

Harvard School of Dental Med. | Oral Medicine and Pathology During the COVID 19 Pandemic

Good morning. It is my great pleasure and honor to welcome everyone to Harvard School of Dental Medicine's continuing professional education, CPE. Today, talk number 4, entitled Oral Medicine and Pathology During the COVID-19 Pandemic, the Show Must Go On. My name is Dr. David Kim. I'm the director of CPE and Harvard School of Dental Medicine.

And I'm very pleased to introduce our moderator, Dr. Nathaniel Treister. Dr. Treister is chief of the division of oral medicine and dentistry at Brigham Women's Hospital, and clinical director of oral medicine and oral oncology at the Dana-Farber Brigham Women's Cancer Center. He is also an associate professor of oral medicine at Harvard School of Dental Medicine. Dr. Treister, oral medicine oral pathology specialists work closely with a wide and diverse group of health professionals to provide treatments to patients with complex medical conditions.

Patients referred to you may be suffering from debilitating mucosa diseases, where there may be high suspicion for malignancy. Many of your patients required [? dented ?] clearance prior to scheduling essential medical procedures. We want to find out how your practice has been changed, impacted, adapted since dentists have been recommended to see only urgent cases.

Thank you, Dr. Kim. Indeed, we've had to adapt to this new recommendation from the Mass. Dental Society, while also working within the guidelines set forth by Brigham Women's Hospital, Dana-Farber Cancer Institute, and the overall partners, [? MGB ?] parent organization. So we've had to quickly pivot and incorporate tele-dentistry and other communication modes to see both new patients, and scheduled follow up patients. It's been a fairly remarkable process, requiring an incredible amount of education and training, coordination, operationalization and management.

Many of our colleagues in the US and around the world have had parallel experiences. So for today, I've asked two of my colleagues at the school and hospital to present how they've been providing patient care during this unique period. It's my great pleasure to introduce our two presenters for today, who will provide timely and I think a quite interesting insight into the practice of oral medicine and oral pathology during the COVID pandemic.

First, I'd like to introduce Dr. Herve Sroussi. He's an associate surgeon and the director of research in the division of oral medicine and dentistry at Brigham and Women's Hospital. He's also an associate professor of oral medicine at Harvard School of Dental Medicine, and a diplomante of the American Board of Oral Medicine Next, I'd like to introduce Dr. Reshma Menon. She's a lecturer at the Harvard

School of Dental Medicine, and she's a diplomate of the American Board of Oral and Maxillofacial Pathology, and a fellow of the American Academy of Oral and Maxillofacial Pathology.

So we're going to have a presentation by both of our guest speakers today. They're going to talk about tele-dentistry during the pandemic, two real but virtual cases from the clinic, as well as practical approaches to clinical and oral maxillofacial pathology. And you'll see how these work very well together. And we're going to follow this by a discussion, with some questions that we have prepared. And we also hope that there might be some questions from the audience that we can incorporate as well. So I think, without further ado, Dr. Sroussi, Dr. Menon, we're going to turn the discussion over to the two of you.

Thank you very much, Dr. Treister. Thank you all for being here with us today. Before getting into our first case, I would like to-- if we could go back one slide-- discuss a little bit the expectation, if you want, we all had. Because we all have experience with virtual video chat with friends and so on. So one of the things that I expected was it could be useful at certain times. I expected that it would be probably better, easier to do with established patient than new patients, that there would be a difference between those who have a tangible lesion that could be examined, as opposed to those who, let's say, have symptoms that are not necessarily related to somatic changes you could see.

I also thought pictures would be very valuable. If you could get patients to provide photographs before the consultation, that would be very useful. And finally, I thought that video chat was probably better than a phone call, allowing me to read facial expression of the patient, and the patient do the same with me.

So next slide. Here's my first case. This is a 32-year-old Caucasian woman with a medical history that is defined here with [INAUDIBLE] anterior chest wall lipoma, bilateral retinal degeneration. And she presented for the evaluation of a mucosal lesion on the lower labial mucosa. She essentially noticed it around two months ago. It seemed to have happened after she bit her lip, but there was no change in appearance. She denied any symptom, no pain, no numbness, no sensitivity. This was the first occurrence of such lesion, as she denied having a similar lesion anywhere else on her skin, or any other mucosal surfaces in her body.

