Dental Professionals and HIV - Part 2

A Peer-Reviewed Publication
Written by Richard H. Nagelberg, DDS

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Educational Objectives
At the conclusion of this educational activity participants will be able to:
1. Describe which HIV-infected patients present the greatest risk of disease transmission.
2. Discuss risk management and infection control strategies for HIV-infected patients.
3. Discuss the CDC recommendations for infection control procedures in the management of HIV-infected patients.
4. Implement barrier control and needle-stick prevention measures.

Author Profile
Dr. Richard Nagelberg has been practicing general dentistry in suburban Philadelphia for 32 years. He has international practice experience, having provided dental services in Thailand, Cambodia, and Canada. He is co-founder of PerioFrogz.com, an information services company, and an advisory board member, speaker, key opinion leader and clinical consultant for several dental companies and organizations. Richard has a monthly column in Dental Economics magazine, "GP Perio-The Oral-Systemic Connection". A respected member of the dental community, Richard lectures internationally on a variety of topics centered on understanding the impact dental professionals have beyond the oral cavity. Dr. Nagelberg can be reached at gr82th@aol.com.

Author Disclosure
Dr. Nagelberg is Editorial Director, Dental Education, PennWell Publishing.
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Abstract
Part one of this course presented current science related to the immune events associated with the oral route of transmission of the HIV virus and oral pathology that is associated with AIDS. This second part discusses the epidemiology of HIV-infected patients, dental healthcare needs and clinical considerations when treating the AIDS patient.

Overview
According to the Morbidity and Mortality Weekly Report (MMWR) published in 2011 there were over 1.1 million adults and adolescents infected with HIV in the United States and individuals newly infected per year ranged from 48,200 to 64,500 persons. Also reported is a disproportionate burden of the disease within racial and ethnic minorities, except for individuals who define themselves as Asians. These statistics also indicate that gay and bisexual men of all races are most affected by HIV infection. Although the incidence of HIV infection does not appear to be increasing, dental personnel need to be aware that of the 1.1 million people living with HIV, approximately one individual in six is thought to be unaware that they have the infection and as a result are not getting treatment. These individuals, if they need oral care, can potentially spread the disease in the dental setting.

Even though the above statistics are distressing, additional MMWR statistics from a recent 2014 study are encouraging as they reveal that of those patients knowing they are HIV infected, most (88.7%) are taking highly active antiretroviral therapy (HAART) and as a result 71.6% demonstrate a virtually undetectable viral load when tested (<200 copies/mL). Further, of those self-identifying themselves as sexually active, many have also been assessed for other diseases such as syphilis, gonorrhea, and chlamydia. Less encouraging, however, are the findings of another study assessing behaviors among injecting drug users where 70% of men and 73% of women report having unprotected vaginal sex and lesser numbers (25% and 21% respectively) unprotected anal sex. Further, many subjects in this latter study had not been checked for hepatitis C. These statistics underscore the importance of effective infection control in the dental setting, particularly in practices located where there may be IV drug use.

In the 2014 MMWR survey cited above assessing behavioral and clinical characteristics of persons receiving medical care for HIV infection, it was found that 22.8% of patients had unmet dental care needs. And in another HIV Cost and Services Utilization Study (HCSUS) conducted by the RAND Corporation, 58 percent of the interviewed participants indicated that they did not receive regular dental care. Research suggests that barriers to the pursuit of dental care in the HIV-infected patient include educational level (lack of a college education), not having dental insurance, ethnicity, and “how HIV was contracted” (e.g. as a consequence of blood transfusion). Discrimination by dental healthcare providers is another factor that has been identified as a barrier to appropriate care of the HIV patient.

The above MMWR and other reports suggest that HIV patients being treated with antiretroviral therapy pose a limited risk to dental personnel but a substantial number of individuals with HIV remain untreated via HAART and thus pose a risk to dental staff and other patients. They also suggest that there is a significant unmet dental need in the HIV-infected community with barriers to treatment, both patient as well as practitioner dependant.

