

# Dental Clinic Aerosol Management with Aero-Shield

Redirecting and trapping airborne particles of dental procedure aerosol for a targeted suction and prevention of clinicians' direct exposure

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## Abstract

Aerosol clouds carry airborne particles including SARS-CoV-2, the virus that causes COVID-19. Dental clinicians are recommended to use heavy duty protective equipment (i.e. level 3 personal protective equipment (PPE)). Current supply shortage, and difficulties with fitting and wearing, remain problematic for dental practices to have a sustainable and long-term work plan. As droplet can stay airborne for a long time after a procedure, dental practices are also recommended to leave sufficient time gap (~60 min.) between each procedure. This makes their operations economically unviable.

As dental clinics are opening post COVID-19, there are still confusions around measures need to be taken to have a safe operational environment. Because of inadequate access to suitable PPE, as well as insufficient guideline and regulations, healthcare clinicians are improvising protective barriers to reduce risks associated to the aerosol spread. In such uncertain time therefore, clinicians must take common sense measures, above and beyond the formal guidelines issued by different authorities.

We are introducing a new design for a barrier to increase protection measures for dental clinicians. By redirecting and trapping the aerosol cloud into a more concentrated area, this barrier,

1. enables a targeted suction, and,
2. reduces time required for the airborne particles to land on a specific surface so they can be cleaned faster. A measure that reduces the time gap requirement between procedures

## Introduction

Dental procedures produce airborne particles (aerosols) including SARS-CoV-2, the virus that causes COVID-19<sup>(1)</sup>. COVID-19 is a new disease and we are still learning about how it may spread in dental practices and what measures need to be taken<sup>(2)</sup>.

As dental practices are beginning to open post COVID-19, there are growing confusions around the use of PPE to create safe operational environments. In such uncertain time, and in the absence of clear guidelines and standards, dental practices must take common sense measures to increase the protection levels.

In the Guidance for Dental Setting issued by CDC (Centre of Disease Control and Prevention)<sup>(2)</sup>, and NHS's new guidelines<sup>(3,4)</sup>, dental practices are recommended to "*avoid aerosol-generating procedures whenever possible*" and if it is not possible, they are asked to take several protective measures during and after AGPs including but not limited to:

- using level 3 PPE to prevent clinicians from exposure to the aerosol cloud during AGP procedure<sup>(3,4)</sup>.
- Leaving sufficient time gap (~60 min.) between each procedure (i.e. patient) to leave time for droplets to be landed in a surface.

Current inadequate access to PPEs due to supply shortage, and difficulties with fitting and wearing level 3 PPEs, as well as inefficiency of work operation as the result of long gaps between procedures remain problematic for dental practices as they are re-opening. Dental clinicians therefore are improvising the use of different barriers and suction to make a safer environment<sup>(5)</sup>.

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We have designed Aero-Shield with specific shape and size to address these issues without creating need for additional high-power suction motors with high energy consumption and regular maintenance procedures including regular change of contaminated filters on site.

## Aerosol

Aerosol (airborne particles), defined as particles less than 50 micrometres ( $\mu\text{m}$ ) in diameter <sup>(6) (7) (8,9)</sup>. The greatest airborne infection threat in dentistry comes from aerosols because they are small enough to stay airborne for an extended period of time before they settle on a surface or enter the respiratory tract <sup>(7, 10, 11)</sup>.

The larger and heavier particles ( $> 5\mu\text{m}$ ) are droplets that can travel up to 1 meter from the source and contaminate surfaces within that range <sup>(12-14)</sup>. The smaller particles (1-5 $\mu\text{m}$ ) are called droplet nuclei that can stay airborne for long periods of time before landing and contaminating surfaces. Both types of particle are relevant to SARS-CoV-2 transmission since this may occur via both direct air-borne infection and indirect spread via contact with contaminated surfaces <sup>(7)</sup>.

## Aero-Shield

### a) Aero-Shield Objective

Dental clinicians are exposed to aerosol cloud generated, more specifically during AGP procedures as shown in Figure 4. Clinicians are therefore recommended to use level 3 PPEs to prevent direct contact. In a recent experimental research, a similar approach used during a simulated endotracheal intubation. With PPE only, the paper reports that “*dye was found on the laryngoscopist’s gown, gloves, face mask, eye shield, hair, neck, ears, and shoes*” <sup>(5)</sup> and “*contamination of the floor occurred within approximately 1m from the head of the bed and also on a monitor located more than 2 m away*” <sup>(5)</sup>. This is a very similar approach to the aerosol contact with the dental clinicians. In the test with aerosol box on the other hand, the paper reports that “*the simulated cough resulted in contamination of only the inner surface of the box and the laryngoscopist’s gloves and gowned forearms*” <sup>(5)</sup> and. “*Examination of the laryngoscopist and the room with ultraviolet light showed no macroscopic contamination outside the box*” <sup>(5)</sup>.