Next slide. So in the context here, we requested the patient provide a picture. And we had an administrative person that coordinates these kind of visits that helped with that. So we had this picture. And as you can see, the picture is actually not too bad, taken by the patient. And you can see that little lesion on the lower lip, around 5 millimeter, a little bubble, if you want, a little lump. You can

operate [INAUDIBLE] solve given the history, the age of the patient, the presentation, its location and so on, we seem to be very comfortable with this kind of assessment.

So next slide. We discussed the finding with the patient. I thanked her for the picture. I told her that my clinical diagnosis based on this was essentially this was a mucous seal, and we discussed management options, from wait and see to excision. We then agreed to re-evaluate the lesion in person in three months if the lesion was still there. And at that time, we examined the issue of excision and biopsy, as opposed to continued follow up. Of course, we made it clear that we are available in the meanwhile if anything were to change.

So next slide. So here, we're very useful, we're very excited. This is a great way to provide care to our patients. Is there anything that could have helped improve the experience? I'm not sure. This seemed to be very smooth and working very well. And then the question is, could this be done virtually again? I mean, could we do this visit even after COVID goes away? And the answer is yes, why not? This actually saved the person the trip and the parking cost and whatnot. And this could be done again, even after COVID is done. So on this happy note, I would like to introduce my colleague, Dr. Menon. Dr. Menon will give her perspective from an oral pathology standpoint as to how to provide care in the COVID pandemic era.

Thank you, Dr. Sroussi. So I'm here to provide sort of the practical approaches of clinical pathology. And as you all already know, both oral pathologists and oral medicine specialists see patients, and we work very closely together to provide care. Typically, a patient would be seen for exams and interpretations. In the beginning, you take a thorough history. Take radiographs if they don't have it already. And perform an thorough extra oral and inter oral exam. I try to obtain clinical photos from the get go at the first visit, after which we move on to a working diagnosis, which could be a differential. And then you're deciding whether you want to use diagnostic adjuncts, cytology, culture, et cetera. And then do you really want a biopsy it to confirm the diagnosis? And we use different types of modalities, as listed here. And then finally, the patient is managed. Do they need further surgery? Is this going to be medication? Or maybe no treatment at all.

So why biopsy in the first place? A biopsy really is the ultimate validation and confirmation of what is really going on, right? You want to take a piece, look at it at the microscope. And 99% of the time, when the biopsy tissue specimen is adequate, we can tell what is going on. And that is really useful, especially in suspicious lesions, et cetera. The million dollar question really is whether to biopsy or not, COVID or no COVID, right? Especially more so now, because of how we want to decide whether it's really that urgent. Does the patient really need to be called in, considering everything?

And I speak from the [INAUDIBLE] school's perspective. Dr. Treister and Sroussi will probably give us a perspective about things from the hospital as well, which may be slightly different. But really, the big question is how urgent is this? Do we really need to call the patient in. And to help us with that decision, here is my take on the different pathologies of the oral maxillofacial region. You can classify them based on either location and appearance. And this would be extremely important to do so when you fill out your requisition form, or any type of communication that the pathologist receives, into whether it's mucosal, or interosseous based on the location.

What do these really look like? Are they white, flat lesions? Are they ulcers, erythema, nodules, masses, et cetera? And then on the other hand, you can also describe it from this really in-depth tree infographic that I have here on the right, which is classifying pathology based on the etiopathogenesis, really. So that's going a step further. But definitely, the more information we get on the requisition form, the more helpful it is when really getting that diagnosis out.

All right, the big questions are like we said already, to biopsy or not? And let's look at that in perspective of white lesions. So here you have a patient who has this white, flat, plaque type of lesion. That's on the [? retro ?] molar [? pad. ?] But if I told you this patient had [INAUDIBLE] erupted tooth on the opposing arch that is really pounding food into this area, then you're thinking maybe it's more sort of reactive traumatic type of a lesion. And indeed, this was biopsied, and was called a benign alveolar ridge keratosis. These are not pre-malignant. They're totally benign, and there is no chance of this becoming a cancer.

Another white lesion-- slightly different flavor to this. Because you get to see a little more red and yellow. This is ulcerated. And this patient had this lesion, and had a similar lesion on the other buccal mucosa, as well on the opposite buccal mucosa. And this was biopsied. It was indeed a classic oral lichen planus.