Dental Intervention for the HIV Patient
Several published references are available to guide dental healthcare providers in the development of general office procedures relating to the treatment of HIV-infected (and other potentially infective) patients. Dental personnel involved in treating HIV-infected patients should be well aware of the current literature and evidence based science that has accumulated since 1983, when AIDS first came upon the scene. Some important highlights from the literature include the following:

1. With the development of antiviral drug strategies, AIDS is now a chronic disease. Highly active antiretroviral therapy has significantly reduced deaths and people with HIV can survive more than 20 years with the disease. This means that more HIV-infected individuals are likely to present for dental treatment over time.
2. Approximately one in five (20%) HIV-infected persons do not know that they are infected.
3. With the exception of a well-publicized case of an HIV-infected Florida dentist who exposed patients to HIV and several other isolated anecdotes, the number of reports documenting practitioner to patient spread of HIV come from care delivered outside the USA. It is reported that thousands of patient records reviewed for 75 HIV-infected dentists and physicians have not identified a single problem with HIV transmission of practitioner to patient in the USA.
4. Exposure to bloodborne pathogens is significantly reduced via the use of personal protective equipment (PPE) during dental treatment but the use of PPE does not prevent all
possible exposures (i.e. needle sticks); hence proper needle technique and disposal are extremely important.

5. Cross contamination from one HIV patient to another can occur via contaminated instruments or equipment surfaces.

6. Systematic literature review indicates that at this time it cannot be said with reasonable certainty that HIV patients are at a greater risk for the development of treatment complications following invasive dental treatments such as orthognathic surgery, periodontal therapy, dental implants, prophylaxis, scaling and root planing, or endodontic therapy in comparison with non-HIV patients.¹⁶

7. The Americans with Disabilities Act (ADA), enacted in 1990, designated HIV-infected people, even if they are asymptomatic, as handicapped. Patients with HIV are protected by law against discrimination, including that which might occur in a dental office, for example, by refusal of treatment. Unfortunately a lack of education regarding the disease has been found to lead five percent of dentists in one US city surveyed to refuse treatment to HIV patients, in violation of law.¹⁷

Clinical Considerations in treating the HIV-infected Patient

Risk Management
Risk management includes the development and implementation of office procedures for identification of possible HIV-infected individuals, protective measures to prevent cross infection of HIV from patient to staff, staff to patient, and patient to patient, reporting of exposures should they occur, and referral for additional medical care and counseling of a suspected HIV-infected patient in accordance with the most current United States Public Health Services (USPHS) recommendations. Every dental office should have available to staff a comprehensive written program for preventing and managing occupational exposures to blood and other potentially infectious agents and a designated compliance officer that provides regular updates of the current science and procedural regulations related to HIV (and other viral pathogens that can be transmitted through dental care).

Infection Control
Infection control includes identification of potential risk based on patient history, protection of personnel via barrier techniques, instrument and treatment room sterilization, and decontamination of laboratory materials (e.g. models, impressions, etc.). In general, every patient should be considered as a possible transmitter of disease and treated the same in terms of infection control procedures.

Patient History Related to Risk
There are certain factors within the medical history that can indicate greater risk of HIV or other contagious infection. Unfortunately, in the dental setting, some of the questions necessary to get at information related to risk of infection with HIV are difficult for clinicians and staff to pose to patients. Nonetheless, while these pertinent questions may not be asked of patients, they should be appreciated. Historical factors which are associated with increased HIV (and some other infectious diseases such as Hepatitis C) risk include: men having sex with men, more than one sex partner, particularly if one of them injects drugs, use of and sharing of needles, syringes, cookers or other equipment used to inject drugs and recent infection with another sexually transmitted disease.

Other less personally invasive questions that can be more easily asked of a patient in the dental setting to assess for possible HIV (via verbal history or questionnaire) include the presence of symptoms indicating illness such as; fever, weight loss, shortness of breath, diarrhea, the occurrence of frequent fungal or yeast infections, liver infection (e.g. hepatitis), recurrent cold sores or oral herpes or other sexually transmitted diseases, prior blood transfusion and whether the patient is caring for an HIV patient with hemophilia.¹⁸

Laboratory and Screening Tests
If HIV infection is suspected it is best to refer the patient for medical evaluation and laboratory assessment for the appropriate screening tests. The standard recommended CDC screening test for HIV infection is the EIA or enzyme immunoassay which evaluates the presence of HIV antibodies. This test is performed on a blood draw which is a procedure not typically provided in the dental setting. Two tests are required to confirm a positive diagnosis. Other tests include the evaluation of oral fluid collected by a special collection device and evaluation of urine with the latter less sensitive and less specific than the salivary test. In addition to the above, a home collection test kit has been developed for patients suspecting HIV.¹⁹

Barrier Techniques
In 1993, to facilitate infection control and reduce risk of transmission of infection (generally and not necessarily related to HIV), the CDC published specific infection control criteria for treating dental patients.²⁰ These recommended procedures and subsequent modifications (in 2003)²¹ are now incorporated into many state dental practice acts and have become the standard of care in the management of all patients and not just those with infectious disease. The document cited above can be used to develop a manual on infection control for office use. A PDF e-book has also been released outlining current recommendations.²² Some of the many recommended procedures include the following.