Smaller / lighter airborne particles travel around the room for an extended period. Depends on several factors such as room size, air conditioning, and locations of windows and doors, particles float until they reach a surface to land. Therefore, a longer time required for the room to go back to a normal and safe operational condition. For this reason, clinicians are recommended to leave time gap (~60 min) between each procedure.

The main objectives for our design are to create a barrier that,

- protects clinicians from direct contact with aerosol cloud without any compromise for clinicians’ access to the patient, line of sight, and ergonomic posture
- re-directs aerosol cloud to a more concentrated area for a targeted suction
- reduces time for the airborne particles to land on a surface
- reduces time gap required between procedures (patients)

### b) Aero-Shield Design

Aero-Shield is designed as a one-piece quarter hemisphere made from cast acrylic sheet, Polymethyl methacrylate (PMMA). The unit sits on a set of rolling legs to provide flexibility for the clinician during procedures. Two circular ports are created for the access to the patient. A removable and wipeable plastic cover (shown in RED) is designed to be hooked to the unit to seal the unit during procedures (Figure 1, Figure 2, and Figure 3).

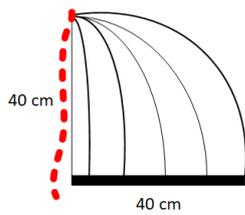


Figure 1: Quarter hemisphere design (dome shape) directs particles to the centre

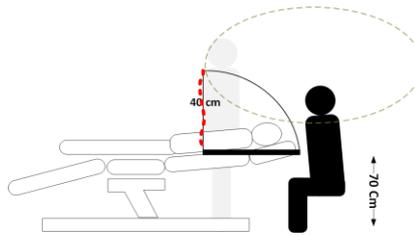


Figure 2: Typical set arrangement



Figure 3: Prototype Image

### c) Advantages of using Aero-Shield

Aero-Shield as a one-piece barrier sitting on a set of rolling legs, provides following advantages:

- **Line of sight** - the edge less design, and rounded shape creates a full line of sight with no obstacle for clinicians
- **Assess** - there are 2 circular access ports. During prototype tests, they were appeared to be perfectly used as armrests for clinicians who participated in the trial
- **Flexibility** - the rolling legs enables clinicians to move in different direction with moving shield creating full flexibility during procedures
- **Disinfecting** – Aero-Shield is designed as a one-piece acrylic unit with no edge and joint. This makes disinfecting simple and straightforward after each procedure. The cast acrylic is a hard surface material with low absorbency and hence is suitable for treatment with any anti-COVID antibacterial surface treatment.
- **Claustrophobia** – the see-through material used in Aero-Shield, as well as circular shape with no edge, creates a safe and comfortable environment for the patient during procedures
- **Aerosol flow** - the quarter hemisphere shape of Aero-Shield redirects and traps the aerosol within the covered hemisphere enabling targeted suction. Also, within the hemisphere, airborne particles reach the surface of the barrier much quicker, resulting in having less particle floating, reducing the time required between procedures.

### d) Disadvantages of using Aero-Shield

Using any sort of barrier in a clinical procedure requires work style adjustment. It is impossible to impose additional safety measures of any type with no complication in working condition. Aero-Shield is not an exception and certainly adds some level of discomfort mainly for the clinicians to adjust, which is inevitable.

## Experiment

We built a prototype unit based on the design. We used high speed cameras and particle counter machine to visualise and assess different scenarios during and after a typical AGP.

### a) Equipment used for the experiment

We worked in a dental clinic with standard equipment such as dental chair, suction, handpieces, and manikin to simulate a typical AGP procedure. In addition, we used following equipment to visualise and gather data:

- Heavy duty lighting – to produce lighting required to capture images of the aerosol cloud generated during a simulated AGP
- High Speed Camera – to capture and record images of the aerosol cloud and its journey
- Particle counter - measuring particulates generated during a simulated AGP (TSI DustTrak 8533 DRX Dust & Aerosol Monitor.)