This one is slightly different, because you're seeing a white plaque that is pretty large. If you think about it, it extends from here to there. And if you were a tiny person, or even a dentist wearing loops, and you looked at it, you'd see little divots in the surface of this lesion, hence it's fissured, so I'm getting a little worried when someone sends me a photograph like this. And indeed, it was diagnosed as mild dysplasia in this patient. Clinically, these are called [? leukoplakias. ?]

So what makes something white? Basically, it could either be thick keratin, alteration to the keratinocytes, like in dysplasia, thick keratin-like in this benign alveolar ridge keratosis, a thick layer of epithelium can make something look white. And other entities, like fibrosis, can also look white,

because of what it looks like histologically. But why do we need to detect these early, especially now more so than ever? Because really, the patient's best chance for improved survival is early detection, as shown by this five-year survival rate for oral squamous cell carcinoma. So that's your chance at helping this patient out.

Another entity that we see often in the clinics are ulcers. And I just want to at the get go talk about what an ulcer looks like histologically for a second. So here on the left, you have normal epithelium. And then when you have a break in the epithelium, that's what an ulcer is. It looks yellow because of the fibrin, and maybe a little red because of all these extravasated red blood cells. There's granulation tissue. So that's what an ulcer looks like.

So with that in mind, here is a child, an adolescent who had these ulcers that are, you can imagine, pretty painful. And a biopsy was performed. And this was a recurrent [INAUDIBLE] that came and went. And then in this case, this was a patient who had this ulcer. And you can see there's a slightly sclerotic margin to it. He was traumatizing it on sharp tooth cusp, which is not seen here. An example of a traumatic ulcer or granuloma.

And here is another very interesting case of a patient who was immunocompromised. She had [? CREST ?] syndrome. And here is an example of an ulcerated lesion. It's not so much an ulcer, it's an ulcerated lesion. And this was biopsied, and was a squamous cell carcinoma in this patient. So my point here is ulcers are all not created equal. You really want to have that high threshold of suspicion for a non-healing ulcer.

So what have we been doing at HSDM during the COVID-19 pandemic? We have had where our operations are very limited, as with everyone around the world, I would imagine. But we have been relying a lot on telemedicine for referral. And that could be as simple as a student getting a call about a patient who sends a photograph in. And then that is sent to me via our electronic health recording system.

I send a differential, and many, many more questions. And really, that's about it. And then you try to offer them some kind of an answer about what might be going on. And then many times, we get to speak with the patient via video calls. That is also helpful, something to just quell the anxiety of both the patient and what is going on.

Biopsy procedures have been limited to only what is really necessary, like I mentioned before, like with the [INAUDIBLE] and neoplasias, and suspicious pre-malignant lesions.

So what's working well is really maintaining an open line of communication with both the patient, the student who may be dealing with this, and the other attendings who may be involved. We work very closely with all our discipline directors at the dental school. So that has been great, where we can just shoot an email and ask for advice. So that's been really great. And I think maintaining an open line of communication has been great, again, COVID or not.

At the end of the day, patient awareness is also important. So when you do give them these differentials or a working diagnosis of what you might be dealing with, it's always helpful to ask-- or rather let the patient know what you might be thinking it is, and also what you think is most likely is, and a little bit about each entity that you may render a diagnosis of. And then ultimately, please, please take and get pictures. Because that really helps with giving the patient an answer.

Here's an example of a patient from Boston who I saw, virtually, that is, when I say saw. And I see her routinely for another condition. But she was worried about this little nodule that you can see in the buccal mucosa. And this is a picture she took on her own. Yes, this is not an ideal picture, but something is better than nothing at this point. And really, she was only so anxious about everything going on, and she didn't realize that she had this identical opening of the [INAUDIBLE] stuck on the other side of the buccal mucosa as well.

But she was so relieved to see and know that that was all that it was. So it really helps to be able to communicate with the patient, even though we're all-- this is really trying times, and we're going through a lot. But the take home message really is when in doubt, phone a friend. Ideally, you have someone who is an oral medicine or pathology specialist.

A referral is always great. At the end of the day, you definitely need to biopsy pre-malignant and suspicious lesions and cancer. Diagnostic adjuncts are useful. And finally, ideally, you want to communicate as thoroughly as possible, and document all that we do.