For protective attire and barrier techniques:
1. Latex or vinyl gloves must be used when there is potential for contacting blood, blood-contaminated saliva, or mucous membranes (although not stated, gloves should...
It is important to pay attention to the category of items 2.  
For sterilization or disinfection of dental instruments:  
1. EPA-registered hospital disinfectant with tuerculocidal activity (intermediate-level disinfectant) is recommended. 
2. It is important to pay attention to the category of items needing disinfection. Those in the critical category are ones that penetrate soft tissue, contact bone, enter into or contact blood. Semi-critical items contact mucous membranes or non-intact skin but do not contact bone or blood. Non-critical items are ones that contact intact skin. The latter includes; the radiograph head/cone, blood pressure cuff, facebow or other hardware used in restorative care and the pulse oximeter.
3. Each dental office should have a designated central processing area divided into sections for instrument receiving, cleaning and decontamination, preparation and packaging, sterilization and storage.
4. Heat tolerant dental instruments must be sterilized by autoclaving, dry heat, or unsaturated chemical vapor. For heat sensitive critical and semi-critical instruments and devices, liquid chemical germicides registered by the FDA as sterilants can be used. Liquid chemical sterilants are highly toxic and must be handled carefully.
5. The dental office should establish and use a monitoring system (a simple pad or software program) to make sure that the sterilization equipment is effective.
6. Manufacturers’ instructions need to be followed for the cleaning and sterilization of handpieces. After operative use, the dental handpiece should be run for a minimum of 20-30 seconds to clear the water lines.
7. Appropriate barriers should be used on dental components that are permanently attached to dental units such as saliva ejectors, high-speed evacuators, and the air/water syringe followed by disinfection with an EPA-registered disinfectant (intermediate-level).

Dental unit water quality  
1. Each dental office should develop a strategy for the cleaning and disinfection of blood spills, medical waste disposal, and utilization of state-approved treatment technologies for containing blood and saliva discharge into the sewer system.
2. To reduce the possibility of virus and other microorganisms contaminating treatment water within dental handpieces, ultrasonic scalers, or air/water syringes, these items should be discharged for 20-30 seconds after each patient’s visit and before next use (even if a device is equipped with an anti-retraction valve).
3. It is important to consider water quality monitoring.
4. Sterile solution systems should be used to cool and irrigate during oral surgical procedures (including implants). Other delivery devices that can be considered to deliver sterile solution include bulb syringes or other single-use disposable products.

Infection control related to laboratory supplies and materials and biopsy specimens  
1. It is important to disinfect materials that will be sent to a laboratory. These include impression materials, models,
appliances, and other materials that have been potentially contaminated by blood or saliva. Disinfection begins with thorough removal of blood and saliva.
2. An EPA-registered hospital germicide labeled with anti-mycobacterial (tuberculocidal) activity (defined as an intermediate-level disinfectant) is recommended for use on laboratory supplies and materials.
3. Materials returned from the dental laboratory need to be cleaned and disinfected prior to placement in the patient’s mouth.
4. The dental office must communicate with the dental laboratory regarding instructions related to handling of contaminated materials.
5. Biopsy specimens need to be handled with care. When placing a specimen for transfer to pathology, it is important to make sure that the outer surface area of the container is not contaminated. If contamination is suspected, the container needs to be disinfected prior to mailing or transfer.

The 2003 guidelines also provide additional sterilization information on a variety of topics such as the handling of extracted teeth, laser/electrosurgery plumes or surgical smoke and dental radiology. Additional infection control internet resources are also provided in the document. The Organization for Safety and Asepsis Procedures (osap.org) has also published a reference source describing CDC guidelines.

Other Clinical Considerations

Needle placement
If needles are to be used repeatedly they should be recapped and placed in a sterile area on the instrument tray. Techniques for recapping have been previously described.

