Management of Anxious and Special Needs Patients: THERE'S ALWAYS A WAY PART 2

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YOU FAILED IN THE OFFICE. NO PROBLEM.

In Part One of this series, we identified the characteristics of anxious and special-needs patients who require additional physical means, drug protocol, or clever techniques to enable us to successfully complete their dental treatment in an office setting. We covered wraps and props, office sedation with nitrous oxide and enteral sedation drugs, radiological equipment and imaging methods, accessibility with movable air-glide operatory chairs, and other tips and tricks to get the job done.

With the correct application of proper techniques, tools and equipment, our experiences have shown success in caring for persons with special needs about 97% of the time. The few failures that occur will happen primarily with the hypo- and non-responders who are drug-resistant, the autistic, or the strong and combative. What is the alternative road for this remaining three percent?

There are two practical options. The first is to relax the patient more deeply in the office. The second is to perform the needed treatment in the operating room of a hospital or surgical center. The second option may be easier, and is certainly more successful.

MODERATE SEDATION

Relaxing the patient more deeply requires at least moderate sedation. Most states in the U.S. already or soon will mandate that dentists must hold a Class I permit to apply enteral moderate sedation (oral or rectal only). To obtain this permit, dentists will generally need:

1. A three-day course that includes discussion of twenty different patient scenarios and doses;
2. Advanced Cardiac Life Support (ACLS) certificate;
3. A site visit including an equipment and supplies evaluation, plus an oral practical knowledge quiz;
4. An application and fee.

Courses are readily available from various dental organizations (AGD, ADA, state dental associations), dental schools, and private, specialized dental training groups (DOCS, American Dental Society of Anesthesiology).

Alternatively, a dentist may consider using either intravenous or intramuscular sedation to totally sedate the patient in the office. However, those deeper sedation protocols now require a Class II sedation permit, which demand more training and preparedness. Some (very few) dentists even perform general anesthesia in the office, which requires a Class III permit, including an anesthesia residency, mini-residency, or other extensive training and certification with testing.

Fig. 1: Dentistry with an anesthesiologist or anesthetist.

There are considerable risks and burdens involved in the provision of office IV or IM sedation. I do not feel comfortable managing both the dental and medical aspects of the case, and applaud those dentists who safely do so. If moderate sedation fails to relax a special needs or anxious patient, I take the ultimate side road, and bring the patient to a hospital or surgical center, where an anesthesiologist or anesthetist can render the patient unconscious. I prefer to focus on what I do best (general dentistry) while leaving the patient's vital signs, overall health, and anesthetic management to someone else (figure 1). Alternatively, some dentists elicit the aid of an anesthesiologist or anesthetist who will come into the dental office to provide anesthesia services for patients undergoing care.

THE OPERATING ROOM: A PATH THAT ALWAYS WORKS

There are times when I fail in the office with special-needs or anxious patients. In the OR, however, that very difficult patient becomes the ideal patient: he or she is asleep and cannot spit on me, bite me, kick my assistant, hit my staff, or resist treatment in any way. A sleeping patient also doesn't pick up the cell phone or take a bathroom break, thus allowing me to perform my best work without distractions or interruptions.

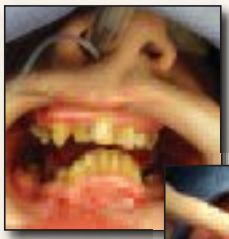

Fig. 2a: A dentist's ideal clinical setting - a dry mouth.

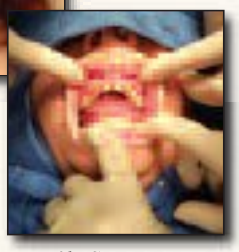

Fig. 2b: Six crowns in the OR.

While under general anesthesia, the patient's behavior is removed from the equation. You can essentially guarantee that you will succeed in completing the case. Success depends only on your clinical dental skills.

Caring for a patient with a dried mouth, an anesthesia tube in their nostril and a throat pack in the oropharynx is no different from working on a Dentiform or on a mannequin. You are in total control of the clinical situation, and can do your finest dentistry (figure 2).

Patients who are too combative or uncooperative to allow radiographs can have excellent quality images taken while they are asleep. For years, we have used the Ergonom-X self-developing films which require no darkroom, no equipment, no electricity, and very little time. Once exposed by the dental assistant or hygienist, the OR nurse or technician can process the films, and place them on an X-ray hanger in 60-90 seconds (figures 3 and 4).