So that's my sort of practical approaches to some of the things we've been dealing with, again, COVID or not COVID, but some questions are more important to be answered now, especially with everything going on. So with that, I'll let you go back to case two with Dr. Sroussi. Thank you for that first really cool case. I'm excited to hear about the next case.

Thank you very much Dr. Menon. And let me now go over a second case, and give you a different experience of telemedicine, teledentistry [INAUDIBLE]. Now this is an 82-year-old lady with a history of breast and endometrial cancer, glaucoma, hypertension, and joint replacement surgery. Now I want to make a clear point here, where we tried to have her-- we used Zoom as our video platform--

we tried to have her use Zoom. It was not possible for her to do so, so that essentially, that the initial consultation-- this is an initial consultation of a patient we've never seen before-- occurred over a phone.

What she told us essentially, that she had an oral lesion that simply would not go away. She had quite a bit of pain, 7, 8 pain at rest, and difficulty eating, and extreme difficulties, I would say, performing home oral hygiene. The lesions were present for two months, and occurred simultaneously with ocular lesions. She also reported a significant amount of bleeding, which clearly made sense when I tell you what the diagnosis was.

And the diagnosis was cicatricial pemphigoid, and that diagnosis was secured by a biopsy that was obtained in her mouth by an oral surgeon in February of 2020. The biopsy also showed that it is [? directing ?] [INAUDIBLE] [? fluorescence ?] deposit of [? IgA ?] along the [? basilar ?] membrane zone, which indicates it supports the biopsy, but from a clinical sample, may indicate that it may be a lesion difficult to control a little more than you would be otherwise. She was currently on 60 milligrams of prednisone, and was waiting for her insurance company to approve CellCept.

And she was going to start CellCept 500 milligrams initially. But she was waiting for insurance to approve that. And again, to get back to that era we live in of COVID modification of treatment, her ophthalmology, we wanted to try start her on Rituxan infusion. But Rituxan infusion would require her coming to the medical center for these infusions. And given her age and given where we stand with all this, it was the hope of the ophthalmologist who was managing the systemic management [? tree ?] of that patient that this will be delayed, and that, in fact, that prednisone CellCept treatment would give us that initial response. And hopefully, later on, if needed, she would be brought in for that Rituxan infusion.

So next slide. So as always, there is an important aspect of how we manage a patient, which is to discuss the diagnosis, discuss management options and prognosis, and educate the patient. And so we did that, and we explained to her how this is significant to oral health. It was also very clear that she was extremely concerned that her inability to perform oral hygiene functions at home would essentially lead to a lot of damage to her [? periodontium ?] and teeth.

And she was correct. And not only that, in fact, the lack of home hygiene, if you want, was also contributing to the disease, and eventually, our ability to control it. So it was very important to [INAUDIBLE]. And we discussed several treatment options, electric toothbrush, soft toothbrush, changing maybe to a toothpaste for which she would have less sensitivity, or pediatric toothpaste or

whatnot. We also did what we often do with this patient, despite the systemic treatment, is to add an adjuvant topical treatment.

And the adjuvant topical treatments we recommended for her were dexamethazone and Nystatin rinses, asking her to mix these two together. And the dexamethazone-- the topical steroid as a rinse-- would go everywhere and treat all parts of her mouth. And it seems from what she was telling us, that many anatomical sites of her mouth were involved, not just the gingiva.

And then the Nystatin would be a prophylactic antifungal treatment. So we say let's start with this. We know you were started on 60 milligram prednisone. We know you're going on CellCept. Let's see how things evolve. Let's meet again in three weeks. So three weeks later, we met again.

And next slide. I have first excellent news. We were able to go on Zoom. We were able to discuss and build that report, and that was very useful. And she told us, I am much better. My spontaneous gingival bleeding is gone. I have found a way to perform oral hygiene at home. She switched to an electric toothbrush with soft bristles. And in part, it may be the change in method, and in part, it may be that she was simply responding to the systemic and topical treatment that she was on.

She said, my symptoms are 75% better than they were when I first talked to you three weeks ago. She was complying with the management strategy we gave her, which is the dexamethazone Nystatin rinses done three times a day for five minutes. We ask the patient not to eat and drink for 20 minutes after that, just that he wouldn't get washed out.

