March 19th, 2020

Dear Prof Cormican,

The undersigned are contacting you in relation to a stakeholder meeting held yesterday, March 18th, at the invitation of the Department of Health and the Chief Dental Officer. The purpose of the meeting was to ascertain the views of various groups regarding the current situation relating to the practice of dentistry during the evolving COVID-19 pandemic.
The following were party to the conversation:

1. Dental Council
2. Irish Dental Association
3. Dublin Dental University Hospital
4. Cork University Dental School and Hospital
5. National Oral Health Office
6. Chief Dental Inspector

We understand that you are a member of the expert advisory group and we would be very grateful if you would circulate this communication to the group for consideration. We would like to express our concern in relation to the proposed HPSC guidelines for the practice of dentistry. Although these guidelines may be appropriate in the containment phase, we believe they do not reflect the current phase. Obviously this is an unprecedented and evolving situation. The considered and agreed view of the undersigned is that the advice regarding the delivery of dentistry during the delay phase of this pandemic and going into the mitigation phase needs to be reviewed. There is serious concern that the advice issuing from the HPSC at present is that routine dentistry remains safe. Many countries have already taken a particular view in relation to the practice of dentistry and limited practice to emergency treatment only. We are in agreement with their position in the current situation.

We have particular clinical concerns in relation to dentistry, all of which I'm sure you will have seen and heard expressed in recent days. However, we would like to reiterate them here:

1. Dentistry, by definition, is a close contact activity
2. Dental patients, by definition, cannot wear masks during treatment
3. Asymptomatic transmission of COVID-19 has been documented[1]
4. Viral shedding has been documented up to 37 days post-infection, with a median of 20 days[2] - there may be many undiagnosed patients in circulation
5. Community transmission is established in Ireland and testing is currently lagging behind the reality - there are very likely many undiagnosed patients in circulation

6. **Routine dental treatment generates significant amounts of aerosol, which can remain suspended in the air for several hours**[3]
7. **2019-nCoV can remain viable on surfaces for up to 72 hours**[3]
8. **Dental patients frequently gag and cough during treatment**
9. **2019-nCoV can be transmitted directly or indirectly through saliva, droplets or aerosols**[4]

Since we suggest that dental practice is limited to emergency care we have a number of concerns that will need to be addressed on this front. They include:

1. An agreed definition of what constitutes a dental emergency
2. Agreement on what centres will provide this care
3. Agreement on who will staff such centres

One of our core concerns is guidance on PPE for dental healthcare professionals. These concerns include:

1. The supply of PPE for use in hospitals needs to be protected – dental practice consumes large quantities of PPE which may be better employed in other services
2. Where dental practice needs to continue, a supply of appropriate PPE must be ensured for clinical personnel - currently supplies are impossible to replenish (e.g. FFP2/FFP3 masks are effectively unavailable at present).
3. The dental profession needs to be assured that **its particular clinical scenarios** are properly considered when issuing guidance on what constitutes appropriate PPE. Amongst other things this would include consideration of:
    a. Categories of procedures
        i. Consultation, examination, non-aerosol-generating treatment
        ii. Aerosol-generating treatment
        iii. Surgical procedures
    b. Categories of patients
        i. COVID-19 positive
        ii. Suspected cases, currently unconfirmed
        iii. Patients with a history of contact or travel
        iv. Asymptomatic patients
        v. Immunocompromised patients

We need to carefully consider how emergency care would be triaged and delivered. Considerations will include:

1. The importance of telephone triage in advance of offering appointments
2. Arrangements for teledentistry and the agreement of a payment to dentists who provide this service

It is our view that any guidance which issues to the dental registrants would find greater acceptance amongst its practitioners if they could be assured that a practising dentist, with a clear understanding of the clinical scenarios and risks, is a part of the group developing the guidance. We appreciate how busy you are at the current time but would be happy to engage with you directly at any time, should you so wish.

Yours sincerely,

Christine McCreary, Dean, University Dental School and Hospital
Brian O'Connell, Dean, Dublin Dental University Hospital
Fintan Hourihan, Chief Executive Officer, Irish Dental Association
Leo Stassen, President, Irish Dental Association
Kieran O'Connor, Vice President, Irish Dental Association
David O'Flynn, Registrar, Dental Council

1. *Rothe et al (2020) Transmission of 2019-nCoV Infection from an Asymptomatic Contact in Germany, N Engl J Med 2020; 382:970-971 DOI: 10.1056/NEJMc2001468*
2. *Zhou et al (2020) Clinical course and risk factors for mortality of adult inpatients with COVID-19 in Wuhan, China: a retrospective cohort study, Lancet 2020, https://doi.org/10.1016/S0140-6736(20)30566-3*
3. *van Doremalen et al. (2020). Aerosol and Surface Stability of SARS-CoV-2 as Compared with SARS-CoV-1. N Engl J Med. 2020 Mar 17. doi: 10.1056/NEJMc2004973.*
4. *Peng et al. (2020). Transmission routes of 2019-nCoV and controls in dental practice. International Journal of Oral Science (2020) 12:9 ; doi: 10.1038/s41368-020-0075-9*