More recently we have incorporated the DEXIS imaging system, which allows us to take excellent quality digital images that are

Fig. 3: Self-developing film in patient's mouth.

reviewed on the laptop in less than a second, with retakes just as fast (figure 5).

The instant digital images taken in the OR can readily be filed, re-organized, archived, shared, e-mailed, or printed, and can even be instantaneously backed up in the office via a VPN (virtual private connection). We continue to use the Ergonom-X self-developing films as a perfect back-up, especially for diagnoses, surgical root tip fractures and for root canal intra-operative and post-operative images.

Fig. 4: Self-developing film on hanger.

Although our OR has an old reliable X-ray unit on wheels, it is bulky and hard to bring close to the OR table. We prefer Aribex's NOMAD-Pro, which weighs 5 ½ pounds, can be hand-held or tripod mounted, and operates cordlessly without the need to worry about electrical outlets.

The light weight and two batteries of the Aribex NOMAD and NOMAD-Pro allow us to use these versatile units anywhere in the hospital, including bedside in the emergency room and in patients' rooms.

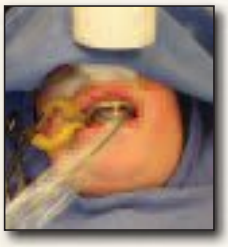

Fig. 5a: DEXIS sensor in the patient's mouth

Another notable advantage of treating patients in the OR is that all scaling and root planing is done by the hygienist in one very short session, with no need for local anesthesia. With the patient asleep, hygienists typically complete all of their work on the most difficult mouths in under an hour (figure 6).

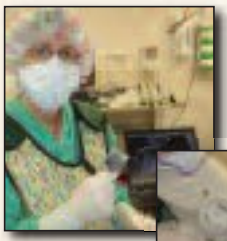

Fig. 5b: DEXIS sensor connected to laptop in OR.

Fig. 5c: DEXIS sensor with Aribex hand-held NOMAD X-ray

Root canal therapy is also completed more quickly in the operating room setting than in the dental office. With the use of a gauze throat pack to protect the airway and prevent the aspiration or water or debris, no rubber dam is needed (figure 7).

Fig. 6: Hygienist scaling teeth in OR.

Extractions, periodontal surgery, finer oral surgery and other surgical procedures, when accomplished in the OR, may be performed more quickly and effectively without the patient wiggling, thrashing, or squirming (figures 8 and 9)

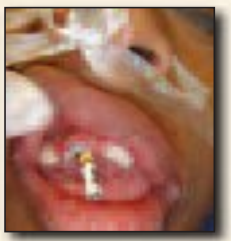

Fig. 7: Root canal on intubated patient.

We do our finest esthetic and other restorative work when there is no blood or saliva interference. Treatment of patients under general anesthesia allows for the maintenance of a dry field. As such, there is no need to redo composites or sealants due to water, saliva or moisture contamination. Placing composites or sealants is not considered underwater dentistry if there is no saliva nearby! (figure 10). Here, also, the total absence of any head or body movements allows us to do our finest quality work.

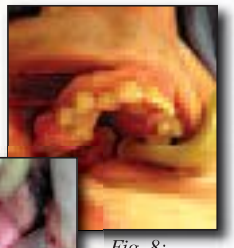

Fig. 8: Periodontal surgery in the OR.

Fig. 9: Torus removal in the OR.

Thus, as general dentists, we are in a unique position. An oral surgeon might not do any restorations or cleaning. A pedodontist might not take out impacted third molars. A periodontist might not do any crowns or root canals. General dentists, on the other hand, can perform all of the above on a special needs or anxious patient under general anesthesia. It's a true win-win: less stressful for the patient, easier and more profitable for us, and more successful all around.

Fig. 10: Composites in a dry mouth.

LESS STRESSFUL FOR THE PATIENT

The American Society of Anesthesiology (ASA) physical status classification system is a categorical system for assessing the fitness of patients prior to surgery. The five-category physical status classification system includes:

1. A normal healthy patient.
2. A patient with discrete or mild systemic disease.
3. A patient with severe, non-incapacitating systemic disease.
4. A patient with severe, life-threatening, incapacitating systemic disease.
5. A moribund patient who is not expected to survive without the operation.

When we treat an ASA type-2 patient in our office, we must be mindful of their systemic disease(s) so that our interventions do not cause a worsening of the patient's health issues. For our ASA type-3 patients, we are likely to trigger a medical emergency in the dental office if we do not take specific precautions regarding the high risk of their particular ailment. ASA type-4 patients are such high risk that they must be closely monitored. They have a life-threatening disease, for which the emotional stress of an office dental procedure, the physical pain of an extraction, or even the injection of a local anesthetic may be enough to trigger a medical crisis. These patients may require more monitoring than our dental office can provide. A hospital or surgical center setting is far better equipped to manage the potential medical emergencies that accompany ASA type-3 and type-4 patients, especially if they have special-needs or are anxious or medically compromised.

