Opioid Prescribing in Dental Medicine: Balancing Our Compassion for Patients with Social Responsibility

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Disclosure

Dr. Schatman has no conflicts of interest to disclose
The Dentist’s Pledge

• “….. let all come to me safe in the knowledge that their total health and well-being are my first considerations”


• Unlike the original AMA Code of Ethics, does not directly address pain
  ▪ “From the age of Hippocrates to the present time, the annals of every civilized people contain abundant evidences of the devotedness of medical men to the relief of their fellow-creatures from pain and disease…..”

Dentists and Pain

- Nor does the ADA Code of Dental Ethics mention pain


- This is clear proof that the public stereotype of dentists as sadists is accurate...

- Or not.....
Dentists and Pain

• Empirical data actually indicate that a considerable majority of patients believe that their dentists demonstrate sincere concern for them


• How do dentists feel about pain?
• No – not theirs – but patients’.....
• Epidemiological data on dental pain is actually quite scarce

Dentists and Pain

• A review of the literature indicates that the majority of research on dental pain pertains to children.

• The ADA’s core competencies for graduating dental students include the abilities to prevent, diagnose and manage pain.


• And perhaps these competencies ought to include sound opioid management.

• Years of indiscriminate prescribing resulted in the current opioid crisis.
Opioid Prescription Among Dentists

- This has clearly included over-prescription by dentists following procedures/surgeries
  - Over 40% are prescribed opioids following tooth extraction, with the rate curiously highest among adolescents (61%)
      - Average prescription is 20 tablets of hydrocodone/APAP
      - 96% of prescribers instruct to “take as needed”
- Recent data – Patients given an average of 28 opioid pills following dental surgery, and reported 15 pills (54%) left over
Opioid Prescription Among Dentists

• Patients from a dental clinic found to be far more likely to non-medically use or divert prescription opioids (37%) than those in the general population

• Survey data – Adolescent non-medical users of prescription opioids – 27% (non-diverted) obtained from a dentist

• South Carolina PDMP data – Dentists made up only 9% of prescribers, but were responsible for 45% of initial-fill scripts
Opioid Prescription Among Dentists

• 2011 data – Dentists were found to be the leading prescribers to young people (10-19 years)

• Dentists found to be only behind primary care as the leading prescribers of IR opioids

• Dentists alone prescribe between 1 and 1.5 billion doses of IR opioids annually
Opioid Prescribing Among Dentists

• Yet, rates of prescribing are decreasing
  • The largest rates of decreased prescribing between 2007 and 2012 were among ER physicians (-9%) and dentists (-6%)

• Few question the efficacy of opioid analgesics for acute pain – including acute dental pain

• Yes – caution should be exercised whenever an opioid is prescribed....at whatever dosage....for whatever time period

• We need to emphasize “to whom”, less so than “how much”

Acute and Post-operative Dental Pain

• Dosing – WHAT A MESS!!!!!!!!!!!!

• 2011 prescribing recommendations for the treatment of acute pain in dentistry


  ▪ Authors recommendation: “If the pain relief (from NSAIDs) is inadequate or severe pain is anticipated, APAP 650 mg and an opioid equivalent to oxycodone 10 mg around the clock every 6 hours for 48 hours is recommended”
  ▪ This should now be considered ludicrous!
Acute and Post-operative Dental Pain

• We now know that pharmacogenomic differences exist, and a “one-size-fits-all” approach is inadequate

• All opioid prescribing, at present, should be as much an art as a science
  ▪ Until insurers begin to routinely pay for PGX testing...