And she reported no side effects, no indication that despite the prophylactic antifungal, she would have had any kind of symptoms of [INAUDIBLE] mouth. There's no indication also that she had any side effect from the prednisone she was on. This, mind you, an 82-year-old lady on 60 milligrams prednisone at that time.

Now as far as we're concerned, she was recently given contact lens bandages for her cornea. She seemed to be [INAUDIBLE]. She mentioned, actually, that she had to keep on washing her eyes every half an hour or so, because they were crusting. And she was actually more concerned with her eyes than she was concerned with her mouth at this point.

She was still on 60 milligram prednisone, by the way. Her CellCept was at 500 milligrams twice a day at this point. She was concerned that CellCept did not seem to help. She thought that would be some kind of a miracle cure it would add [INAUDIBLE]. But it didn't yet. And we tried to encourage her to continue, because we know that CellCept takes quite a while before it kicks in in order to get really a

treatment response from it.

And as far as the Rituximab intrusion, her primary team continued to consider this, because again, mostly because of the ocular lesion. If we were not in 2020 and COVID-19 did not exist, this patient would have started by then with the infusion. But again, treatment modification necessity of the time, this was not part of it. So our next slide.

So we ask her to continue with dexamethasone Nystatin rinse. In the conversation we had with her whether the gingiva was much better, she did mention that there was one ulcer on her tongue that was the bulk of the symptoms she had at this point. So we also introduced a [? clobetasol ?] gel treatment that she could apply there. We asked her whether she was accessible to her. She was actually on the video showing us the lesion and where it was. You couldn't see much from the video.

But sufficiently, we could understand that she had an ulcer on the side of her tongue. She could put her finger on it, and if she could put her finger on it, she could apply [? clobinazole ?] gel, and that would help her as well. So we introduced that also to the management approach. We scheduled a visit in six weeks, still virtual. We don't know where we're going to be at the time. And we discussed an in-person visit.

And it is clear to me that this kind of case would eventually require in-person visit, that there is no way, first, that we should manage patients like this virtually only, and that we should talk about an in-person visit. But it was not the time yet to be able to schedule that. Because we don't know where we're going to be in a month or two. This is an 82-year-old woman with a heavy medical history and so on. And there's no reason, especially if we immunosuppress her with prednisone and CellCept, to bring her into the medical center at this point.

Next slide. So what did we learn? And we came with expectation, and what did we learn? Was it useful? Yes, this was useful. And for the past few weeks now, we've been delivering care through Zoom, or sometimes phone calls. And it is always useful.

And it's always useful, because it could be that, in fact, no resolution can occur. No management resolution can occur through this interaction, other than to say, I have to see you in person. And then you have to weigh the risk benefit of that. If this is the resolution of the case-- we say, look, I can't see the ulcer. I don't understand what you have, and potentially, the differential diagnosis would include concerning diagnosis, then fine, than the resolution is that the patient has to come in. So it is, in my view, always useful, at least in this era, to conduct this kind of thing.

What could have helped improve the experience? I mean, there is the technical aspect of training of patients, or through maybe using the staff to make sure they can go into that, to teach [INAUDIBLE] to take pictures and so on. This is complicated. It's demanding. The staff is itself very stressed by the amount of interaction we get. This could happen, and they may be, and we'll discuss that later as to whether other people have experience with that, and whether you can suggest a way to improve this kind of interaction.

And then the question is, could this be done virtually in the post COVID world. And I will first say first and foremost that I'm in no way comfortable that I would manage a patient with conditions such as cicatricial pemphigoid. We're not seeing them. Maybe for some established patients, some recall visits, yes. But that there would be no face-to-face interaction in a post-COVID world for this kind of patient. It's simply not reasonable.

But as you can see, we made progress. We could get the patient to improve. We could educate a patient and help her sort out the oral hygiene, bring in some topical adjuvant treatment to a systemic treatment. And we were making progress in this case. And there's no doubt there is value to it, but not as the only way of doing that.

So next slide? I will now address my initial expectation and where I stand at this point. Again, as I said, it's not that it could be useful sometimes. It is always useful. It's an issue of allocation of time and resources. If you can have a video call with any patient before they come in and sort it out, especially in a medical center such as ours, where we have patients coming from very far away-- we know traffic in Boston, we know how difficult it is to park your cars and whatnot-- they're older people, are hard to move? Yes. Always useful to decide and sort out [INAUDIBLE] we should come or not.