### b) Experimental scenarios

We simulated similar conditions for two types of scenarios (with and without Aero-Shield) to be able to compare and assess the impact of Aero-Shield. We simulated a worst-case scenario to generate the maximum

level of aerosol (i.e. much higher than a typical AGP operation). We run the simulations over 7 continuous slots as follow:

- Slot 1 (15 min) – leaving the room in a standstill condition with no operation
- Slot 2 (15 min) – simulating AGP operation with Aero-Shield
- Slot 3 (45 min) – stopping the operation and moving around the room for cleaning and sanitising the equipment
- Slot 4 (15 min) – leaving the room in a standstill condition with no operation.
- Slot 5 (15 min) – simulating AGP operation with no barrier
- Slot 6 (45 min) – stopping the operation and moving around the room and cleaning and sanitising the equipment
- Slot 7 (15 min) – Leaving the room in a standstill condition with no operation.

## Results

### a) Real time image

Figure 4 shows the aerosol flow. In the scenario without Aero-Shield, the thick aerosol cloud first contacts with clinicians and then continues floating around the room. In the scenario with Aero-Shield, aerosol cloud appears to be running toward inside the hemisphere with nearly zero visible contact with clinicians. For the imaging purpose, we did not use cover so we can see the cloud path but in reality, the coder (shown in RED) will re-direct the flow to inside the hemisphere.

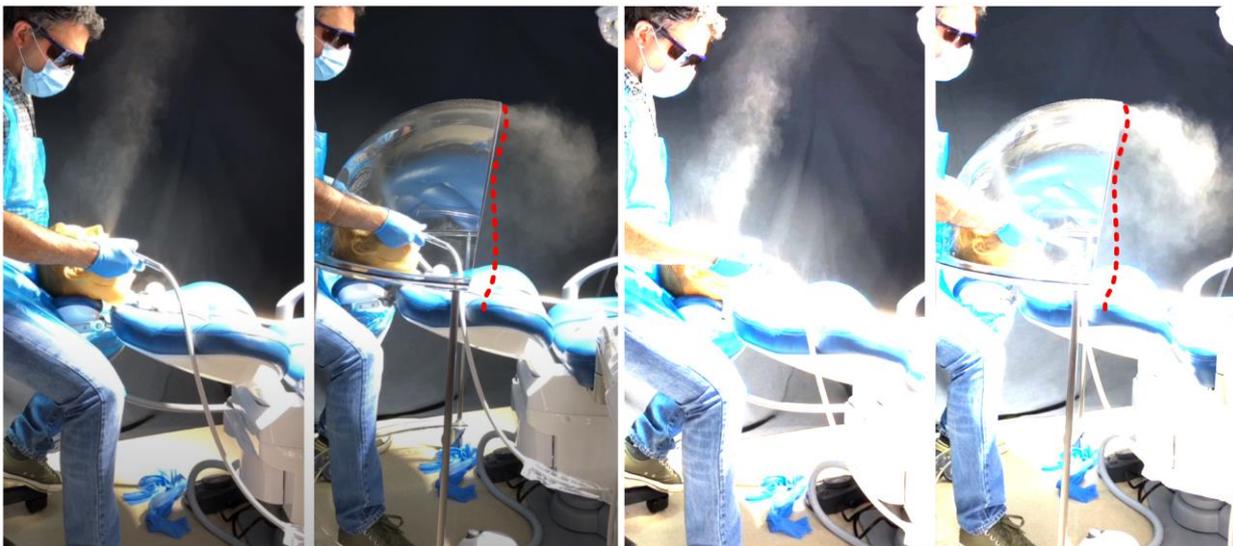


Figure 4: Dentist exposure to the aerosol cloud (with and without barrier)

### b) Aerosol Counting

The TSI DustTrak 8533 DRX Dust & Aerosol Monitor, measures and reports particulate and aerosol contaminants and simultaneously measure size-segregated mass fraction concentrations corresponding to PM1, PM2.5, PM10, Respirable and Total PM size fractions. We set the machine behind the dentist closer to the upper side of the body. Figure 5, shows the results gathered over 7 slots (near 180 min in total). The data gathered provides two main conclusions:

- In 15 minutes of AGP, aerosol particle concentration in the room (floating particles) is nearly double in size in compare to the results with Aero-Shield
- It takes nearly 45 min until the aerosol particle concentration size in the scenario without Aero-Shield reduces and reaches the size achieved in the scenario with Aero-Shield after 15 min.