• An individual’s CYP2D6 phenotype has been established as determining oxycodone’s addictive potential
  

• Poor metabolizers have a 2- to 20-fold decrease in analgesic effects compared to extensive metabolizers, while ultra-rapid metabolizers have a 1.5- to 6-fold increase in analgesic effects

Acute and Post-operative Dental Pain

• Common sense should rule when prescribing to patients at high risk for aberrancy
  ▪ E.g., tapentadol has been found to be effective for post-op dental pain
    ▪ Tapentadol abuse is significantly less common and appealing than that of unimodal opioid agonists
      ▪ Diversion of tapentadol is rare
Chronic Pain in Dentistry

• Few outside of dentistry seem to comprehend the prevalence of chronic dental pain....as well as its potential severity

• TMDs – Prevalence studies have yielded variable results
  ▪ 2010 study – found at least one TMD symptom in 39% of population, with pain in 16%
  
  ▪ Up to 40% of TMD patients treated in tertiary care settings can be refractory to treatment

Chronic Pain in Dentistry

- TMDs are often accompanied by comorbidities (e.g. migraine, CFS), with these comorbidities associated with greater pain intensity and duration


• How much do TMDs hurt?
• Quantitative analysis cannot answer that question
• “Pain is whatever the experiencing person says it is, existing whenever he/she says it does”

McCaffery M. Nursing practice theories related to cognition, bodily pain, and man-environment interactions. Los Angeles, CA: University of California at Los Angeles;1968.

• Failure to respect the phenomenology of pain disrespects and further marginalizes the sufferer

The Demise of Opioid Analgesia

- As a result of “the opioid crisis”, the pendulum has swung awry

- Welcome to the era of frank opiophobia!
- Opiophobia → Oligoanalgesia
The Demise of Opioid Analgesia?

- Opioid analgesia for chronic pain is on its way to becoming a thing of the past
- Arguments are being made that analgesia should not necessarily be the ends of pain medicine


- Has anyone bothered speaking to patients suffering from pain about this decision?!?!
- A bit paternalistic......?
Opioid Pendulum

• WE MUST FIND A MIDDLE GROUND!!!!!!!!!!!!!!!
• Yet doing so, within our health care system, may be impossible
• There are so many players......
• And so many battles being waged.....
• The battle over opioids is not simply between the anti-opioid zealots that are dominating prescribing guideline committees and those of us who believe that opioids still have their place, if prescribed responsibly, for well-selected patients for whom there are no other options
Opioid Pendulum

• This is definitely a war in which some of us are directly involved


• Is “balance” possible when there are so many stakeholders in American pain medicine?

• Things have changed dramatically since the days when the patient-healer dyad was considered sacred.....
Regarding the Anti-Opioid Zealots
Will Dentists Become the New Targets?

• Dentists were found to be less concerned about the opioid epidemic than other prescribers


• Prescribing guidelines for dentists are much more balanced than those for physicians
  ▪ “Fears of investigation or sanction by federal, state and local regulatory agencies may also result in inappropriate or inadequate treatment of chronic pain patients”

Will Dentists Become the New Targets?

• Much of “dental overprescribing” has historically not been by dentists, but by ED physicians


• However, guidelines for ED treatment of emergency dental patients have resulted in a reduction of prescribing


• Which is probably a good thing

• Particularly with regard to diversion
Will Dentists Become the New Targets?

• Bad news – the anti-opioid zealots are creating language in order to scare dentists away from prescribing
  ▪ “Prescribe opioids for dental pain only after complex dental procedures and at the lowest dose and duration”


▪ Does this suggest that severe pain that requires opioid analgesia cannot possibly result from a simple procedure?!?!
Will Dentists Become the New Targets?

• Difficult to find cases of state dental boards going after prescribers

• Same with the DEA....other than for truly malfeasant behavior


• The DEA’s concern seems to be primarily with diversion

• Although “overprescribing” can be construed as a cause of diversion

Furst RT. J Addict Dis. 2014;33:177-186.
Are Dentists at Risk?

• We need to consider the recent CDC guideline

• Due to conflicts of interest of the authors, the guideline hits an all-time ethical low

• Another time, another lecture

• Guideline is geared toward PCPs, but states that the findings may be relevant to dentists
Are Dentists at Risk?

• To refer to the guideline as “voluntary” is disingenuous

• Its potential to become de facto law is very real

• States are already passing more draconian legislation consistent with the CDC guideline

• And Medicare/Medicaid’s adoption of it is a fiasco

• “Clearly the intent of CDC is that the guideline be distributed to and adopted by state public health entities and certifying organizations as if it had the legal authority of a regulation”
  Hansen CW. American Cancer Society Letter to Drs. Frieden and Houry (CDC), October 1, 2015.
Are Dentists at Risk?

