Treating Patients with Anxiety or Special-Needs

THERE IS ALWAYS A SOLUTION

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Imagine you are driving home and encounter a roadblock. You detour and make it home, albeit late. Management of anxious patients similarly starts out on a main road. Due to circumstances beyond your control, you are forced to try another approach or two, or even three. Eventually, you arrive, having treated your patient successfully...every single time.

**ANXIOUS PATIENTS**

Anxiety by definition is “worry gone out of control.” It is irrational but frighteningly real to the patient. Unless you’ve personally experienced paralytic anxiety, you cannot understand it. Try describing the color blue to a congenitally blind person or a Beethoven symphony to a deaf person and you will appreciate the impossibility of understanding a patient’s immobilizing situational anxiety.

Now magnify that anxiety with the kind of fear felt by children too young to understand, Alzheimer’s patients who can no longer understand, mentally challenged patients who never understood, or autism spectrum patients who often live within an isolated world. Not all anxious people are considered “special needs patients,” but all patients with special needs are anxious.

How do we gain the cooperation of anxious patients so we can successfully treat them? There is always a solution. Always!

**PRESCRIPTION DRUGS FOR CONSCIOUS SEDATION, PLUS NITROUS OXIDE**

We start by relaxing the patient with some medicine. We prescribe an oral sedative the night before and/or just before the appointment. Nitrous oxide gas may be used in addition to or instead of the drugs. Over the past 40 years, we documented a 70% success rate in treating this patient population with benzodiazepines alone. We calculated a similar 70% with nitrous oxide alone. By combining both oral conscious sedation drugs plus laughing gas, our success skyrockets to 96%.

Our office protocol has been successful in all but 4% of our more than 37,000 oral sedation cases. Patients are relaxed enough to be wrapped, propped, radiographed, and treated to completion.
WRAPS

To prevent patients’ self-injurious behavior, we restrain their hands using soft wraps.

We place the wrap onto the operatory chair before the patient is seated. We then seat the patient and gently secure the wrists with Velcro (Image 1) and the legs (Images 2 and 3) to prevent sudden movement.

The head is immobilized by commercial head restraints or by a caregiver.

MOUTH PROPS

To open the mouth, we start with a foam-covered mouth rest. We then switch to a ratchet mouth prop on the other side.

What if the patient will not open? There’s always a way. A simple technique prompts the patient to open the mouth, with a >98% success rate. We pinch the nose while hovering around the lips with the mouth rest. As soon as the patient takes a breath, we slide in the mouth rest horizontally and rotate 90 degrees as illustrated below. The remaining 2% are opened by techniques taught in our hands-on courses using acupressure points. I have successfully used facial pressure points: CO-24 (chin button), GV-26 (philtrum), TW-17 (behind the ear), and my personal favorite, MHN-18 (mental nerve).

Once the mouth prop is in the vertical position, you can easily insert and immobilize a ratchet prop.

We often use a combination mouth prop, tongue retractor, cheek retractor, saliva ejector, and light source to illuminate the mouth.
ACCESSIBILITY

According to the Americans with Disabilities Act, an office must accommodate wheelchairs. We use movable operatory chairs.

A switch turns the heavy operatory chair into a hovercraft. A cushion of forced air allows a clinician to move the chair out of the way with one finger. This enables patients to remain in the comfort of their wheelchair or gurney.

When wheelchairs don’t have a headrest, we clip one on, or use the hands and chest of a caregiver as shown to the right.

RADIOGRAPHS

For radiographs, we love the portable, hand-held, cordless x-ray units. Digital imaging x-ray systems enable us to expose, process, immediately view images, and retake within seconds.

What if you don’t have an assistant, a functioning computer, or electric power? What if you are on a Dental Mission, and have no digital x-rays? Our answer is Self-developing Dental Film in conjunction with a hand-held x-ray unit. For about $1.50, you have a complete film and darkroom enclosed within a packet the size of a #2 dental film.

A high-quality film results when the film packet is exposed, withdrawn, squeezed, and rinsed with water.
ADDITIONAL TOOLS FOR SUCCESS

Other supplies and equipment that are extremely helpful and often vital will be mentioned here, but details are beyond the space available in this brief review. They include: Intraoral camera with video to explore the mouth of an uncooperative patient; OraVerse to more quickly reverse the numbing effect of a local anesthetic and prevent biting one’s lip, cheek, or tongue; head lights; chair overlay to seat a child in a standard adult operatory chair; Kovanaze nasal spray and NumBee to anesthetize without needles; Identafi to retract the cheek while illuminating and examining teeth in both arches; CariVu to detect carious with no radiation exposure; silver diamine fluoride to contain carious lesions especially in children and hospice patients; Rhondium “One Visit Crowns” for OR patients who need crowns made and cemented that same session; blindfolds and headphones to reduce visual or auditory triggers in patients with Autism; head lights so I can visualize the mouth as they move their head.
MODERATE SEDATION

Relaxing the patient more deeply requires moderate sedation. The dentist must hold a Class I permit, which generally requires a 3-day course, ACLS card, and site visit.

OPERATING ROOM: A PATH THAT ALWAYS WORKS

When all else fails, I work on the ideal patient: one who is asleep and cannot spit, bite, kick, hit, or resist treatment in any way. Once a patient is under general anesthesia, it is virtually guaranteed that you will complete the case. Success depends only on your clinical dental skills and not the patient’s uncooperative behavior. This allows you to do your finest dentistry.

We have calculated, based upon our last 2,000 OR cases, the hourly net income in the OR is more than four times that of our office cases. All our general anesthesia OR work is done with no interruptions by the patient. This applies to both hospitals and surgical centers.

Advantages to having work done in the OR include: 1) This may be the patient’s last resort; 2) the patient has no unpleasant memory of being restrained or operated on; 3) the work gets done four times faster than it would in an office; and 4) dentists and hygienists do their best work when patients are not moving at all.

To treat patients in an OR, you do not need a special permit. You only need what you already have: a license, liability insurance, and basic CPR card.

CONCLUSION

With no known exception, every patient can be treated successfully in a dental office or in an operating room. Determining the best path for each patient requires resourceful creativity that results from knowledge, skill, and practice. If you have the motivation, you can learn the clinical skills in CE courses and/or mentorships. There is always a primary or secondary road that will enable you to treat any patient, in the appropriate setting, either awake or asleep.

Dr. Harvey Levy practices in Frederick, MD. He holds nine fellowships, five diplomate certificates, Mastership in the AGD, and five AGD LL SR awards. He is the recipient of the inaugural Maryland State Dental Association Humanitarian Award, the ADA Access to Care Award, the AGD Humanitarian Award, Tufts University Distinguished Alumni Award, MD Governor Dr. of the Year Award, and Special Care Dentistry’s Saul Kamen Award. Dr. Levy is an ASU’s faculty at University of Maryland and a 3-time Martial Arts Black Belt Hall-of-Famer. For copies or comments, please contact Dr. Harvey Levy at drhlevy@gmail.com or visit drhlevyassoc.com.

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