Established as opposed to new patients. Well, yes, but I gave you in the first example a case of a new patient where it worked beautifully well. So it's not so much about establishing a new patient, that's one parameter of course, but it's also what you're dealing with. So [INAUDIBLE] tangible lesion as things that you cannot examine.

One issue of this is that-- especially in the new patient-- the fact that a patient may be reporting symptoms that may be at the end neurogenic with have no somatic finding, no objective finding. It's something that you can only assert by actually examining the patient. So you can't simply-- if you a patient with the so-called burning mouth syndrome, all these [INAUDIBLE], and they present with all the classic patterns, you can't really tell a patient like that that there is nothing causal that would explain their burning or their pain or their needles or whatever symptoms they have without the

examination.

So especially in a new patient that has to be established, and it is a big difference between these two. Now providing photographs, my colleague Dr. Menon said, it is very valuable. Photographs are very valuable, and you will see some interesting photographs a bit later. And as far as the video chat versus the phone calls, we've had both of these patient. And yes, the interaction, the report you can deal the patient is much better on a video chat than it would be on the phone. So with this said, I will end my presentation now and give the baton back to Dr. Treister.

Great, thank you both so much. So here's a great clinical photo for everyone to wrap their heads around that was actually sent to us last week. So I really want to thank both of you so much, this was an excellent presentation. I think we've gained a lot of great insight and information about how we're all managing this and how oral medicine and pathology care is being provided during this interesting period.

So we've had a few questions, and actually we have a few prepared questions. One of the questions that came through I am actually going to address very quickly because it's actually very relevant because some of these questions are coming from all over the world. One of the questions was asking if we can actually prescribe for these patients when we see them virtually. And the short answer is yes. I wouldn't want to answer for the entire country and every state and every institution. But these virtual visits do serve in place of an in clinic visit, with the understanding that-- especially for a new patient-- that we will see them when the time is appropriate.

But with that being said, given the consenting process, the patient agreeing to the visit, and the clinician using, obviously, their best clinical approach to the diagnosis and management, we very much can and do. So Dr. Sroussi showed a great example of a team approach to care in managing a patient with a quite complex mucous membrane pemphigoid or cicatricial pemphigoid.

I was involved in managing a patient in the last couple of weeks with a new diagnosis of pemphigus vulgaris that with confirmation of pathology that had been already obtained, but not actually confirmed with the diagnosis, we indeed were able to start, in this case, really critical systemic therapy for a patient. So it's actually been very eye opening for all of us. So thank you for whoever that was from Brazil, I believe, who submitted that question because there are differences in who can prescribe various medications and in what context those medications can be prescribed.

So I wanted to take this opportunity, we have we have a few questions. We have about 15 minutes for questions. And after I asked this question, I'm going to look and see what other questions are coming

in. And actually, I think the first one I want to start with has us take a little bit of a step back. And that's that we all know the pandemic has brought to light many, many societal inequities with many haves and have-nots experiences being quite different in many cases-- and not just related to, of course, access to medicine.

I'm wondering if the two of you can at least try to comment on how this potentially may be impacting oral medicine care during this period. And what, if any, lessons may be taken from this looking into the future about how we try to provide care and provide access to care to as many people as possible. Whoever would like to start.

So the issue of access to care, the question is, is telemedicine adding a hurdle? I mean, telemedicine may, in a way, resolve or add hurdles to the providing care. It may in a way resolve hurdles, in the sense that-- let's say having an 82-year-old patient that cannot easily come to a clinic or requires the resource or requires someone to drive her-- whether that will be provided by friends or family or by some kind of a service that do that for her-- where providing health care at distance make in a way reduce the hurdle and access to care.

On the other hand, of course, as we know that in education as well-- in the field of education-- the fact that you need a computer, the fact that you need internet access, the fact that you need to be savvy enough and be exposed to it, may be an additional hurdle that may hurt those who already are suffering from lack of access to care. So there's two edges to that sword.

And so it may help in a way, but make it more difficult for some as well. We have to be cognizant of that. And from that standpoint, even if the Zoom doesn't work, even if we would like to see the face of a patient and so on, most people at least have a phone, and we can do that over the phone. And we should not deny access to those who don't have internet or access to Zoom, or who don't have the technical skills to be able to do that.