• While not “for dentists”, CDC felt compelled to provide a webinar series “to familiarize providers, including dental professionals, with the new CDC Guideline”


• The Guideline has spawned new, draconian dental guidelines, and broader guidelines with dental sections
  ▪ Oregon guideline recommends 3-day prescriptions of 10 pills

Are Dentists at Risk?

• No one knows what failure to abide strictly to state guidelines will mean

• The media loves to characterize all patients with pain as “addicts” and all prescribers as “drug pushers”

• “Unfortunately, the (opioid) situation has been blurred by some politicians, health professionals, and the media by their using inadequate concepts, misrepresenting and exaggerating facts, and demonizing pain patients”

Ethical Prescribing

• Years of indiscriminate prescribing cannot be “undone” by shifts in practice
• Yet history should not be allowed to be the cause of opiophobia, oligoanalgesia, and needless suffering
• The opioid crisis affects not only individuals, but society as a whole
• “Just saying no” is not the answer….although it seems to be “convenient” for many physicians....as well as policy-makers
Ethical Prescribing

• “Just saying no” is not ethical practice; allowing patients to needlessly suffer when we have medication to relieve pain may actually be construed as patient abandonment

Ethical Prescribing

• Abuse and addiction will always be risks
• Dentists are morally obligated to be risk managers as an expression of nonmaleficence


• Are risk mitigation strategies a panacea?
• Hardly
• Yet the available data suggest that they help

Opioid Risk Mitigation

• Recent data indicate that 77% of dentists use patient history forms that included questions about illicit drug use

  ▪ This is up from 64% in a 2010 study

Tufts Health Care Institute Program on Opioid Risk Management: The role of dentists in preventing opioid abuse. Tufts Health Care Institute;2010.

• But is this enough?

• Hardly!

• Despite efforts to promote risk mitigation practices, there has been relatively little uptake in dental medicine

Opioid Risk Mitigation

• Dentistry, as a whole, seems ambivalent regarding its role in risk mitigation

• While 77% reportedly ask patients about substance misuse, 2/3 do not agree that such screening is compatible with their professional role
  ▪ Younger, more recent grads are more likely to ask about substance misuse, and also see doing so as compatible with their roles as dentists

Oral Health Issues Associated with Opioid Misuse

- Xerostomia
- Burning mouth
- Taste dysfunction
- Eating difficulties
- Mucosal infections
- Dental caries
- Periodontal disease
- Bruxism
- Candidosis
- Necrotizing gingivitis
- Mucosal dysplasia

Opioid Risk Mitigation

• South Carolina Board of Dentistry (in a joint guideline with the Medical and Nursing boards) recommends consultation with “specialists in psychology, psychiatry, and addiction management if possible….when opioids are identified as the best treatment option for complex or high-risk patients”


• Sounds good in theory....

• If we can’t get this in place with medical patients, good luck doing it with dental patients!
Opioid Risk Mitigation

• The only realistic approach is that dentists themselves become better and more consistent opioid risk mitigators.

• The good news – the ADA guideline on the use of opioids in the treatment of dental pain calls for appropriate education on addictive disease and pain management in all dental schools, as well as pain-and-addiction CE.


• More good news – several dental boards are now mandating pain-and-addiction CE.

Opioid Risk Mitigation

• Screening for psychosocial and behavioral risk factors:
  ▪ Recent data suggest that such screening is provided by only 6% of physicians


• And among dentists?

• Kulich et al (2016) – “screening for substance abuse and related risk factors requires brief, directed questioning, as well as access to other sources of patient information”

Assessing Risk Factors

• Record review and communication with the patient’s other health care providers can also provide important data
• Questionnaires on risk factors – many lack validity and reliability
  • Ideally - use those that are psychometrically robust
    ▪ Screener and Opioid Assessment for Patients with Pain – Revised (SOAPP-R)
    ▪ Pain Medication Questionnaire (PMQ)
• But may be too lengthy for dental practice
• The Quick Screen was developed by NIDA

NIDA Drug Screening Tool. NIDA-Modified ASSIST (NM ASSIST) 2012. Available at: https://www.drugabuse.gov/nmassist/step/0.
In the past year, how many times have you used the following?

