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CORONAVIRUS MYTH AMONG PRACTICING DENTISTS IN CHHATTISGARH - A QUESTIONNAIRE BASED SURVEY

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ABSTRACT

Aim: The aim of this survey study was to assess the level of awareness amongst dentists regarding the myth related to COVID-19. Method: A survey was conducted amongst 250 dentists to assess their level of awareness regarding the myth of COVID-19. Result: The results revealed that a considerable percentage of dentist learned about the pandemic were aware of the myth spread about virus and also related information of COVID-19 and prevent it from spreading. But considerable percentage of people was also not fully aware regarding the myth related to virus would be the cause for spread of infection due to incomplete knowledge and awareness. Conclusion: Upon understanding the percentage of people not aware about the age groups this virus will be affecting, keeping in mind good amount of knowledge amongst individuals about maintaining hygiene and social distancing, this survey would help the health care workers to create awareness regarding the myth related to virus in different age groups to help prevent carelessness amongst dentist in following regime.

Key words: COVID-19 myth; Awareness; Dentist; Age groups; Virus.

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INTRODUCTION

The latest threat to global health is the ongoing outbreak of the respiratory disease that was recently given the name Coronavirus Disease 2019(Covid-19) [1]. The Covid-19 outbreak is a stark reminder of the ongoing challenge of emerging and reemerging infectious pathogens and the need for constant surveillance, prompt diagnosis, and robust research to understand the basic biology of new organisms and our susceptibilities to them, as well as to develop effective countermeasures [2]. This virus affects the lungs majorly as it attacks the host cells via the enzyme ACE2, which is most abundant in type 2 alveolar cells of the lungs [3-4]. This virus has a surface glycoprotein called a "SPIKE" which connects to ACE2 and enters the host cells. This virus abundantly also affects the gastrointestinal organs as ACE2 is also expressed in cells of gastric, duodenal and rectal epithelium and small intestine [5,6]. This virus can survive on surfaces for about 72 hours. From the time of exposure to onset, the symptomsis shown between 2-14 days, with an average of 5 days [7,8]. The standard test to be conducted for the detection of the virus is reverse transcription polymerase chain reaction (rRT-PCR) from a nasopharyngeal swab [9,10].

The WHO (World Health Organization) declared the corona virus outbreak 2019-2020 as a public health emergency of international concern (PHEIC) on 30 January 2020 and a pandemic on 11 March 2020[11,12], real-time analyses of epidemiological data are needed to increase situational awareness and inform interventions [13]. India braces for the COVID-19 pandemic; healthcare workers on the frontlines are particularly vulnerable to this infection. The virus that causes COVID -19 was initially called as 2019-nCoV and was then termed as syndrome coronavirus 2 (SARS-CoV-2) by the International Committee on Taxonomy of Viruses (ICTV) [14].With this mode of transmission, healthcare workers are among the highest risk of being infected. The highly contagious SARS-CoV-2 virus is an additional hazard for the healthcare system apart from the burden of extended working hours, physical and psychological stress, burnout, and fatigue [15]. Dental care settings invariably carry the risk of SARS-CoV-2

infection due to the nature of procedures performed. The asymptomatic incubation period for individuals infected with SARS-CoV-2 is variable but can be protracted. It has been confirmed that those without symptoms can still spread the virus. This makes it extremely difficult to identify those individuals that pose a risk. The droplet and aerosol transmission of SARS-CoV-2 are the most important concerns in dental clinics and hospitals [16], because it is hard to avoid the generation of large amounts of aerosol and droplet mixed with patient's saliva and even blood during dental procedures [17]. A common clinical manifestations included fever (88.7%), cough (67.8%), fatigue (38.1%), sputum production (33.4%), shortness of breath (18.6%), sore throat (13.9%), and headache (13.6%). Human-to-human transmission of SARS-CoV-2 occurs mainly between family members, including relatives and friends who intimately contacted with patients or incubation carriers. [18]

MATERIALS AND METHOD

A cross sectional descriptive questionnaire study was conducted among dentist of Chhattisgarh from the month of may to August. The self administered 20 item questionnaire was framed utilizing the guidelines given in WHO website. The questionnaire consisted question regarding corona infection with respect to medicine, climate, vaccination, vector related transmission and covid 19 control measure. This study was adapted from WHO website from section of myth buster related to covid -19 conducted using a survey adopted from which was disseminated personally via personal interview. The survey was conducted among 250 dentists. This survey, which was conducted, contained 20 questions with multiple choice. All the individuals who answered the survey were informed about the confidentiality of their response and were also informed about the purpose of conducting this survey. The data was entered & tabulated in Microsoft excel sheet and percentage of responses given by study population was calculated using SPSS software.

