

Pennsylvania Guidelines

on the use of

Opioids in Dental Practice





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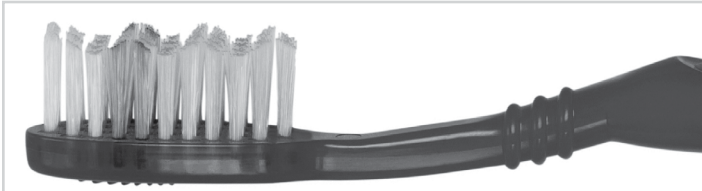
Dentists provide acute pain treatment as part of routine dental care and management of dental emergencies. In addition, dentists may be involved in the management of chronic oral-facial pain. Acute and chronic pain therapy may involve the administration of potent opioids. However, the prescribing of potent opioids is associated with significant risk of harm, including sedation, altered mental status, and respiratory depression and arrest, as well as the risk for misuse, diversion and substance use disorders.

These guidelines address the use of opioids for the treatment of acute dental pain. Guidelines are available to provide information regarding the use of opioids for the treatment of chronic non-cancer pain, including chronic head and face pain. These guidelines are intended to help health care providers improve patient outcomes when providing this treatment, including avoiding potential adverse outcomes associated with the use of opioids to treat pain. These guidelines are intended to supplement and not replace the individual prescriber’s clinical judgment.

Opioid analgesics may be necessary for the relief of pain, but improper use of opioids poses a threat to the individual and to society. Providers have a responsibility to diagnose and treat pain using sound clinical judgment, and such treatment may include the prescribing of opioids. Providers also have a responsibility to minimize the potential for serious adverse effects, including the abuse and diversion of opioids. Therefore, providers should use proper safeguards to minimize the potential for abuse and diversion of opioids.

Dental care providers should incorporate the following key practices into their care of the patient receiving opioids for the treatment of acute dental pain:

1. Before initiating pain therapy, clinicians should conduct and document a medical and dental history, including documentation and verification of current medications, and a physical examination. Appropriate diagnostic imaging and testing, if indicated, should be completed before starting therapy. If opioids are to be prescribed, the initial evaluation should include documentation of the patient’s psychiatric status and substance use history.
2. Clinicians should administer non-steroidal anti-inflammatory drugs (NSAIDs), as first-line analgesic therapy, unless contraindicated. NSAIDs have been demonstrated to be very effective for the treatment of dental pain, and indeed are often more effective than opioids. Consideration should be given to initiating NSAID therapy immediately before the procedure, then continuing dosing on a scheduled basis immediately following the procedure.
 - A. Clinicians may wish to consider the administration of a selective NSAID, such as celecoxib, to avoid an increased risk of bleeding.
 - B. Extreme caution should be used in patients taking any other anticoagulant, as the risk for bleeding is significantly increased when NSAIDs are used in combination with other anticoagulants, including aspirin.



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- C. Caution should be used in patients with a history of hepatic or renal impairment, or who report a previous adverse reaction to acetaminophen and/or NSAIDs.
3. Acetaminophen has been shown to be synergistic with NSAIDs with the efficacy of low dose opioids. When clinicians administer acetaminophen, it should be on a scheduled basis unless contraindicated
 4. Clinicians should consider the use of local anesthetic techniques, including local infiltration of dental local anesthetics and regional nerve blocks whenever possible to assist in pain management and reduce the requirement for opioid analgesia.
 5. If an opioid is to be administered, the dose and duration of therapy should be for a short period of time, and for conditions that typically are expected to be associated with more severe pain. Do not prescribe doses or amounts that are in excess to the expected opioid requirements.
 - A. When opioids are indicated, the provider should choose the lowest potency opioid necessary to relieve the patient's pain.
 - B. Long-acting opioids or extended-release preparations are contraindicated for the treatment of acute procedural pain.
 - C. Providers should be aware of concurrent medications and the potential for drug interactions. Interactions with other medications the patient is taking can either increase or decrease the potency of certain analgesics. The provider should assess the risk for drug-drug interactions before prescribing analgesics.
- i. Some concurrent medications, such as antidepressants, can interfere with the metabolism of some prescribed opioids and can increase the risk of adverse events.
 - ii. Opioids should not be administered in combination with benzodiazepines or other centrally acting sedating medications, due to the increased risk of serious adverse effects, including death, when these medications are used together.
- D. Care should be used when prescribing opioid combination product medications, to ensure that the total dose of acetaminophen does not exceed 3,000 mg / day in adults.
 - E. Care should be used when administering opioids to individuals with obstructive sleep apnea, as these patients are at increased risk for opioid-induced adverse events.
 - F. Upon development of a controlled substances database by the Commonwealth of Pennsylvania, providers should access the database as indicated.
6. Unless the clinician has training and experience in the use of opioids for the treatment of non-cancer pain or chronic facial pain, long acting or extended-release opioids should not be prescribed.
 - A. Patients reporting unexpectedly prolonged pain, especially those patients who do not have clear evidence of ongoing pathology, should not be prescribed opioids. The clinician should consider patient referral to appropriate dental or chronic pain specialists in patients who request continuation of opioids beyond the normal, expected recovery period.



- B. A patient whose behavior raises the provider's concern for the presence of a substance use disorder should be encouraged to seek evaluation and possible treatment for this condition through his or hers "primary medical care provider," local substance treatment programs, or other appropriate referral sources.
7. The clinician should coordinate pain therapy with other clinicians before the procedure whenever possible in patients who are receiving chronic opioids, who have a history of a substance use disorder, or who are at high risk for aberrant drug-related behavior. It is not appropriate to refer patients receiving chronic opioid therapy to the emergency department to obtain prescriptions for opioids.
8. Extreme caution should be exercised when responding to requests for opioid analgesics, especially from patients who are new to the practice or who have not been recently seen and evaluated. In general, it is not proper to prescribe opioids absent a face-to-face patient evaluation.
9. Providers should provide patients with instructions on safe disposal of unused medications, including opioids, to ensure these medications are not available for possible diversion or misuse.
10. Clinicians should be aware of and understand current federal and state laws, regulatory guidelines, and policy statements that govern the prescribing of controlled substances.

References

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