Changing Prescribing Practices In Dentistry

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Pain, Pain Management & the Opioid Epidemic

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PJD Background / Disclosures

- Clinical pharmacologist, general dentist, former Academic Dean, former pharma executive
- Principal Investigator on 120+ trials in acute pain
- Taught clinical pharmacology and therapeutics to over 2500 practicing dentists
- Was responsible for 7 acute pain clinical research centers in the U.S. and UK
- My clinical trials were sponsored by virtually every manufacturer of new analgesic drugs (> 50 commercial sponsors), and several foundations.
- The opinions expressed are Dr. Desjardins' personal opinions and do not represent the views of any pharmaceutical sponsors or organized dentistry.

Why Are Dentists Part of This Discussion?

- About 188,000 practicing dentists in the US – 80% General dentists and 20% Specialists; most work in small practices < 5 dentists.
- 75 - 90% of active dentists prescribe opioids - 60% allowed 1 refill (2011 survey WA dentists, 2016 FL survey) – usually immediate release opioids
- Fifth leading group of prescribers of opioids (almost all immediate release opioids)
- Most common indication: Pain after extractions, root canal treatment
- Patients often share unused pain relievers, unaware of potential dangers (Drug diversion)

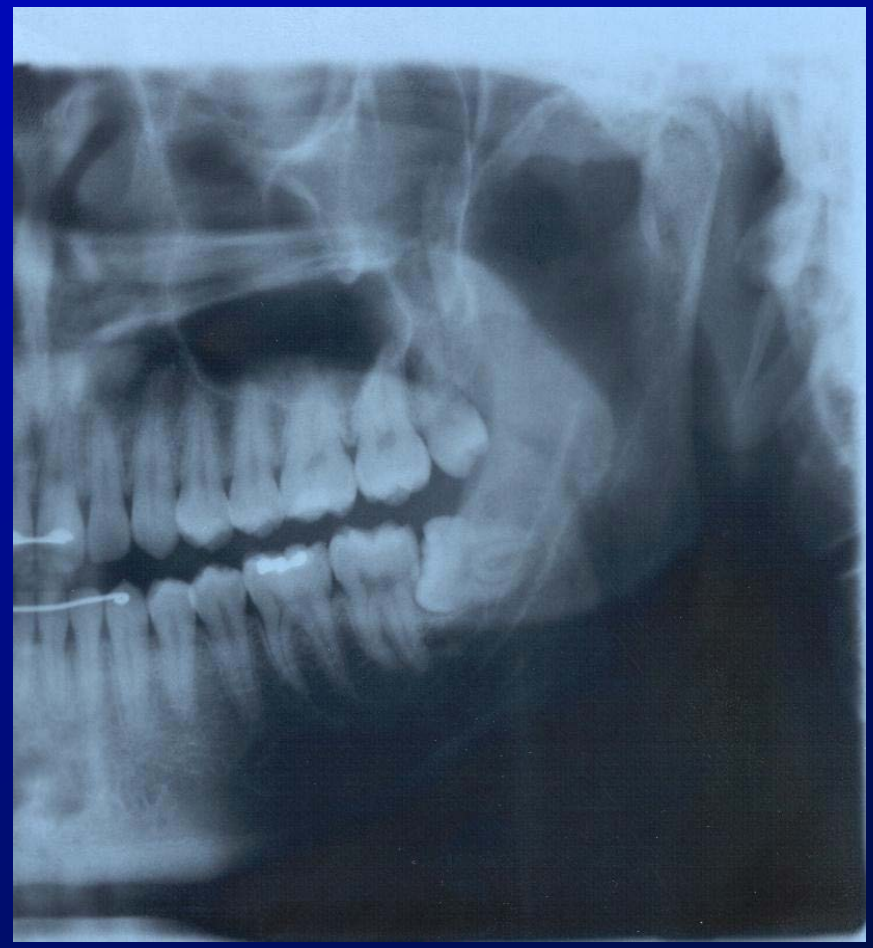
Why so much attention on Opioids?

- Drug overdose leading cause of accidental death in US with 47,055 lethal ODs in 2014
- Four of 5 new heroin users started out misusing Rx pain relievers
- In 2012, 259 million Rxs written for prescription opioids
- Drug diversion is a real risk – Shared, stolen or sold drugs
- ***How has this affected dental practice? PDMP, opioids not convenient to prescribe, early awareness of diversion risks***
- Amer Soc of Addiction Med, 2016 Opioid Addiction Facts & Figures