Yeah, I totally second that. I agree, it has really helped with triaging more straightforward cases, and not so much the complicated ones like you just discussed. Patients are definitely at a disadvantage when they need to be tech savvy, and they are living on their own, and those kinds of situations. So it's definitely come up a lot when you see a number of different patients. Yeah, I totally agree with that.

Good. I'm going to switch up the order a little bit because there was another good question that came in that I think dovetails a little bit with one of the other questions we had. There was a question asking about what type of medically necessary or essential urgent dental care has been provided during this

period? And I think that might be something that Dr. Sroussi can answer a bit better just because of him working out of our hospital based practice at Brigham Women's Hospital.

But I think in addition, that question and one of the questions we had prepared was, in that context, if you could also comment on any mandated screenings that are done for the patients who are scheduled to be seen, and then specifically for patients who will be undergoing dental procedures that might be aerosol generating. Well, try and keep that a fairly small packaged answer.

Yes, so that's a long question, I'll make it a short answer. We in our clinic provide not only mucosal and oral medicine, we also provide dentistry in medically compromised people in general. But we have found ourselves during this pandemic providing care, and we build this interaction with the emergency department where people have a dentist, they can't access care, come to ED, and we provide the essential care.

So we have provided a crown has fallen, a filling has fallen, a dental abscess is there. We have provided care actually recently to some of a frontline worker, we had an emergency room doctor who is providing care to common patient. We had an amalgam filling fall out and needed-- and so we just examined the patient, and took a radiograph, and quickly put some kind of temporary restoration in there just to get that patient through that [? care. ?] So we do provide this.

Now as far as guidelines, as long as we examine people, we have taken biopsies also of patients, and we have done intralesional injection in inflammatory condition on this patient. We've done that with an N95 mask, with a face shield, and totally covered with a head cover as well. But the patient was not COVID tested. Now in those cases where we needed to provide care that we were required to drilling or potentially drilling, then we have sent the patient for COVID testing.

We're able to do that, order that. The turnaround time is, essentially, we can order that the day before, and we'll get by the next day. If the patient tests COVID negative, we still come in with the same precaution we talked about and provide that care.

We've had patients-- just as of recently we had a couple of people who were essentially in the pipeline for a lung transplant and have a source of dental infection-- broken root that may be a source of infection-- that needs to be dealt with, so that the patient can go on the list for transplant. So clearly, this is one of those cases where waiting for the dental office to open is not reasonable. So we provide this kind of care.

And now I want to say that these precautions, I think, we came up with in a medical center as to who

should be COVID tested and who shouldn't. And this is something that is in flux, like everything else in this field. And when you hear this version from me right now, you may hear a different version from me in a week or two, and you may hear a different version in different health centers.

Excellent, thanks for the answer. Reshma, do you have anything you wanted to add?

Oh, not to that specifically, that's so hospital based. I mean, just with the way everything has been happening at the school, I think Dr. Sroussi is definitely a better answer.

All right, I'll let you take the first lead on this next question. This is one of the ones we had talked about. So during the pandemic-- and in particular with the stay at home orders, which are still in place as of today in Massachusetts-- people have been spending a great deal of time online, as we know. And we're also aware that patients who have problems are in many cases delaying care due to fear of visiting hospitals and clinics.

We've all heard about the numbers of emergency room visits being significantly down across the country, for example. So how can a non-health professional who's seeking information about a potential oral medicine problem, maybe something they're actually quite concerned about, find information that would lead to seeing an appropriate specialists like one of the two of you? And Reshma, I'll let you start.

Yeah, I mean that's a really great question. I honestly think one of the ways to-- I mean, and that's probably where teledentistry and telemedicine has helped in this situation because I've had patients reach out and, first of all, ask me if these are the kinds of things I treat, and if I am able to provide advice, do I need to come in in-person, those kinds of things. So it's great that this exists because you can send an email and get answers almost immediately or within 24 hours at least. So that has been really helpful.

In general, I think it's great what you all are doing, especially you have great access to medical information on your website, on the Brigham Women's hospital or medicine page. Patients can go look that up and definitely see if some of the symptoms match to what they're experiencing to see if they really need to take those extra steps. So I think reaching out and communication is probably the best way, rather than maybe doing a Google search on it and getting totally terrified about what they may potentially not even have.

Good, thank you. Herve, do you have anything to add?

No, I don't.