Questionnaire

SR. No	Question	Option
1	Studies show hydroxychloroquine does not have clinical benefits in treating COVID-19.	A) Yes
		B) No
		C) May be
2	People should NOT wear masks while exercising	A) Yes
		B) No
		C) May be
3	The coronavirus disease (COVID-19) is caused by a virus, NOT by bacteria	A) Yes
		B) No
		C) May be
4	The prolonged use of medical masks when properly worn, DOES NOT cause CO2 intoxication nor oxygen deficiency	A)Yes
		B)No
		C) May be
5	Most people who get COVID-19 recover from it	A)Yes
		B)No
		C) May be
6	Drinking alcohol does not protect you against COVID-19 and can be dangerous	A)Yes
		B)No
		C) May be
7	Thermal scanners CANNOT detect COVID-19	A)Yes
		B)No
		C)May be
8	Adding pepper to your soup or other meals DOES NOT prevent or cure COVID-19	A)Yes
		B)No
		C) May be
9	Spraying and introducing bleach or another disinfectant into your body WILL NOT protect you against COVID-19 and can be dangerous	A)Yes
		B)No
		C) May be
10	Exposing yourself to the sun or temperatures higher than 25°C DOES NOT protect you from COVID-19	A)Yes
		B)No
		C) May be

11	Being able to hold your breath for 10 seconds or more without coughing or feeling discomfort DOES NOT mean you are free from COVID-19	A)Yes
		B)No
		C) May be
12	The COVID-19 virus can spread in hot and humid climates	A)Yes
		B)No
		C) May be
13	Cold weather and snow CANNOT kill the COVID-19 virus	A)Yes
		B)No
		C) May be
14	Taking a hot bath does not prevent COVID-19	A)Yes
		B)No
		C) May be
15	The COVID-19 virus CANNOT be spread through mosquito bites	A)Yes
		B)No
		C) May be
16	Hand dryers are NOT effective in killing the COVID-19 virus	A)Yes
		B)No
		C) May be
17	Vaccines against pneumonia DO NOT protect against the COVID-19 virus	A)Yes
		B)No
		C) May be
18	Rinsing your nose with saline does NOT prevent COVID-19	A)Yes
		B)No
		C) May be
19	Eating garlic does NOT prevent COVID-19	A) Yes
		B) No
		C) May be
20	People of all ages can be infected by the COVID-19 virus	A) Yes
		B) No
		C) May be

RESULTS

			Qualification		Total
			BDS	MDS	
Q1	Yes	Count	68	37	105
		% within Qualification	41.7%	42.5%	42.0%
	No	Count	48	33	81
		% within Qualification	29.4%	37.9%	32.4%
	Maybe	Count	47	17	64
		% within Qualification	28.8%	19.5%	25.6%
Total		Count	163	87	250
		% within Qualification	100.0%	100.0%	100.0%

			Qualification		Total
			BDS	MDS	
Q2	Yes	Count	84	60	144
		% within Qualification	51.5%	69.0%	57.6%
	No	Count	58	22	80
		% within Qualification	35.6%	25.3%	32.0%
	Maybe	Count	21	5	26

		% within Qualification	12.9%	5.7%	10.4%
Total		Count	163	87	250
		% within Qualification	100.0%	100.0%	100.0%

			Qualification		
			BDS	MDS	Total
Q3	Yes	Count	142	83	225
		% within Qualification	87.1%	95.4%	90.0%
	No	Count	9	1	10
		% within Qualification	5.5%	1.1%	4.0%
	Maybe	Count	12	3	15
		% within Qualification	7.4%	3.4%	6.0%
Total		Count	163	87	250
		% within Qualification	100.0%	100.0%	100.0%

			Qualification		
			BDS	MDS	Total
Q4	Yes	Count	77	48	125
		% within Qualification	47.2%	55.2%	50.0%
	No	Count	43	33	76
		% within Qualification	26.4%	37.9%	30.4%
	Maybe	Count	43	6	49
		% within Qualification	26.4%	6.9%	19.6%
Total		Count	163	87	250
		% within Qualification	100.0%	100.0%	100.0%

