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Reply to: "Coronavirus Disease 2019: Implications for Clinical Dental Care"

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We would like to thank Drs. Jadhav and Mittal for their letter to the editor in which they have put forward their concerns and suggestions regarding the manuscript titled ‘Coronavirus Disease 19 (COVID-19): Implications for Clinical Dental Care’ (1). We appreciate their insight and would like to take the opportunity to comment on their suggestions.

We strongly agree with the concerns expressed by the authors regarding asymptomatic carriers of Coronavirus Disease 19 (COVID-19) and the potential transmission to dental health care professionals. The authors raise an important point about the use of pulse oximetry to detect low blood oxygen saturation levels in asymptomatic carriers. However, it is noteworthy that pulse oximeter detects hypoxemia in contrast to “hypoxia” as mentioned by the authors. The term hypoxia denotes reduced tissue level oxygenation and is not synonymous with hypoxemia (reduced blood oxygen saturation) (2). In agreement with the authors, oxygen saturation measurements are a vital screening tool to identify potential asymptomatic patients and should be incorporated into routine dental clinical practice. Notably, the potential importance of silent hypoxemia in COVID-19 patients has become evident only more recently (3). Thus, at the time of this manuscript submission, we refrained from making recommendations without proper scientific citable evidence. As more is known about COVID-19, we believe that readers should maintain a pragmatic approach incorporating new peer-reviewed evidence in their practice.

We appreciate the authors for elaborating on the outline and basic design considerations for negative-pressure rooms/ airborne infection isolation rooms for dental practices. Given the surge in airborne infections over the past few decades, and the fact that only 2%-4% of rooms are equipped with negative pressure in approximately half of urban hospitals (4), efforts could be directed towards creating more negative-pressure rooms for health care providers. As mentioned by the authors, negative-pressure rooms should be built following stringent guidelines. In addition, these isolation rooms require continuous monitoring to measure pressure differential and proper training of staff to operate and check these rooms for “leaks”.
Failure to do so have led to nosocomial spread of infection in the past (5). As an alternative, knowledge of health care centers with provision for negative pressure room would help dentists to provide emergent dental care to patients with confirmed or suspected COVID-19 infection, as mentioned in our article (1).

Regarding the Centers for Disease Control and Prevention guidelines on sequence for putting on personal protective equipment (PPE), it is important to note that these guidelines have been issued keeping in mind the shortage of PPE during this pandemic (6). However, it is in the best interest of the healthcare providers to use both goggles or loupes and face shield for added protection, if there is an adequate supply.

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