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<th>Drug Type</th>
<th>Never</th>
<th>Once or Twice</th>
<th>Monthly</th>
<th>Weekly</th>
<th>Daily or Almost Daily</th>
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<td>- For Men more than 5 drinks a day</td>
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<td>- For Women more than 4 drinks a day</td>
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<td>Tobacco products</td>
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<tr>
<td>Illegal drugs</td>
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Quick Screen

• Sensitivity for drug dependence of 97% along with specificity of 79% established in primary care
  ▪ Found to be as good or better than longer established measures

• When self-administered using a computer, the Quick Screen performed well

• Argued that it should be used only for triage

• Used routinely at TUSDM
Assessing Risk Factors

• Exercise extra caution with populations at highest risk:
  ▪ Patients with histories of or current substance abuse
  ▪ Those already on opioids
  ▪ History of a DUI or substance-related arrest
  ▪ Cigarette smokers
  ▪ Depression
  ▪ Anxiety


• Going with your “gut feeling” – established as inaccurate

Urine Drug Testing (UDT)

• Only for chronic opioid therapy?
• Passik advocated for use of UDT along with abuse deterrent formulations in the treatment of acute pain

  ▪ Given, he was employed by a UDT company at the time....

• How many prescribers routinely use UDT, and how often?
• No real guidelines for UDT in dentistry – so rely on the better medical guidelines
UDT

• “Guidelines” should not translate into rigidity!
• Tailor your UDT practices to the specific patient
• Take time to explain that the purpose of testing is to protect your patient from harms
• Acute pain: UDT prior to a procedure if a patient is in your estimation at high risk
• Chronic pain: UDT prior to initial prescription if you sense that COT will be necessary…and then randomly on an ongoing basis
  ▪ No data on ideal frequency, although should be individualized based on a patient’s level of risk

Prescription Drug Monitoring Programs (PDMPs)

- **NEED TO BE MANDATORY!!!!!**
  - Only 17 of 49 states have an enrollment mandate
  - Only 8 of 49 require accessing the PDMP prior to prescribing
  

- New York – mandatory program – found to substantially decrease both frequency and quantity of dental prescribing


- Although this study may be methodologically-flawed due to the co-variation of the “chilling effect” of “narcoterrorism”
PDMPs

• Outreach efforts to register more physician users not effective
    ▪ No available data on registering dentists

• Efficacy of PDMPs: Empirically established for reducing OD deaths and doctor-shopping
Mandatory Education in Opioid Safety

• A contentious topic in medicine – particularly among primary care providers

• Would such mandatory education have allowed physicians to make better decisions in the face of fraudulent Pharma marketing of opioids as “non-addictive”?


• Undergraduate medical education in pain management is beyond deficient
  ▪ Only 4 of 104 medical schools surveyed had a required pain course

  ▪ There are no full-term pain residency programs
  ▪ Fellowships in pain medicine are available only for a few types of specialists

And in Dentistry?

• No data on the percentage of dental schools that offer pain management courses

• Massachusetts has taken “drastic” measures to combat opioid abuse associated with dental practice

• All 3 of the state’s dental schools last year agreed to teach skills in managing pain, prescribing painkillers, and detecting improper use of opioids
  Freyer FJ. Boston Globe, February 11, 2016
And in Dentistry?

- Massachusetts Governor Charlie Baker led this initiative, and has a “colorful” history of combatting opioid abuse
  - Appointed co-chairs - Drs. Huw Thomas, Ron Kulich, and David Keith - to spearhead this effort
- Massachusetts Dental Society also became involved
  - Recently became one of only 5 states that require prescribers of opioids to avail themselves of CE in pain management/controlled substances

Dynamic Dental Educators. State Requirements for Dental Continuing Education. Available at: https://dynamicdentaled.com/requirements.php.