			Qualification		
			BDS	MDS	Total
Q5	Yes	Count	106	65	171
		% within Qualification	65.0%	74.7%	68.4%
	No	Count	38	15	53
		% within Qualification	23.3%	17.2%	21.2%
	Maybe	Count	19	7	26
		% within Qualification	11.7%	8.0%	10.4%
Total		Count	163	87	250

			Qualification		
			BDS	MDS	Total
Q6	Yes	Count	97	72	169
		% within Qualification	59.5%	82.8%	67.6%
	No	Count	37	11	48
		% within Qualification	22.7%	12.6%	19.2%
	Maybe	Count	29	4	33
		% within Qualification	17.8%	4.6%	13.2%
Total		Count	163	87	250
		% within Qualification	100.0%	100.0%	100.0%

			Qualification		
			BDS	MDS	Total
Q7	Yes	Count	79	67	146

		% within Qualification	48.5%	77.0%	58.4%
	No	Count	49	17	66
		% within Qualification	30.1%	19.5%	26.4%
	Maybe	Count	35	3	38
		% within Qualification	21.5%	3.4%	15.2%
Total		Count	163	87	250
		% within Qualification	100.0%	100.0%	100.0%

			Qualification		
			BDS	MDS	Total
Q8	Yes	Count	81	66	147
		% within Qualification	49.7%	75.9%	58.8%
	No	Count	52	9	61
		% within Qualification	31.9%	10.3%	24.4%
	Maybe	Count	30	12	42
		% within Qualification	18.4%	13.8%	16.8%
Total		Count	163	87	250
		% within Qualification	100.0%	100.0%	100.0%

			Qualification		
			BDS	MDS	Total
Q9	Yes	Count	89	59	148
		% within Qualification	54.6%	67.8%	59.2%
	No	Count	50	20	70
		% within Qualification	30.7%	23.0%	28.0%
	Maybe	Count	24	8	32
		% within Qualification	14.7%	9.2%	12.8%
Total		Count	163	87	250
		% within Qualification	100.0%	100.0%	100.0%

			Qualification		
			BDS	MDS	Total
Q10	Yes	Count	86	66	152
		% within Qualification	52.8%	75.9%	60.8%
	No	Count	52	12	64
		% within Qualification	31.9%	13.8%	25.6%
	Maybe	Count	25	9	34
		% within Qualification	15.3%	10.3%	13.6%
Total		Count	163	87	250
		% within Qualification	100.0%	100.0%	100.0%

			Qualification		
			BDS	MDS	Total
Q11	Yes	Count	77	63	140
		% within Qualification	47.2%	72.4%	56.0%
	No	Count	51	20	71
		% within Qualification	31.3%	23.0%	28.4%
	Maybe	Count	35	4	39
		% within Qualification	21.5%	4.6%	15.6%
Total		Count	163	87	250
		% within Qualification	100.0%	100.0%	100.0%

			Qualification		
			BDS	MDS	Total
Q12	Yes	Count	112	69	181
		% within Qualification	68.7%	79.3%	72.4%
	No	Count	34	13	47
		% within Qualification	20.9%	14.9%	18.8%
	Maybe	Count	17	5	22
		% within Qualification	10.4%	5.7%	8.8%
Total		Count	163	87	250
		% within Qualification	100.0%	100.0%	100.0%

			Qualification		
			BDS	MDS	Total
Q13	Yes	Count	101	75	176
		% within Qualification	62.0%	86.2%	70.4%
	No	Count	44	10	54
		% within Qualification	27.0%	11.5%	21.6%
	Maybe	Count	18	2	20
		% within Qualification	11.0%	2.3%	8.0%
Total		Count	163	87	250
		% within Qualification	100.0%	100.0%	100.0%

			Qualification		
			BDS	MDS	Total
Q14	Yes	Count	95	73	168
		% within Qualification	58.3%	83.9%	67.2%
	No	Count	38	11	49
		% within Qualification	23.3%	12.6%	19.6%
	Maybe	Count	30	3	33
		% within Qualification	18.4%	3.4%	13.2%
Total		Count	163	87	250
		% within Qualification	100.0%	100.0%	100.0%