Syringe systems designed to reduce needle stick injury
To reduce needle stick exposure associated with conventional syringes, several manufacturers have marketed devices designed to automatically cap the needle post-use. Many of these ‘safety’ dental syringes have been removed from the market because of user dissatisfaction (and at least one study suggesting they may be no safer than traditional needles) but several are still available. They include the Ultra safety Plus XL Syringe™ (Septodont, Lancaster, PA, USA), the UltraSafe Syringe™ (Safety Syringes Inc, Carlsbad, CA, USA), the HypoSafety Syringe™(Dentsply MPL Technologies, Susquehanna, PA, USA), the SafetyWand™ (Milestone Scientific Inc., Livingston, NJ, USA) which is touted as the first injection device to be fully compliant with OSHA regulations under the federal Needlestick Safety Act, and the RevVac Safety Syringe™(Revolutions Medical Inc., Charleston, SC, USA). Few of these devices have been subjected to stringent study related to purported prevention efficacy but they might be considered if there is concern regarding needle stick injury.

Sharps injury and HIV exposure
Sharps injuries and other forms of exposure can occur during dental treatment and if the patient is known to be HIV-infected, appropriate post exposure management is critical. The CDC has published information on their web site: http://www.cdc.gov/niosh/topics/bhp/emergnedl.html.

It is suggested that post-needle stick, the affected area should be immediately washed with soap and water; splashes to the nose, mouth (with contact to the mucosa) or skin should be flushed with water; the eyes should be irrigated with clean water, saline, or sterile irrigating solutions post exposure to fluids. Any exposure incident should be immediately reported and medical treatment should be quickly pursued (within one to two hours). Even with exposure by percutaneous needle stick, the risk of contracting AIDS is small (estimated from a number of studies to be in the range of 0.32%). Mixed risk results are reported for mucous membrane exposure with one source indicating an estimated risk of 0.09% and another less than .03%.

Reported factors that increase the risk of HIV infection following exposure include: deep penetrating injury, visible blood on the injury device, injury from a needle placed in a patient’s artery or vein and inoculation by a terminal HIV-related patient not on therapy or with a very high viral load.

It is important to note that the risk of infection by needle exposure from an untreated HIV-infected patient is low to begin with and if the patient is on HAART and has minimal HIV virus at the time of the needle stick injury, it may be essentially nonexistent. Further, it should be appreciated that pure saliva not contaminated by blood has not been implicated in the transmission of HIV. The virus, however, has been isolated from subgingival biofilm in HIV-infected patients. Hence, to be on the safe side the above precautions should be used in case of any type of exposure involving contact with oral fluids.

Managing dental apprehension in the HIV patient
Fear of dental procedures including injections and subsequent numbness is common in both healthy and HIV infected patients. HIV infected patients; however, experience other fears related to dental care not typically encountered by healthy patients. In a qualitative study assessing HIV-related stigma in the dental setting, 45 percent of 60 HIV-infected individuals interviewed indicated that they anticipated judgment, stigmatization or disrespectful treatment in the dental office because of their HIV status. Thirty-five percent indicated a fear of the dentist and an equal number expressed concerns about confidentiality and receiving humane treatment. Some were concerned with giving HIV to the dentist. The authors of this study conclude that dental “providers should be aware of and better manage these issues”.

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Management of dental fear may require counseling, sedation and sometimes cognitive behavioral psychology. Several strategies related to local anesthesia and oral sedation may be helpful in managing the fearful patient. These include the use of vasoconstrictors, the use of lidocaine and prilocaine dental gel to produce a profound topical anesthesia during deep scaling and root planning, and the use of sedative/anxiolytics for sedation. Articaine hydrochloride has also been recommended if repeated injections are anticipated but recent research suggests that there are toxicity issues (paresthesia) associated with this anesthetic so it should be used with caution.

Summary
Dental patients have an expectation that appropriate infection control measures are in place in the dental office. The primary concerns identified in one study relate to the possible transmission of infectious diseases such as HIV (as well as hepatitis B, hepatitis C and tuberculosis). It is expected that dental personnel will wear masks, gloves, and glasses, but CDC and ADA guidelines extend far beyond these simple measures; and it is recommended that these more extensive measures be implemented in clinical practice. While clinical personnel should take comfort in knowing that in the age of HAART; patients receiving HIV treatment pose little risk of exposure to other patients or staff. But precautions still need to be taken to prevent exposure from those patients who are unaware that they are HIV-infected. Given the risk of infectious disease transmission in general, all dental patients should be treated using the recommended CDC infection control guidelines. This course discusses important clinical considerations helpful in managing the dental needs of HIV-infected patients.

