

Root of the Matter: Q&A

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Practice Advisors at the College welcome the opportunity to correspond with registrants and members of the public to answer questions related to the Dental Hygiene Scope of Practice, Practice Standards and Code of Ethics. The following are a few of the most common practice questions we have been receiving over the past few months.

Q: What are the guidelines for treating a client with Herpes Simplex Virus (HSV-1)?

A: HSV-1 (commonly called a herpetic lesion, cold sore or fever blisters) is a highly transmissible virus that is most contagious during the active phase when the lesion presents as fluid-filled vesicles and during prodromal burning/tingling sensation.^{1,2,3}

Best practice guidelines indicate that dental hygienists should not treat a client presenting with an active lesion and treatment should be postponed until the lesion has healed and has fully scabbed over, which can take 10-14 days.^{2,3,4} Even with routine infection prevention and control (IPAC) precautions, risk of transmission of the virus is high.^{2,4,5} HSV-1 is transmitted via contact with the virus contained in the sore, saliva and surfaces in and around the mouth, with the greatest risk when client is experiencing active symptoms.⁶ Risks of treating a client during the active phase include:

- Autoinoculation, the transmission of HSV-1 to other regions of the client's head and neck, can occur when saliva or fluid from the lesion (cold sore) is unintentionally transferred via contact with items such as intraoral gloves, gauze, handpieces, saliva ejector etc.³
- Ocular herpes or herpetic infection of the cornea can occur as a result of saliva spatter, calculus and other contaminants that come in contact with the eye of the client or clinician.²
- Inoculation of the hygienist, due to a micro-tear in operators gloves or needle stick injury, causing the clinician herpetic whitlow.²
- HSV-1 virus can survive on dry inanimate surfaces for short periods of time. Even with diligent IPAC practices, the virus can spread to other clients and co-workers via transfer of through objects contaminated outside of the dental hygiene operatory. These types of transmissions can occur when the client touches the HSV-1 lesion and subsequently contacts other objects in the office (e.g., door handle, objects in restrooms, magazine etc.).⁷

Client education should be provided about the lesion and prevention of transmission of the virus.^{1,2} Clients should be informed that when aware of the initial symptoms to reschedule their dental hygiene appointments.^{2,3} Education should be provided on antiviral medications available to reduce symptoms and severity and any stimuli that may trigger onset (such as manipulation of tissues during dental hygiene treatment).^{1,2}

Dental hygienists have an ethical obligation to ensure they uphold the [Dental Hygienist Regulation](#), [CDHBC bylaws](#) and [CDHBC IPAC Guidelines](#) to ensure safe and ethical client care.

Q: Can dental hygienists perform Botox Injections?

A: Botulinum toxin Type A (neuromodulators such as: Botox[®], Dysport[®], Xeomin[®]) and dermal fillers are considered medical procedures as well as restricted activities that do not fall within the dental hygiene [Scope of Practice](#). As such, a dental hygienist must not perform procedures that incorporate the administration of Botox[®] (or similar related drugs) or dermal fillers.

For more information see “Root of the Matter” in [ACCESS Spring 2009](#).

Q: Is Velscope within the Dental Hygiene Scope of Practice?

A: Dental Hygienists are allowed to incorporate the Velscope as an adjunct to the intra-oral assessment during the ADPIE process of care. Appropriate education and training are necessary prior to implementing this adjunctive assessment tool into practice. The dental hygienist must also incorporate appropriate documentation, follow up and referral processes.

The use of the Velscope is considered a screening tool used to assess tissues, as such, there is no diagnosis being made. When tissues are observed that are not normal, the same process would occur when observing abnormal/atypical tissues during the intra-oral assessment; this process includes comprehensive documentation describing the lesion. This documentation must outline the appropriate follow-up which may include: re-evaluation of the tissues to note any changes in the lesion, consultation with the dentist, and a possible referral to the appropriate health care professional or agency for further analysis and diagnosis of tissues.

References:

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3. Little JW, Falace DA, Miller CS, Rhodus NL. Dental Management of the Medically Compromised Patient. 8th ed. St Louis: Mosby; 2013.
4. Centers for Disease Control and Prevention [Internet]. Guidelines for Infection Control in Dental Health-Care Settings (MMWR Article); 2003 [cited 2018 April 12]. Available from: <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5217a1.htm>
5. College of Dental Hygienists of British Columbia [Internet]. Infection Prevention and Control Guidelines; 2012 [cited 2018 April 5]. Available from: <http://www.cdhbc.com/Documents/Infection-Prevention.aspx>
6. World Health Organization [Internet]. Herpes simplex virus; 2017 [cited 2018 April 12]. Available from: <http://www.who.int/mediacentre/factsheets/fs400/en/>
7. Government of Canada [Internet]. Pathogen Safety Data Sheets: Infectious Substances – Herpes simplex virus; 2011 [cited 2018 April 5]. Available from: <https://www.canada.ca/en/public-health/services/laboratory-biosafety-biosecurity/pathogen-safety-data-sheets-risk-assessment/herpes-simplex-virus.html>