,000	Low
400*	80	One patient in 1,250	Low
500	100	One patient in 1,000	Moderate

This table assumes an asymptomatic rate of 20%.
*400 cases per 100,000 is the usual public health threshold for an epidemic.

Then apportioning this risk and applying measures to mitigate. As of today's date, Auckland likely has average cases in the community of 400 per 100,000 people. This bears out our experience of encountering cases and reports from other dental practices of subsequently diagnosed COVID positive cases which have been attended too.

We have at least till now experienced no cases of COVID 19 in a workplace setting amongst our staff. I do feel this early risk isn't at the levels that initially people feared.

Measures to manage this risk – Especially as it relates to dental aerosol generating procedures (AGP's) and the risk of transmission – order of success in my view.

1. The epidemiological questions have been the most successful, at least in my view. Me and my staff have identified COVID risk and then applied the guidelines.
2. PPE has been the next most successful. Although operator comfort is an issue. I think, masks gowns visors in that order.
    - A note to masks. Given we worked the first L4 amongst high COVID case numbers, when obtaining N95's of sufficient quality was hard and subsequent fit testing showed them to be at levels like high level surgical masks I am less convinced as to the relative benefits of high-level surgical masks vs N95's.
3. Reception protocols – waiting in cars or outside
4. Fallow time – the application of this concern has been a moving target and only as time has gone on has been introduced to a greater extent.

- I am less convinced as to this benefit and/or at least the need.
- By default, negative pressure and various filtering methods are similar.

I feel for the public it has been very hard to access dental care in Auckland for a variety of reasons.

1. Firstly, due to the anxiety around the virus – which while not trying to underrate the situation, this was at least strong. Affecting the public and the oral heath care staff too.

2. Secondly – the guidelines were initially too strict as to procedures we could do, resulting in a backlog of treatment required.

3. Thirdly, fallow time means that most of us are stuck running at approximately 50-60% of capacity and that is then not covering the dental care needs of the Auckland population. Getting the right balance is key and I still feel the risk in dental AGP's is still not apportioned correctly. It is rated too high at least in my view when other risk management criteria are applied.

4. Children are a particular case. Due to the needs of epidemiological questions for them and support people this system has ground to a halt.

My feedback would be

1. To enlarge the low-risk group to include some elements of the non-vaccinated
2. Reduce the fallow time across all considerations by 50%
3. I don't support negative pressure considerations and filtering elements due to the added compliance and then cost considerations which doesn't usually improve access to care, but just further hinders it.
4. Do something for the children.

The speed of consultation in this situation isn't ideal and while I note this will be a public document, it feels more like a draft. However, I believe getting the guideline settings right is still not there hence my feedback. If I can be of assistance please come back to me.

Finally, I wish to recognise this is a living situation and all the efforts of so many during these difficult times. Thank you!

1. Sottish Dental Effectiveness Programme. Mitigation of Aerosol Generating Procedures in Dentistry. A Rapid Review. Version 1.2. 19 April 2021

2. Occurrence and transmission potential of asymptomatic and presymptomatic SARS-CoV-2 infections: A living systematic review and meta-analysis.
   Diana Buitrago-Garcia ,Dianne Egli-Gany , Michel J. Counotte, Stefanie Hossmann, Hira Imeri, Aziz Mert Ipekci, Georgia Salanti, Nicola Low. Published: September 22, 2020
   https://doi.org/10.1371/journal.pmed.1003346

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