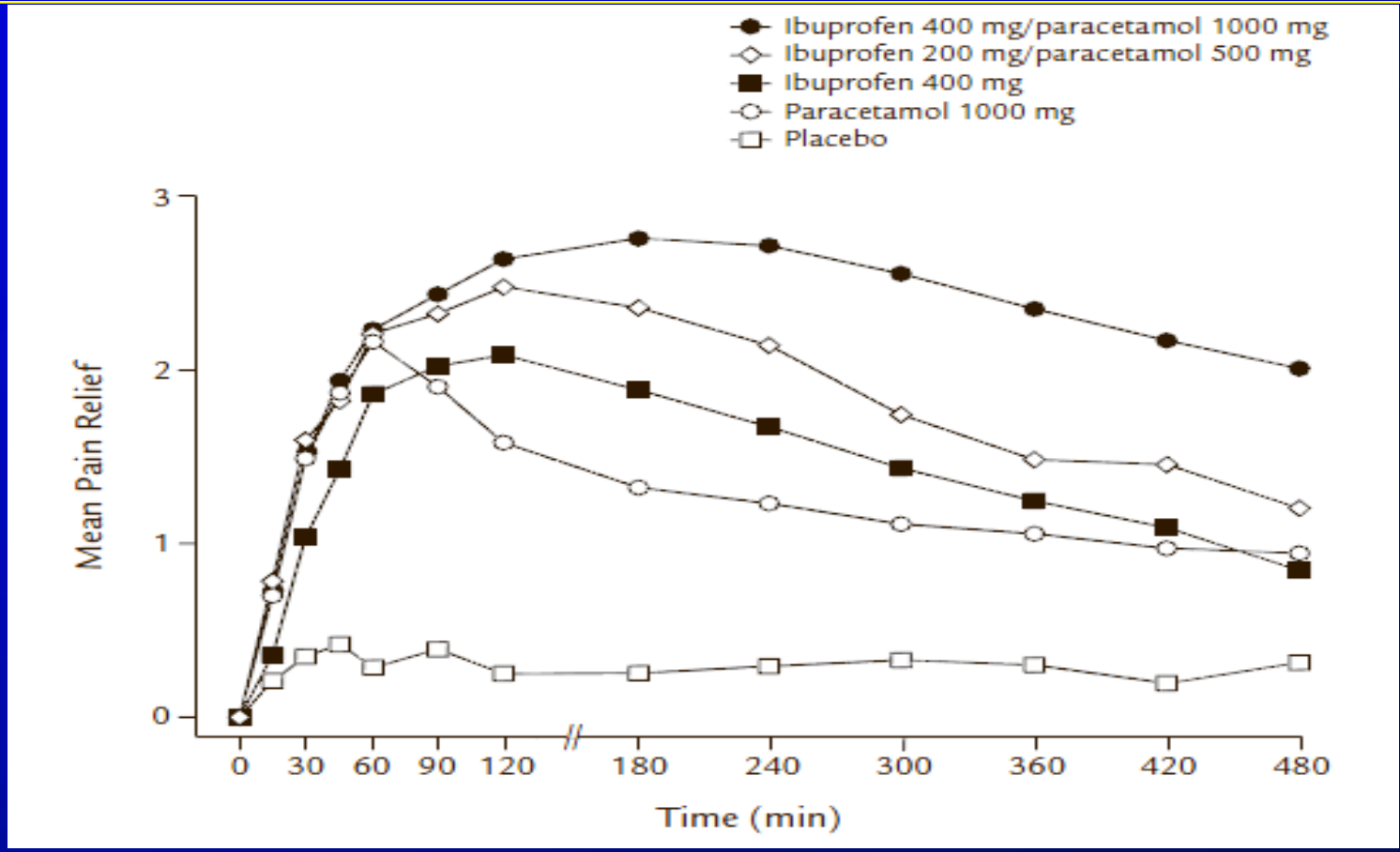
We Have Strong Evidence of Which Pain Relievers Work Best After Dental Surgery

(DENTAL IMPACTION PAIN MODEL)

- Experience: Extensive > 300 trials in medical literature, young adults,men and women
- Surgical / Anesthesia: short acting local ; local and sedation
- Study designs: Randomized, double-blind, standardized pain intensity and relief questions over 6-24 hours
- Duration of “moderate to severe” pain * 24 - 48 hours



IBUPROFEN AND ACETAMINOPHEN - ADDDITIVE ANALGESIC EFFECTS:
Effective Alternatives to Opioid Combos are Available



Mehlisch DR, *et al. Clinical Therapeutics* 2010;32(5):882-95

WHAT HAVE WE LEARNED?

- Acetaminophen (Tylenol) and NSAIDS (Advil and Aleve) are very effective in treating acute dental pain – more effective than opioids!
- If postop pain is severe – combinations of acet or ibu with opioids are effective but they come with additional risks - to the individual and to society
- Little evidence that single entity opioids (morphine, oxycodone, hydrocodone, others) have any role in routine dental practice – Unfavorable benefit / risk
- A small subset of appropriately trained specialists do treat patients with chronic oral / facial pain – same guidelines should apply to them as to physicians – drug abuse risk assessments, patient contracts, regular follow-up, PDMP
- Prescribing habits are hard to change

WHAT REMAINS TO BE DONE?

- Combating the opioid epidemic is like playing “Whack-A –Mole”, simple solutions don’t work – long term strategy and focus needed
- Make the practicing community aware of the risks and their role
- in controlling the risks
- Teach rational prescribing to dental students and practitioners
- Collaborate with committed leaders in public health, public policy, medical & dental education, community resources - listen and learn
- Prescribing habits are hard to change: create win – win scenarios for all involved : Manage pain, decrease risks, decrease costs