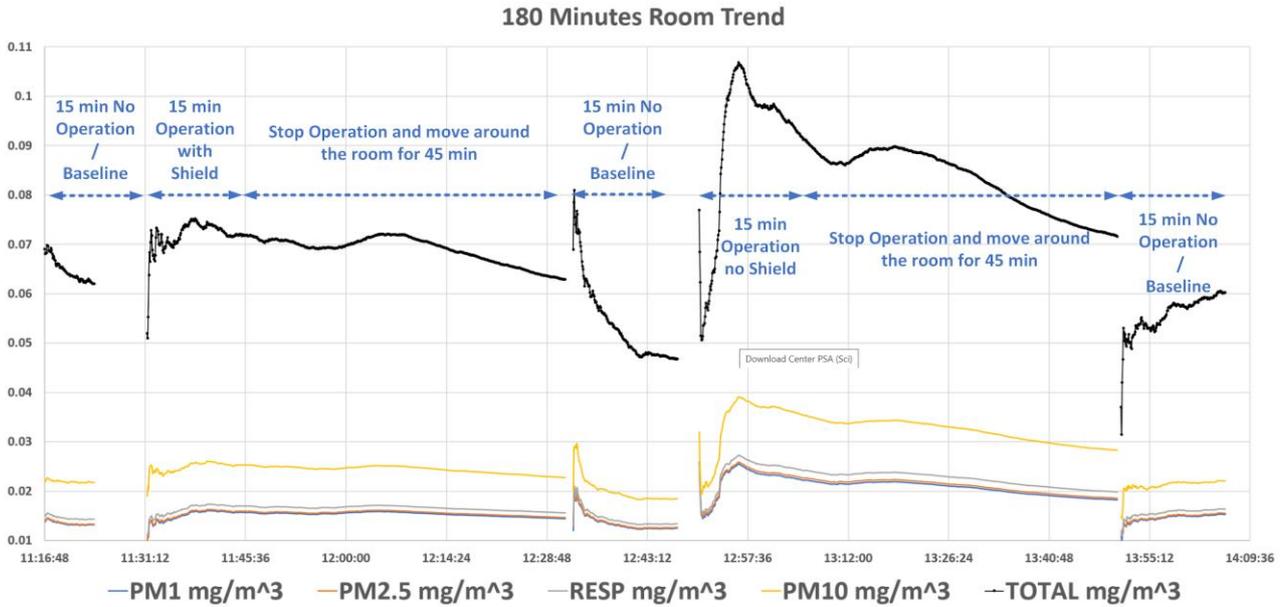


Figure 5: Running experiments in a clinic over nearly 180 continuous minutes with 7 slots

For a direct comparison, we overlapped the results of the 60-minutes operations of two scenarios. Figure 6, Figure 7, Figure 8, and Figure 9 respectively present results of the size-segregated mass fraction concentrations corresponding to PM1, PM2.5, PM10 and Total.

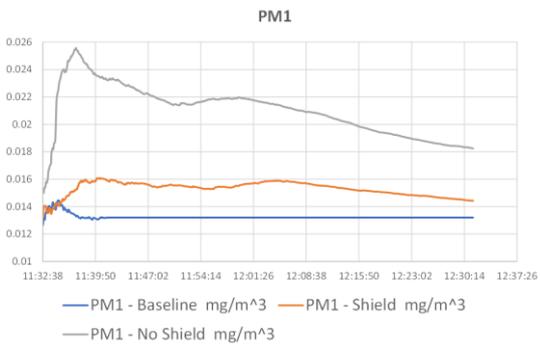


Figure 6: PM1 trend (60 min. experiment)

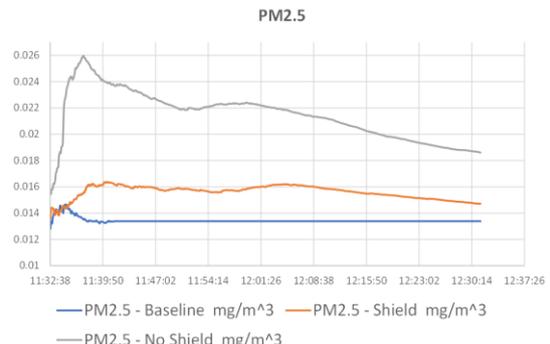


Figure 7: PM2.5 trend (60 min. experiment)

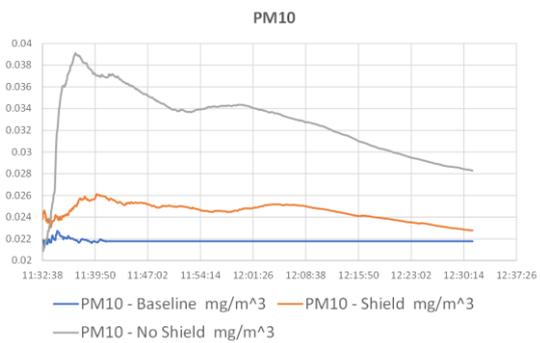


Figure 8: PM10 trend (60 min. experiment)