OK, so there was a nice question comment that came in that I think I'm going to react to before we get to maybe one other question. And it was actually a comment from a colleague of ours about the importance of having that initial visit with a patient to really establish rapport, develop trust, and to be able to guide the path forward.

And I think maybe I'll leave it there, and I'm curious to what the two of yours experiences have been with how that connection has been made or not made either over the phone or by video in some of your situations. I could talk extensively about it because I've been actually pretty amazed by what we can accomplish with someone we've never met before. But I want the experts to speak.

Well, it's not ideal. But on the other hand, I think there is [INAUDIBLE]. I mean, I have gray hair, I'm not in a generation where I would meet someone online and marry them without meeting them, which I understand may be comfortable to the newer generation. So I'm not, nor am I an early adopter.

So look, the bottom line is yes. Interacting with patients directly, all the nonverbal cues that you get in this kind of facial interaction, and the fact that you have 2D picture of your face that sometimes goes in and out and so on off the screen, it's not ideal.

And yet I will say this, there's no patient that I've seen through Zoom with whom I didn't interact physically beforehand that I wouldn't want to interact eventually with. So there is no way that for me it seems reasonable to see a patient for the first time on Zoom, manage whatever condition they have, even if it seemed to be very successful from this interaction.

You may have a patient with a yeast infection in their mouth, you recognize it by a symptom, by pictures they sent, maybe even the patient opening their mouth in front of the camera. You send them a course of anti-fungal medicine, you know why they have a yeast infection. Let's say, they want a course of antibiotics for that, I don't think that for me-- and that's my opinion-- that I could end it there. There has to be a time where I would interact physically with this patient, bring them in, even if they're well, just for well visit if you want to close the chapter.

Yeah, I agree, and I think that patients actually are looking for that as well. So some of them are asking to be seen even sooner than we would expect in that situation. Reshma, did you have anything you wanted to add or say?

I was just going to say that I think a connection is a connection, virtual or not. I think patients really appreciate being able to see who they are connecting with. And I think even in these times, I've made

several new connections-- patients are not-- even virtually. So I think that's really helpful to be available to your patients, and for them to be able to make that connection-- virtual or not. So I think it's a great tool we have right now. Yes, we're not going to be able to do everything virtually, but that's a start I think.

Good. These are great questions, and I'm really glad we got to actually incorporate some of these live questions coming in. There's a lot of really good ones. Unfortunately, not only can we not get to those questions, we can't get to even other questions that we had prepared because time flies when you're having fun. But as we said, the show has to go on. And I guess now the show going on means that we're just up at 11:45, so it's time to start wrapping things up.

But really want to thank both of the panelists, Dr. Sroussi and Dr. Menon, for their invaluable information. Thank you for taking the time. It's just like when we're hanging out in the room talking, but we're all in three different places right now. Also, just thank you everyone from throughout the Harvard system and well beyond, nice seeing some familiar names in some of the chats coming in, truly from locally and all over the world. So it's really touching.

And I just, again, hope everyone is staying safe, stays as well connected as possible as we continue to navigate through all this. As Dr. Sroussi and Dr. Menon both mentioned a few times, there's no answers here. Even some of the questions that came in are great questions, but I wouldn't even dare address them because what we do here may be different from what's going to be done at the dental school, which may be different from what's going to be done over at the Mass General hospital where Dr. Kim works. So I think with that, I will see if Dr. Kim has any final thoughts.

Sure. On behalf of the Harvard School of Dental Medicine Continuing Professional Education Committee, we'd like to thank our presenters and moderator for enlightening us with the valuable information as we are getting prepared to reopen our dental practices. Next Tuesday, which is May 26th, we'll have a CPE Today Talk number five entitled, Remote Orthodontic Care Beyond the Pandemic, and presenters will be from Harvard School of Dental Medicine and Massachusetts General Hospital Dental Group.

Please visit our school's website, which is www.hsdm.harvard.edu, for registration. And also, you could download the previous CPE Today Talk series number one through three, and number four is being ready right now. So please join us, and then for additional seminar next week. And as Dr. Treister has mentioned, we'd like everyone to be safe, and we are ready to go back to our offices, and then to our hospital. And we'd like to thank everyone for tuning in to our CPE Today Talk series. Thank you so

much.

Thank you.

Thank you, bye.

Be well.

Bye.