			Qualification		
			BDS	MDS	Total
Q15	Yes	Count	101	64	165
		% within Qualification	62.0%	73.6%	66.0%
	No	Count	45	18	63
		% within Qualification	27.6%	20.7%	25.2%
	Maybe	Count	17	5	22
		% within Qualification	10.4%	5.7%	8.8%
Total		Count	163	87	250
		% within Qualification	100.0%	100.0%	100.0%

			Qualification		
			BDS	MDS	Total
Q16	Yes	Count	104	71	175
		% within Qualification	63.8%	81.6%	70.0%

	No	Count	39	13	52
		% within Qualification	23.9%	14.9%	20.8%
	Maybe	Count	20	3	23
		% within Qualification	12.3%	3.4%	9.2%
Total		Count	163	87	250

			Qualification		
			BDS	MDS	Total
Q17	Yes	Count	79	67	146
		% within Qualification	48.5%	77.0%	58.4%
	No	Count	45	11	56
		% within Qualification	27.6%	12.6%	22.4%
	Maybe	Count	39	9	48
		% within Qualification	23.9%	10.3%	19.2%
Total		Count	163	87	250
		% within Qualification	100.0%	100.0%	100.0%

			Qualification		
			BDS	MDS	Total
Q18	Yes	Count	92	63	155
		% within Qualification	56.4%	72.4%	62.0%
	No	Count	48	19	67
		% within Qualification	29.4%	21.8%	26.8%
	Maybe	Count	23	5	28
		% within Qualification	14.1%	5.7%	11.2%
Total		Count	163	87	250
		% within Qualification	100.0%	100.0%	100.0%

			Qualification		
			BDS	MDS	Total
Q19	Yes	Count	66	55	121
		% within Qualification	40.5%	63.2%	48.4%
	No	Count	64	19	83
		% within Qualification	39.3%	21.8%	33.2%
	Maybe	Count	33	13	46
		% within Qualification	20.2%	14.9%	18.4%
Total		Count	163	87	250
		% within Qualification	100.0%	100.0%	100.0%

			Qualification		
			BDS	MDS	Total
Q20	Yes	Count	135	87	222
		% within Qualification	82.8%	100.0%	88.8%
	No	Count	20	0	20
		% within Qualification	12.3%	.0%	8.0%
	Maybe	Count	8	0	8
		% within Qualification	4.9%	.0%	3.2%
Total		Count	163	87	250
		% within Qualification	100.0%	100.0%	100.0%

Table 1: Mean Age of the study group with respect to Gender

	Gender	N	Mean	Std. Deviation	Std. Error Mean
Age	Male	108	27.6852	4.40613	.42398
	Female	142	26.4718	3.70488	.31091

Table 2: Comparison of Mean Score of Study subjects with respect to Qualification

	Qualification		N	Mean	Std. Deviation	Mean Difference	T	P value
Score		BDS	163	11.4785	4.23439	3.578	-6.840	0.001*
		MDS	87	15.0575	3.31787			

Table 3: Mean score of Study subjects with respect to Experience

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean	
					Lower Bound	Upper Bound
1-2 years	144	12.2778	4.19364	.34947	11.5870	12.9686
2-3 years	58	13.3966	4.10366	.53884	12.3176	14.4756
3-4 years	14	11.6429	4.23551	1.13199	9.1973	14.0884
4-5 years	22	14.3182	3.84691	.82016	12.6126	16.0238
More than 5 years	12	13.1667	6.24985	1.80418	9.1957	17.1376
Total	250	12.7240	4.28782	.27119	12.1899	13.2581

ANOVA Score					
	Sum of Squares	Df	Mean Square	F	Sig.
Between Groups	129.534	4	32.384	1.784	.133
Within Groups	4448.422	245	18.157		
Total	4577.956	249			

Figure 1. Mean score of the male study subjects was comparatively higher than those of the female study subjects but the difference was not statistically significant (p=0.332).