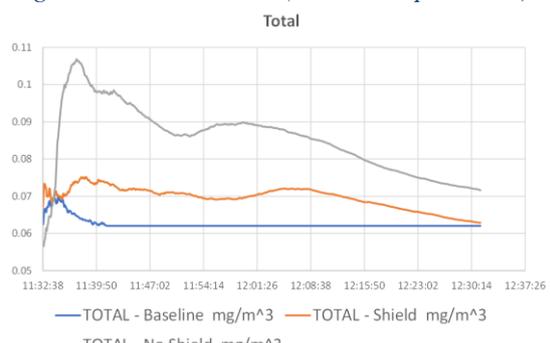


Figure 9: Total trend (60 min. experiment)

## Conclusion

The results illustrate two distinctive conclusions for the use of Aero-Shield in a dental practice:

1. Aero-Shield reduces the level of aerosol particle concentration (floating airborne particles), protecting clinicians from direct exposure. This could potentially result in a review on the necessity of the use of level 3 protective PPE in a long run.

2. Aero-Shield redirects airborne particles to within the hemisphere. Using the protective cover as well as suction inside the hemisphere, resulted in a much shorter time for particles to reach a surface. The results show a 45-min time difference between the two scenarios until they reach the same level of floating particles. This could potentially result in a review on the necessity of 60-min time gap between procedures.

As caveat in our experiment, in our simulation droplets are produced much more than a real scenario. Also, we are not counting the materials of less than 1 micrometres ( $\mu\text{m}$ ) in diameter that could potentially be infectious. We are suggesting that the use of Aero-Shield in conjunction with standard PPEs reduces the exposure to the aerosol, a measure that will create a safer working environment.

## References

1. Lai C-C, Shih T-P, Ko W-C, Tang H-J, Hsueh P-R. Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) and coronavirus disease-2019 (COVID-19): The epidemic and the challenges. *International Journal of Antimicrobial Agents*. 2020 2020/03/01/;55(3):105924.
2. Prevention C-CfDCa. Guidance for Dental Settings - Interim Infection Prevention and Control Guidance for Dental Settings During the COVID-19 Response. 2020.
3. NHS. COVID-19 guidance and standard operating procedure - For the provision of urgent dental care in primary care dental settings (from 8 June 2020) and designated urgent dental care provider sites. UK2020.
4. Programme S-SDCE. Resuming General Dental Services Following COVID-19 Shutdown - A guide and implementation tools for general dental practice For Phase 2 of dental services remobilisation. 2020.
5. Canelli R, Connor CW, Gonzalez M, Nozari A, Ortega R. Barrier Enclosure during Endotracheal Intubation. *New England Journal of Medicine*. 2020 2020/05/14;382(20):1957-8.
6. Micik Re Fau - Miller RL, Miller RI Fau - Mazzearella MA, Mazzearella Ma Fau - Ryge G, Ryge G. Studies on dental aerobiology. I. Bacterial aerosols generated during dental procedures. (0022-0345 (Print)). eng.
7. Harrel SKM, John. Aerosols and Splatter in Dentistry: A Brief Review of the Literature and Infection Control Implications. *J Am Dent Assoc - JADA*. 2004:429-37.
8. Szymańska J. Dental bioaerosol as an occupational hazard in a dentist's workplace. (1232-1966 (Print)). eng.
9. Holbrook Wp Fau - Muir KF, Muir Kf Fau - Macphee IT, Macphee It Fau - Ross PW, Ross PW. Bacteriological investigation of the aerosol from ultrasonic scalers. (0007-0610 (Print)). eng.
10. WC. H. Aerosol technology: Properties, behavior, and measurement of airborne particles. Wiley. 1982:6-8.
11. Cottone JA TG, Molinari JA. Practical infection control in dentistry. Baltimore: Williams & Wilkins; 1996.
12. Wells WF. On airborne infection: study II. Droplets and droplet nuclei. *American Journal of Hygiene*. 1934 20: 611-8.
13. Region WHOWP. Practical guidelines for infection control in health care facilities. Manila: WHO; 2005
14. Garner JS. Guideline for isolation precautions in hospitals. *Infection Control and Hospital Epidemiology*. 1996;17.