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Author Profile
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Author Disclosure
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Questions

1. MMWR weekly reports suggest that HIV-infection is a serious disease. Which of the following statements is most accurate in describing the problem of HIV-infection?
   a. There is a disproportionate burden of the disease within racial and ethnic minorities
   b. One individual in five with HIV-infection does not know that they have the disease
   c. Over one million US citizens currently have HIV infection
   d. All of the above

2. What is considered an ‘undetectable’ load of HIV virus?
   a. Less than 200 copies/ml
   b. More than 200 but less than 500 copies/ml
   c. More than 500 but less than 750 copies/ml
   d. None of the above

3. A MMWR report indicates that of those knowing they are HIV positive, how many are taking HAART?
   a. Greater than 90 percent
   b. 80 to 90 percent
   c. 50 percent
   d. Less than 50 percent

4. For injection drug users, the reported number of individuals having unprotected sex is:
   a. 50 percent
   b. 60-70 percent
   c. 70-80 percent
   d. 90 percent or greater

5. MMWR assessment of behavioral and clinical characteristics of persons receiving medical care for HIV suggest that 22.8% had unmet dental care needs and 58% did not receive regular care. Barriers to dental care reported are included:
   a. Not having dental insurance
   b. Ethnicity
   c. Discrimination by dental providers
   d. All of the above

6. MMWR data indicate which of the following?
   a. HIV patients being treated with HAART pose a limited risk to dental personnel
   b. Very few HIV-infected individuals remain untreated
   c. The dental health needs of HIV-infected individuals are being met
   d. None of the above

7. Which of the following statements is accurate?
   a. AIDS is not considered a chronic disease
   b. HAART has not reduced deaths associated with HIV infection
   c. Neither a or b
   d. Both a and b

8. The percentage of HIV-infected persons that do not know they are infected is:
   a. Less than 10 percent
   b. 10 percent
   c. 30 percent
   d. 50 percent

9. HIV infection transmission from dentist to patient has been extensively reviewed. With the exception of the Florida dentist who exposed patients to HIV, what is the result of these reviews?
   a. Multiple dentists have exposed their patients to HIV virus
   b. Not a single problem with HIV transmission from practitioner to patient has been identified in the USA since the Florida case
   c. Both a and b
   d. Neither a or b

10. Exposure to bloodborne pathogens is reduced by which of the following?
    a. The use of personal protective equipment
    b. Needle stick prevention
    c. Both a and b
    d. Neither a or b

11. Which of the following statements related to HIV-infection is most accurate?
    a. Cross contamination from one untreated HIV-infected patient to another can occur via contaminated equipment surfaces
    b. There is little likelihood of cross contamination from one untreated HIV infection patient to another
    c. The cleaning of equipment surfaces is not likely to reduce contamination
    d. None of the above
12. Systematic literature review indicates that HIV patients receiving orthognathic surgery, periodontal therapy, dental implants or prophylaxis:
   a. Are at greater risk for complications following these invasive interventions
   b. Are at no greater risk than non-HIV infected individuals for complications associated with the procedures
   c. Are likely to spread the HIV disease to dental personnel via these procedures
   d. Are likely to have treatment failure

13. With respect to the Americans with Disabilities Act (ADA) enacted in 1990, which of the following statements is most accurate?
   a. HIV-infected individuals are protected by law against discrimination
   b. It is easier for dental practitioners to refuse treatment under the law
   c. The risk of lawsuit has been reduced because of the law
   d. None of the above

14. Risk management as it applies to dentistry includes:
   a. Use of protective measures to prevent cross infection
   b. Development and implementation of office procedures to identify possible HIV-infected individuals
   c. Referral of individuals suspected of having HIV infection for medical evaluation and care
   d. All of the above

15. When treating dental patients, which of the following should apply in terms of infection control?
   a. HIV-infected patients need to be isolated from other patients
   b. Every patient should be considered as a possible transmitter of infectious disease and treated the same
   c. Infection control procedures only apply to HIV-infected patients
   d. All of the above

16. Which of the following patient history factors increase the possible risk of HIV infection in a dental patient?
   a. Men having sex with men
   b. Recent infection with another sexually transmitted disease
   c. Having more than one sex partner
   d. All of the above