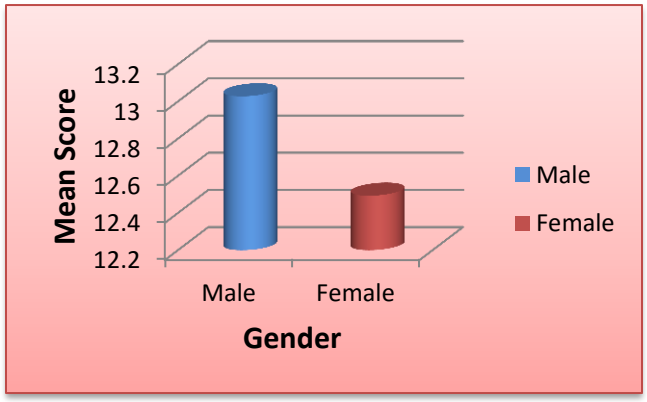


Figure 2. Qualification of the study subjects
Student t test/ Independent t test

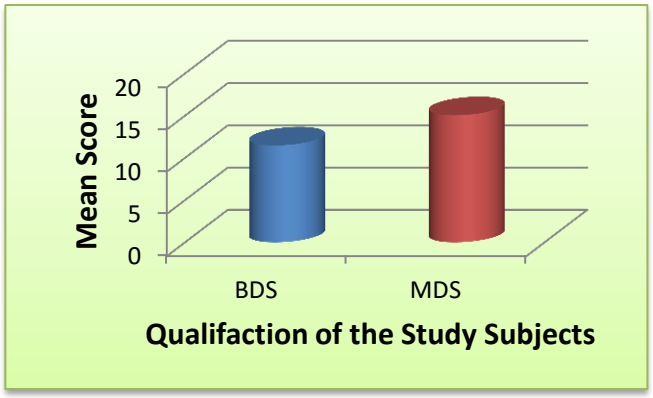
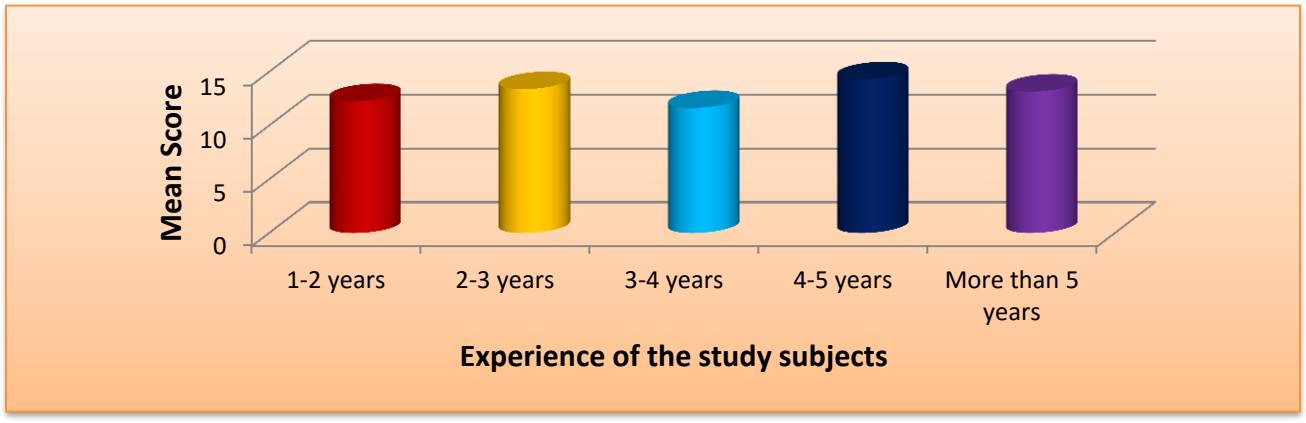


Figure 3. Mean score of the study subjects with a post graduate degree (MDS) was more than the graduate study subjects with a mean difference of 3.578 and a significant statistical difference (p=0.001).



DISCUSSION

The progression of the COVID-19 outbreak, such a long delay would be counterproductive. This approach facilitated the entry of robust and standard data on clinical and demographic information. Looking to the future, collection of patient data in the context of emergencies. Furthermore, data interpretability could be improved by gathering more quantitative information on how case definitions are used in practice. [19] Awareness of the use of personal protective equipment (PPE) for suspected/confirmed COVID-19 cases was high among all groups of healthcare professionals. The CDC has provided Interim Infection Prevention and Control Recommendations for Patients with suspected or confirmed coronavirus disease 2019 (COVID-19) in Healthcare Settings for PPE [20]

