June 29, 2015

Dr. James M. Boyle, III, Chair
Council on Dental Education and Licensure
American Dental Association
211 East Chicago Avenue
Chicago, IL 60611

Dear Doctor Boyle:

As a member of the community of interest, the American Dental Society of Anesthesiology (ADSA) appreciates the opportunity to respond to the Call for General Comments requested by the American Dental Association’s Council on Dental Education and Licensure (CDEL) regarding the ADA’s Guidelines for the Use of Sedation and General Anesthesia by Dentists (hereinafter referred to as the Use Guidelines) and the ADA’s Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students (hereinafter referred to as the Teaching Guidelines). The ADSA feels overall, that the proposed revisions of both documents are smart, sensible and clear, and that their overall framework is sound. We are especially appreciative of the committee’s efforts to clarify the topics concerning moderate sedation. However, the ADSA has concerns with a few of the suggested revisions. In the interests of time and space we have not addressed all of our concerns in this document, but instead focused on several specific recommendations the ADSA believes should be considered. They are as follows:

• Line 77 and line 813: The ADSA feels the term “direct supervision by trained medical personnel” is far too vague, and allows too many conflicting interpretations. ADSA suggests “direct supervision by a qualified dentist” be substituted, as it both clarifies the intent and yet still allows the dentist to command others to perform required and necessary actions.

• Lines 119-123, lines 854-858: The ADSA suggests that due to the variability in absorption and distribution of enterally administered sedatives, titration is an inadvisable term to use with oral sedation. The ADA should clearly define titration to apply to intravenous and inhalational routes of administration only.
• Lines 299-303, lines 399-404, lines 414-415, lines 516-522, and lines 534-536: The ADSA strongly believes that consistency and clarity help ensure safety. For this reason, ADSA asks that all pre-operative preparation guidelines eliminate “within the previous 30 days” and instead require an immediate pre-operative review prior to the administration of sedation. These sections discussing patient evaluations for the various levels of sedation/anesthesia should all read the same for consistency.

• Lines 315-316: In the lines above this reference (312-314) and elsewhere, baseline vital signs are required unless “invalidated by the nature of the patient, procedure or equipment.” In lines 315-316, “recording the patient’s body weight” has no similar exception clause. In addition, there is no mention of the more appropriate weight parameter, Body Mass Index (BMI). Also, recording of the patient’s temperature should be only as necessary, as it is not indicated for every anesthetic case. The ADSA feels that this section should be rewritten to read: “A focused physical evaluation must be performed including recording the patient’s BMI and temperature if deemed appropriate.”

• Lines 353-354: The ADSA strongly believes that pulse oximetry is unnecessary during minimal sedation including when nitrous oxide with supplemental oxygen is used as a single sedative agent in the appropriate concentrations or during the use of a single enteral sedative drug in a single dose within the MRD. Furthermore, the ADSA strongly believes that, due to patient variability, the combination of single or multiple doses of enteral sedative drugs with nitrous oxide and oxygen must be considered moderate sedation and require the same care and training as other methods within that modality.

• Lines 432-433, and lines 562-563: The ADSA feels strongly that a pre-procedural checklist of equipment should be created, performed and recorded. However, the ADSA doubts the usefulness of a therefore redundant post-procedural equipment check, and recommends this requirement be eliminated. The ADSA also believes that calibration of anesthesia equipment and monitors beyond customary manufacturer’s requirements are unnecessary.

• Lines 438-440 and lines 462-466: The ADSA recognizes that the current requirements for monitoring ventilation under moderate sedation may be insufficient. We are also aware of the recent campaign to mandate end tidal CO₂ (capnography) for moderate sedation with which we took exception. Because moderate sedation does not require the presence of a second assistant, visual changes in an end tidal CO₂ waveform might escape detection in the absence of such an individual dedicated to continuously observing the monitors. Conversely, the ADSA believes that for moderate sedation, a precordial/pretracheal stethoscope can be a highly useful and reliable monitor, because it provides instantaneous feedback regarding the presence or absence of breath sounds, which, in many instances, may make it more practical than end
tidal CO₂ (capnography). Therefore it is our recommendation that either a precordial/pretracheal stethoscope or capnography should be acceptable options to monitor ventilation on patients undergoing moderate sedation. Moreover because of these advantages, it is our recommendation that both capnography and a precordial/pretracheal stethoscope should be considered for open airway deep sedation/general anesthesia unless precluded by the patient or procedure.

- Lines 1122-1123 and 1390-1391: The ADSA recognizes that the ADA represents all dentists, and therefore strongly believes that the ADA should develop and include appropriate training guidelines for the sedation of children 12 years and under by those dentists not residency trained in pediatric dentistry or deep sedation/general anesthesia. The absence of such training guidelines in the AAP/AAPD document, to which these ADA Guidelines defer, leaves regulatory agencies with little guidance in formulating regulations which protect children in this age bracket while still allowing adequate access to care. Such training guidelines should be developed with full participation of the communities of interest in dentistry particularly the pediatric dental community.

- Line 1390: The ADSA strongly agrees that increased training in managing a compromised airway is critical to the prevention of emergencies. However, it feels strongly that “supervised clinical experience” should be replaced with “Additional training.” As this is currently written, all dentists who complete 60 hour programs would seem to be limited to procedures for ASA I and II patients only. Some consideration should be given to additional training requirements for ASA Class III and IV patients.

- Lines 1411: The ADSA strongly feels that a participant to faculty ratio of two-to-one is simply too high to be practical. A ratio of four-to-one has worked well at the various anesthesia training programs chaired by our members, and would be a safe, effective and achievable ratio.

The ADSA is grateful for the opportunity to recommend possible changes to the ADA’s Anesthesia Guidelines documents and would be happy to discuss our complete list of concerns with the Council at their convenience.

Sincerely,

Kenneth L. Reed, DMD

Kenneth L. Reed, DMD
President, ADSA