

新型冠狀病毒威脅：牙科醫療院所該如何因應？

The Coronavirus Threat: How Should Dental Offices Be Prepared?

By Katharyn Edwards, RDH - February 24, 2020



世界衛生組織(WHO)於2月11日宣布其為「國際關注的公共衛生緊急事件」，這是在中國武漢出現的冠狀病毒，現在被稱為 COVID-19。

在 COVID-19 中，“CO”代表冠，“VI”代表病毒，“D”代表疾病。這種疾病被稱為“2019 年新型冠狀病毒”或“2019-nCoV”。由於該病毒突破了湖北省武漢市和中國的邊界，因此獲得了 WHO 授予的名稱。

2020 年 1 月 31 日，美國衛生與公共服務部部長宣布這是美國的公共衛生緊急事件。疾病控制中心(CDC)和美國牙科協會(ADA)已經就牙科治療需要採取的預防措施發表了公開聲明，以解決這「國際關注的緊急情況」。疾病預防控制中心繼續積極監測這次疫情，並在 www.cdc.gov 上更新其建議。

衛生專家發現自己在牙科實務中處於合規性準則的第一線，為了納入保護牙科人員和患者的方案，牙科團隊應了解什麼是 COVID-19，為什麼與「季節性流感」不同，以及 CDC 建議採取哪些預防措施以最大程度地減少傳播。

COVID-19

這種獨特的冠狀病毒，最初在中國湖北省武漢市報導，是一個較大的病毒家族的一部分，該病毒在不同動物物種中都很常見。駱駝，蝙蝠和貓已被證明是該病毒的始作俑者，儘管中間的動物宿主可能已允許該病毒「跳」到人類身上。

冠狀病毒雖然很少見，但確實會感染人並可以在人與人之間傳播。COVID-19 就是這種情況。2002 年出現的 SARS 也是如此。SARS 是另一種起源於中國東南部的著名冠狀病毒。

由於症狀較輕微的患者可能不需要就醫，因此追蹤可能會被漏報。目前沒有可用於 COVID-19 的疫苗。症狀主要是呼吸道疾病，在接觸後 2 到 14 天內會出現發燒，咳嗽和呼吸急促。

COVID-19 與「季節性流感」的比較

截至 2 月 15 日，在美國已確診 15 例 COVID-19 患者。隨著「鑽石公主號」遊輪(Diamond Princess)報告船上有近 300 例病例，其中有許多美國公民被列為乘客，因此新增病例的可能性很高。當前的協議是在懷疑有 COVID-19 或有人與確診的 COVID-19 病例接觸時，隔離 14 天並監測症狀。在嚴重的情況下，COVID-19 會攻擊肺部並自我複製，最終導致肺炎。內科受損和老年患者更容易受到這種危險轉變的影響。與季節性流感相比，季節性流感也可能侵襲肺部導致肺炎、缺氧和系統性衰竭。

COVID-19 的死亡率是流感的 20 倍，而我們追蹤該病毒的傳播僅兩個月。美國疾病預防控制中心 (CDC)發布了推薦的牙科操作規程，以最大程度地減少包括季節性流感和 COVID-19 在內的所有傳染病的傳播。

冠狀病毒對牙科實務的影響

對牙科實踐的影響是雙重的。由於隔離檢疫和停工，實務中可能會發現從中國運出的產品和供應品有延遲。實務還發現，他們需要採取預防措施來保護醫護人員和患者，同時盡其所能，以最大程度地減少病毒的潛在傳播。CDC 建議如下：

- 詳細記錄旅遊和健康史。在從中國旅行或與其他從中國旅行的人接觸後的 14 天內，請勿為患者提供非緊急或美容治療。重新安排有呼吸道症狀的患者，以防止感染擴散。這包括具有任何流感症狀的患者。
- 與患者接觸後，請用肥皂和水洗手至少 20 秒鐘，如果沒有肥皂和水，請使用含至少 60%酒精的酒精類洗手液。避免用未洗的手觸摸眼睛、鼻子和嘴巴。
- 生病時待在家裡；用紙巾遮住咳嗽和打噴嚏，然後將紙巾丟進垃圾桶；並清潔和消毒經常觸摸的物體和表面。
- 美國牙科協會(ADA)敦促所有執業的牙醫、牙科輔助人員和牙科實驗室採用 2003 CDC 指南和 2016 CDC 摘要中所述的適當感染控制程序，並保持最新狀態，因為科學信息可以改善感染控制、風險評估和口腔保健中的疾病管理。

對於可能暴露於 2019-nCoV 的人群，目前尚無美國食品藥物管理局(FDA)批准的暴露後預防措施。最好的做法是在牙科診所的入口張貼一個標誌，指示有症狀的患者或在 14 天內從中國旅行過來的患者重新安排約診。在確認和安排患者時詢問旅遊歷史記錄，如果有必要，可以在預約之前重新安排時間。

牙科團隊面臨許多職業危害，包括感染、肝炎、經皮暴露、電離輻射、噪音、肌肉和骨骼挑戰、皮炎、眼外傷、過敏反應、心理和壓力挑戰等。國家生物技術資訊中心(NCBI)認為牙科是一個極其危險的職業。

這些挑戰通常不在臨床醫師的控制範圍內。但是，按照 CDC 的建議採取措施使傳染病的傳播最小化，將減少接觸，並在本已高度暴露的職業中增加一層保護，在外保持安全。

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Declared a “public health emergency of international concern” on February 11, by the World Health Organization (WHO), the coronavirus that presented itself in Wuhan, China, is now known as COVID-19.