For the patient, there are numerous advantages to having treatment performed in the operating room setting: 1) Treatment in the OR may

be the patient's only option, whether for psychological, behavioral or medical reasons; 2) OR-based care is atraumatic for the patient, who wakes up after the procedure with no memory of being held, restrained, or operated on; 3) Treatment is accomplished four times as quickly in the OR as it would in our office, saving time for the patient and oftentimes their caregiver(s). Procedures in the operating room are done six-handed, without interruptions initiated by the patient (figure 11).

Fig. 11: Six-handed dentistry in the OR.

EASIER AND MORE PROFITABLE FOR US

To treat patients in a surgical center or hospital OR you do not need a Class II (deep sedation) or Class III (general anesthesia) permit. In fact, you do not even need a Class I (moderate sedation) permit! You already have what you need: a dental license with proof of liability insurance, and a basic CPR card. Other requirements are fairly simple: apply for facility privileges, demonstrate that you know how to wash your hands, and fill out an application. Obtaining OR privileges for your dental assistant or hygienist is similar, and just as easy. Even though the facility provides nurses, it is advantageous to bring your own staff, as they already know your expectations, the dental tools and terminology, making the case flow even faster and smoother.

Being able to treat patients in an operating room will enable your practice to present a wider portfolio of treatment offerings and modalities. It may provide an exciting expansion of your skills, and further your opportunities for personal and professional growth. Your patients will benefit from your services, your practice will grow, and you may very possibly find a renewed energy in your staff, your practice and yourself. The increased income is not bad either.

We have calculated, based upon our last 1,200 documented OR cases, that the hourly net income in the OR is four times that of our office cases (figure 12).

Fig. 12: Average income per OR hour by year.

With all these advantages to the OR one might ask, why even bother to treat anxious or special-needs patients in the office? Two reasons: the OR may be more expensive for the patient, and sometimes the risk of anesthesia is not justifiable in cases of minor procedures. However, as a tertiary road after all other alternatives have been exhausted, the OR is a foolproof solution for completing the treatment plan.

CONCLUSION

In this two-article series, we have shown that there is always a way to successfully treat any patient, if not in a dental office, then in a hospital or surgical center's operating room. To determine the best path for each patient—whether to go directly to the OR, or to try different roads when you identify obstructions on your current path—requires knowledge, skill, and resourceful creativity, which you can obtain through continuing education courses and oftentimes from other sources in your own community.

As I like to say, special-needs patient care is more than "why do people climb mountains" and "let's make a dollar." It's a golden opportunity to use your gift, leave your mark, and make a positive difference. If you have the clinical skills and motivation, there's always a road that will enable you to treat any patient, always.

Dr. Levy's on-line courses: www.DentalEdu.TV, or direct link from www.DrHLevyAssoc.com/clinicians.htm

For copies or comments, please contact Dr. Harvey Levy at DrHLevy@gmail.com or visit DrHLevyAssoc.com

Resources for Article Parts 1 and 2

ADSA
877-255-3742
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Aribex NOMAD hand-held X-ray
801-226-5522
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www.dentalez.com

Dentist's Advantage Ins.
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www.dentists-advantage.com

DEXIS X-ray Systems
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www.dexis.com

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www.cramerdental.com

Isolite Systems
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www.isolitesystems.com

M-DEC
800-321-MDEC
www.portabledentistry.com

Novalar Pharmaceuticals
888-888-1441
www.novalar.com

Porter Instrument - Nitrous Oxide
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www.porterinstrument.com

SheerVision
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www.Sheervision.com

Special Care Dentistry Association
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http://scdaonline.org

Specialized Care Co.
800-722-7375
www.specializedcare.com

Triodent, Inc
800-811-3949
www.triodent.com

Walter Lorentz Surgical / Biomet
574-267-6639
www.biomet.com

About the Author

Dr. Harvey Levy is a general dentist from Frederick, Maryland who has earned Mastership and two Life Long Service Recognitions in the AGD, eight fellowships and four diplomate certifications. He has published numerous articles and offered seminars and participation workshops all over the country. His work with anxious and special-needs patients earned him the 1986 AGD Humanitarian Award, the ADA Access to Care Award and the honor of being a 2002 Winter Olympic Torch runner.