17. When taking a history, which of the following factors do not suggest possible HIV infection?
   a. Frequent recurrent cold sores, oral herpes or thrush
   b. Prior blood transfusion
   c. Weight gain
   d. A patient caring for an HIV patient who has hemophilia

18. What is the best thing to do if HIV-infection is suspected in a dental patient?
   a. Immediately dismiss the HIV patient and seek CDC help
   b. Do a blood draw to screen for HIV antibodies
   c. Refer the patient for medical evaluation and laboratory assessment
   d. Collect saliva for analysis of possible HIV

19. How many EIA or enzyme immunoassay tests are necessary to confirm a positive HIV diagnosis?
   a. Two
   b. One
   c. None, the EIA test is not appropriate
   d. Three

20. The CDC has recommended the use of barrier techniques in treating dental patients. These include:
   a. The use of latex or vinyl gloves
   b. Non-sterile gloves for examining patients
   c. Sterile gloves for surgical procedures
   d. All of the above

21. When should hand washing occur during treatment of dental patients?
   a. Before placement of gloves
   b. After placement of gloves
   c. Before disinfection of previously worn gloves
   d. None of the above

22. Which of the following is suggested by the CDC?
   a. Old gloves can be reused provided that they are properly disinfected
   b. Washing and disinfection of previously worn gloves is an approved way to prevent cross-contamination of patients
   c. Both a and b
   d. Neither a or b

23. Regarding mask and face shield use, which of the following is suggested by the CDC?
   a. As long as masks do not become wet or moist they can be continuously used during repeated patient care
   b. Masks need to be discarded and replaced between patients
   c. Face shields need not be worn except in cases where HIV-infection is suspected
   d. Face shields do not need to be cleaned between patients

24. Which of the following accurately reflects CDC recommendations?
   a. Protective reusable or disposable gowns and laboratory coats or uniforms must be worn when treating dental patients
   b. Since there is little risk associated with contamination of gowns or coats they need not be removed when exiting the treatment room
   c. Laboratory coats or dental uniforms need to be cleaned with special disinfectants
   d. None of the above

Notes
Dental Professionals and HIV - Part 2

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Educational Objectives
1. Identify which HIV-infected patients present the greatest risk in terms of disease transmission.
2. Describe what constitutes risk management and infection control in the management of HIV-infected patients.
3. Identify the infection control procedures that the CDC has recommended in the management of HIV-infected patients.
4. Implement barrier control and needle-stick prevention measures.

Course Evaluation
1. Were the individual course objectives met?
   Objective #1: Yes No
   Objective #2: Yes No
   Objective #3: Yes No
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   Please evaluate this course by responding to the following statements, using a scale of Excellent = 5 to Poor = 0.

2. To what extent were the course objectives accomplished overall?
   5 4 3 2 1 0

3. Please rate your personal mastery of the course objectives.
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4. How would you rate the objectives and educational methods?
   5 4 3 2 1 0

5. How do you rate the author’s grasp of the topic?
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   5 4 3 2 1 0

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   5 4 3 2 1 0

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10. Do you feel that the references were adequate? Yes No

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We encourage participant feedback pertaining to all courses. Please be sure to complete the survey included with the course. Please e-mail all questions to: feedback@pennwell.com

All questions should be only one answer. Grading of this examination is done manually. Participants will receive written confirmation of passing or failing of examination form. Submission of Participant form will be mailed within two weeks after taking an examination.

COURSE OBJECTIVES

PennWell is an ADA-CERP Recognized Provider. ADA CERP is a service of the American Dental Association to assist dental professionals in identifying quality providers of continuing dental education. ADA CERP does not approve nor endorse individual courses or instructors, nor does it imply acceptance of credit hours by a state or provincial board of dentistry or AGD endorsement. The current term of approval extends from (11/1/2011) to (10/31/2015) Provider ID# 320452

PennWell maintains records of your successful completion of any exam for a minimum of six years. Please contact our office for a copy of your continuing education credit report. This report, which will list all credits earned (to date), will be forwarded and mailed to you within five business days of request. Please allow approximately 2-3 weeks for delivery.

If you or any member of your staff has concerns or complaints about a CE Provider may be directed to the provider or to ADA CERP or www.ada.org

PennWell is a California Provider. The California Provider number is 4221.

In order to receive credit for this continuing dental education course, you must complete the examination and provide requested information as specified.

For Questions Call 216.398.7822

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