In COVID-19, the “CO” stands for corona, the “VI” for virus, and “D” for disease. Formerly, this disease was referred to as “2019 novel coronavirus” or “2019-nCoV.” As the virus breached the borders of Wuhan City, the Hebei Province, and eventually China, it has earned the title bestowed by WHO.

On January 31, 2020, the U.S. Department of Health and Human Services secretary declared it a U.S. public health emergency. The Center for Disease Control (CDC) and the American Dental Association (ADA) have made public statements regarding precautions that dental practices need to take in order to address this “emergency of international concern.” The CDC continues to actively monitor this outbreak and update their recommendations at www.cdc.gov.

Hygienists find themselves on the front line of enforcing compliance guidelines in the dental practice and need to be aware of current recommendations. Following the CDC guidelines is a best practice even if the dental practice is located in one of the 22 states that dictate their own OSHA plan that may, or may not, incorporate CDC guidelines into mandatory regulatory requirements. In order to incorporate protocols to protect dental staff and patients, dental teams should review what COVID-19 is, why it is different from the “seasonal flu,” and what the CDC recommended preventative measures are to minimize transmission.

COVID-19

This unique coronavirus, originally reported in Wuhan City, Hebei Province, China, is part of a larger family of viruses that are common in different species of animals. Camels, bats, and cats have been

documented originators of the virus, although an intermediary animal host may have allowed the virus to “jump” to humans.

Although rare, coronaviruses do infect people and can spread from person to person. This is the case with COVID-19. It was also the case with SARS, which emerged in 2002. SARS is another well-known coronavirus that originated in southeast China.

As of the date this article was written, SARS has proven to infect fewer people but had a larger mortality rate. According to the National Center for Biotechnology Information (NCBI), SARS is estimated to have infected more than 8,500 people, spreading to 30 countries within six months. The death rate was high, with a crude mortality of 9%, or approximately 765 patients. Compare that to COVID-19 data as of February 15, which shows an infection tally of more than 58,000 people in 25 countries in just two months with a crude mortality rate of less than 1% at approximately 1,500 deaths.

Tracking may be underreported, as patients with mild symptoms may not seek medical care. There is currently no vaccine available for COVID-19. Symptoms are primarily respiratory in nature with fever, cough, and shortness of breath appearing within two to 14 days of exposure.

COVID-19 vs. The “Seasonal Flu”

As of February 15, COVID-19 has been positively identified in 15 patients in the United States. The potential for additional cases is high as the cruise ship, Diamond Princess, is reporting nearly 300 confirmed cases on board with a number of U.S. citizens listed as passengers. The current protocol, when COVID-19 is suspected or when someone has been in contact with a confirmed COVID-19 case, is to quarantine for 14 days and monitor for symptoms. In serious cases, COVID-19 attacks the lungs and replicates itself with an end result of pneumonia. Medically compromised and elderly patients are more susceptible to this dangerous turn. Compare that to the seasonal flu, which can also attack the lungs leading to pneumonia, a lack of oxygen, and system failure.

According to preliminary estimates from the CDC, 14,000 people have died, and 250,000 people have been hospitalized during the 2019-2020 flu season. A large difference between the flu and COVID-19 is the availability of vaccines. There is currently no vaccine available for COVID-19. The mortality rate for the seasonal flu is less than 0.1%. Comparing COVID-19 to the flu with the intent of minimizing COVID-19, on the premise that the seasonal flu is worse, may minimize the response and open pathways to further transmission.

The death rate for COVID-19 is 20 times that of the flu, and we are only two months into tracking the spread of this virus. The CDC has posted recommended dental practice protocols to minimize the transference of all infectious diseases, including the seasonal flu and COVID-19.

Coronavirus Impact on Dental Practices

The impact on dental practices is twofold. Practices may find a delay in products and supplies shipped from China due to the quarantine and work stoppage. Practices also find they need to take precautionary steps to protect staff and patients while doing their part to minimize the potential spread of the virus. The CDC recommends the following:

- Take a detailed travel and health history. Do not provide non-emergent or cosmetic treatment to patients within 14 days of travel from China or exposure to others that have traveled from China. Reschedule patients with respiratory symptoms to prevent the spread of infection. This includes patients with any flu-like symptoms.
- Wash hands with soap and water for at least 20 seconds after contact with patients or use an alcohol-based hand sanitizer with at least 60% alcohol if soap and water are not available. Avoid touching the eyes, nose, and mouth with unwashed hands.
- Stay home when sick; cover coughs and sneezes with a tissue and throw the tissue in the trash; and clean and disinfect frequently touched objects and surfaces.
- The ADA urges all practicing dentists, dental auxiliaries and dental laboratories to employ appropriate infection control procedures as described in the 2003 CDC Guidelines, and 2016 CDC Summary and to keep up to date as scientific information leads to improvements in infection control, risk assessment, and disease management in oral health care.

There is currently no FDA-approved post-exposure prophylaxis for people who may have been exposed to 2019-nCoV. Posting a sign at the entrance to the dental practice that instructs patients with symptoms, or those that have traveled from China within 14 days, to reschedule their appointment is a best practice. Asking for travel history when confirming and scheduling patients provides an opportunity to reschedule ahead of the appointment if necessary.

Dental teams are exposed to a number of occupational hazards, including exposure to infections, hepatitis, percutaneous exposures, ionizing radiation, noise, muscle and skeletal challenges, dermatitis, eye injuries, allergic reactions, psychological and stress challenges and more. NCBI considers dentistry an extremely hazardous career.

These challenges are often not within the clinician's control. However, taking steps to minimize the spread of infectious disease by following the CDC recommendations will reduce exposure and add a layer of protection in an already high exposure career. Stay safe out there.

文章來源：<https://www.todaysrdh.com/the-coronavirus-threat-how-should-dental-offices-be-prepared/>