- Hopefully the start of a trend....
And in Dentistry?

• Yet overall, speculation has suggested that dental pain management training is insufficient
  

• The American Academy of Orofacial Pain published a position paper on appropriate pharmacotherapeutic management of OFP
  

• General dentistry lags behind....
And in Dentistry?

- Dental school curricula may not change quickly
- This is certainly the case with medical school curricula – as curriculum committees are the “last bastion of feudal fiefdom”


- Is the same true of dental school curriculum committees?
- They seem far more interested in curricular change and innovation

And in Dentistry?

• CE around opioid practices needs to be available, as our understanding of opioids is changing dramatically
• And the CE needs to be mandatory
• This has been a problem in medicine
  ▪ Half of all PCPs said they would discontinue opioid prescribing if they had to avail themselves of opioid education or were compelled to provide patient education


• American physicians seem to value their own autonomy over patient and societal well-being at times

And in Dentistry?

• An online CE course on prescription drug abuse in dental patients has been developed:

• Developed in response to data on the rise in prescription drug abuse in dental practice

And in Dentistry?

• The new emphasis on CE around opioid prescribing is on interprofessional education (IPE)

• The ADA has outlined goals for pain management involving IPE

• National Pain Strategy report – Emphasizes involvement of physicians, nurses, clinical pharmacists, dentists, clinical health psychologists, physician’s assistants, nurse practitioners, and other health professionals in developing core competencies
Summary & Conclusions

• Let dentists not make the same mistakes around opioids that physicians have made
• We have risks mitigation tools – use them, and use them wisely and consistently
• If dentists don’t begin to universally mitigate risk associated with opioid prescribing, the media and guideline committee zealots will “mitigate risk” by making opioids simply “go away”
• This is already tragically happening in medicine....
Summary & Conclusions

• No one will claim that opioids are not potentially dangerous
• Indiscriminate prescribing fueled by fraudulent marketing in the beginning of this millennium demonstrated such
• Yet, irrespective of the disingenuousness of the forces of anti-opioid zealotry, our current lack of options for access to safer and more effective chronic pain management necessitates the continued inclusion of opioids in dentists’ pain management armamentaria
Summary & Conclusions

• Are regulatory agencies a threat to dentists who prescribe opioids?
• Not if their risk mitigation practices are thorough, consistent, and documented
• But opioid prescribing guideline committees – dominated by zealots – are a threat....although primarily to dental patients with pain
• As is the media

Summary & Conclusions

• “Just saying no” to prescribing probably feels safe
• Yet doing so will cause needless suffering among millions of dental patients for whom there is presently no better option
• Practicing aggressive risk mitigation is the only ethical answer
• Sometimes, doing the right thing is not necessarily easy
• Yet it’s still the right thing....
THANK YOU
Providers’ Clinical Support System for Opioid Therapies (PCSS-O) Training

- PCSS-O is a collaborative effort led by the American Academy of Addiction Psychiatry (AAAP) in partnership with: Addiction Technology Transfer Center (ATTC), American Academy of Neurology (AAN), American Academy of Pain Medicine (AAPM), American Academy of Pediatrics (AAP), American College of Physicians (ACP), American Dental Association (ADA), American Medical Association (AMA), American Osteopathic Academy of Addiction Medicine (AOAAM), American Psychiatric Association (APA), American Society for Pain Management Nursing (ASPMN), International Nurses Society on Addictions (IntNSA), and Southeast Consortium for Substance Abuse Training (SECSAT).

- For more information visit: www.pcss-o.org
- For questions, email: pcss-o@aaap.org
- Visit us on Twitter: @PCSSProjects

- Funding for this initiative was made possible (in part) by Providers’ Clinical Support System for Opioid Therapies (grant no. 1H79TI025595) from SAMHSA. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.
Webinar Evaluations (Post and 30-Day)

• Each PCSS-O partner organization is asked to distribute a post and 30-day evaluation to participants for their completion.

• Participants in today’s webinar will be emailed the following link to complete their evaluation:
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