The nature of the dental setting puts both the dentist/dental team and the patient at high risk of cross-infection. The COVID-19 pandemic, has led to the absolute requirement for strict and effective infection control protocols beyond those that already exist within the dental setting. [21]

There is limited evidence suggesting in vitro activity of CQ/HCQ against SARS-CoV-2. The available in vivo empirical data is limited to two studies, with very small sample sizes, a number of methodological flaws, and conflicting results. On the basis of preliminary results from ongoing clinical trials, some countries have incorporated CQ/HCQ into their treatment protocols for certain patients with COVID-19. There is presently no medium to long-term follow-up data to support this approach. The very limited safety data available has not revealed serious side effects of these medications in the context of treating COVID-19. [22] People should NOT wear masks during exercise, it makes breathing difficult, wearing a mask while being active may exacerbate the existing symptom. Sweat may also make mask wet, further hindering breathing and encouraging the growth of microorganisms according to (WHO).[23] Coronaviruses are medium sized positive stranded RNA viruses that are named for the crown-like characteristic structures seen in electron micrographs. [24]While many different coronaviruses exist, seven types are known to cause disease in humans. [25] Four of these viruses 229E, OC43, NL63 and KHU have been associated with mild disease symptoms. Three of the viruses have been associated with causation of more severe illnesses and worse outcomes in humans. The first of these to appear was named Severe Acute Respiratory Syndrome (SARS) and was first reported in Asia in February 2003, although retrospectively it was present in 2002.[26]

Use of medical masks can be uncomfortable. However, it does not lead to CO2 intoxication nor oxygen deficiency. The use of alcohol increases your risk of health problems. Thermal scanners are effective but cannot detect people who are infected with COVID-19. Hot peppers in your food, cannot prevent or cure COVID-19. Do not under any circumstance spray or introduce, these substances can be poisonous if ingested and cause irritation and damage to your skin and eyes.[23]

The relationship between weather and COVID −19 are still not conclusive. Some of the studies (Shi et al. 2020; Cai et al. 2020) did not show any evidence that COVID-19 case counts could decline as the weather warms up.[27]

Routes of transmission:

The three most common transmission routes [29] of novel coronavirus include:

i. Direct transmission (through cough, sneeze or droplet inhalation),

ii. Contact transmission (through oro-nasal-ocular route) and

iii. Aerosol transmission.

Asymptomatic carriers of the infection are equally capable of transmitting the virus as symptomatic patients [30]. Vaccines against pneumonia, is not use as it is new and different that it needs its own vaccine. Researchers are trying to develop a vaccine against COVID-19, and WHO is supporting their efforts. There is no evidence that regularly rinsing the nose with saline has protected people from infection with the new coronavirus. Garlic is a healthy food that may have some antimicrobial properties, but no evidence from the current outbreak that eating garlic has protected people from the new coronavirus. Older people and younger people can be infected by the COVID-19 virus. [23]. The distribution of non-communicable comorbid conditions—which are already known to increase the risk of severe disease from COVID-19,[31] might be differently distributed by age [32], along with other risk factors such as undernutrition [33]. Second, communicable comorbidity such as HIV [34], tuberculosis co-infection which has been suggested to increase risk [35] and others [36] could alter the distribution of severe outcomes by ages.

Treatment Categories

For these guidelines development, dental procedures are proposed to be divided into five categories:

A. Emergency management of life-threatening conditions.
B. Urgent conditions that can be managed with minimally invasive procedures and without aerosol generation.
C. Urgent conditions that need to be managed with invasive and/or aerosol-generating procedures.
D. Non-urgent procedures.
E. Elective procedures

Treatment considerations

1. Intraoral imaging should be restricted and extraoral radiographs should be utilized to reduce the excessive

salivation and gag reflex associated with intraoral radiographs.
2. Using 0.23% povidone-iodine mouthwash for at least 15 s before the procedure can reduce the viral load in the patient's saliva (Eggers et al., 2018).
3. Disposable and single-use instruments and devices should be used whenever possible to reduce the cross-infection risks.
4. Rubber dam should be used whenever possible as this will significantly reduce the spread of microorganisms (Cochran et al., 1989).
5. The dental treatment should be as minimally invasive as possible.
6. Aerosol-generating procedures should be avoided whenever possible.
7. Whenever pharmacologic management of pain is required, Ibuprofen should be avoided in suspected and confirmed COVID-19 cases (Day, 2020).[36].

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