

GUIDELINES

Approved by Council - November 2015

The Role of Opioids in the Management of Acute and Chronic Pain in Dental Practice

The Guidelines of the Royal College of Dental Surgeons of Ontario contain practice parameters and standards which should be considered by all Ontario dentists in the care of their patients. It is important to note that these Guidelines may be used by the College or other bodies in determining whether appropriate standards of practice and professional responsibilities have been maintained.

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Introduction

The management of pain is an important component of dental practice. In this context, dentists frequently consider the use of analgesics and other drugs to manage the patient's condition, which requires appropriate knowledge, skill and professional judgment to be effective and maintain safety.

Before prescribing any drug, dentists must have current knowledge of the patient's true health status and clinical condition. This can only be acquired by obtaining a medical history and conducting an appropriate clinical examination of the patient in order to make a diagnosis or differential diagnosis, or otherwise establish a clinical indication for the use of a drug. There must be a logical connection between the drug prescribed and the diagnosis or clinical indication.

For many dentists and patients, the management of pain and the use of opioids are often linked. However, in most instances, dental pain is best managed with effective, timely and safe treatment, and the use of non-opioids, including acetaminophen and non-steroidal anti-inflammatory drugs (NSAIDs). In those instances in which the patient's pain cannot be managed with non-opioids, dentists must consider whether an alternate treatment or drug is clinically appropriate.

Dentists must exercise reasonable professional judgment to determine whether prescribing an opioid is the most appropriate choice for a patient. These drugs are highly susceptible to misuse, abuse and/or diversion, and may result in harm. If there are no appropriate or reasonably available alternatives, the benefits of prescribing an opioid must be weighed against its potential risks, especially when used long-term.

In addition, dentists who prescribe an opioid for a patient should place reasonable limits on their prescriptions and consider opportunities for collaborating with other health care professionals,

particularly when complications begin to exceed their competence to manage independently.

The purpose of this document is to guide dentists in the appropriate role of opioids in the management of acute and chronic pain in dental practice, and to present "best practices" for their use.

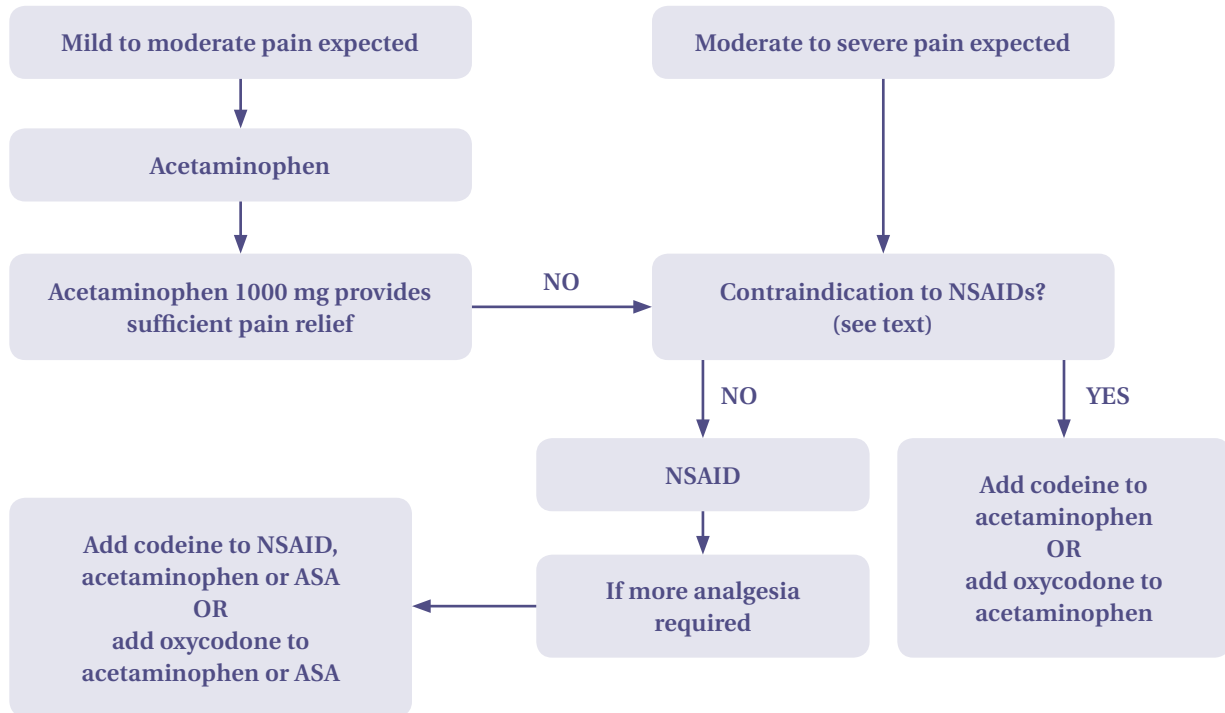
Management of Acute Pain

Patients presenting in acute pain deserve effective, timely and safe management of their condition. This should involve active intervention through dental procedures (e.g., caries removal, pulpectomy, incision-and-drainage, extraction) that are carried out as soon as possible, whenever possible.

For the majority of patients, postoperative pain will be most significant for approximately two to three days, after which it is expected to diminish. Thus, in most situations, analgesics should be prescribed for the management of postoperative pain for three days, with declining amounts needed thereafter.

Before recommending or prescribing any drug for postoperative pain, the following principles should be considered:

- Patients deserve effective, timely and safe pain management.
- The source of the patient's pain should be eliminated directly through dental procedures that are carried out as soon as possible, whenever possible.
- The use of any drug involves potential risks.
- The use of an analgesic should be individualized, based on the patient's medical history and the level of anticipated post-operative pain.
- A non-opioid (e.g., acetaminophen or an NSAID) should be maximized before adding an opioid.
- A preoperative and/or loading dose of an NSAID may be beneficial.

ALGORITHM FOR MANAGEMENT OF ACUTE PAIN

Attribution: Adapted with permission from Haas, D.A. (2002). An Update on Analgesics for the Management of Acute Postoperative Dental Pain. *Journal of the Canadian Dental Association*, 68(8),476-482

- The dose and frequency of an analgesic should be optimized before switching to another analgesic.
- Long-term use of any analgesic should be avoided, whenever possible.
- The analgesic dose should be reduced in older individuals.
- For children, the analgesic dose should be calculated on the basis of weight.

From a risk/benefit standpoint, acetaminophen should be the first analgesic to consider and is usually sufficient for mild to moderate pain. Studies of acute pain in dentistry demonstrate that an appropriate dose of an NSAID should manage the vast majority of moderate to severe pain experienced by dental patients. There is some evidence that suggests alternating acetaminophen with an NSAID may be beneficial for managing moderate to severe pain.

Only in a minority of situations is an opioid required.

The above algorithm suggests the following approach:

1. First consider acetaminophen. If professional judgment determines that an adult dose of 1,000 mg q4h (maximum of 4 g per day) is, or will be, insufficient, then consider point 2.
2. Consider an NSAID. If deemed insufficient, then consider point 3.
3. Consider a combination of acetaminophen or an NSAID with codeine 15 – 30 mg, q4-6h prn pain. If deemed insufficient, then consider point 4.
4. Consider a combination of acetaminophen or an NSAID with codeine 30 – 60 mg or oxycodone 5 – 10 mg, q4-6h prn pain.

Before prescribing an analgesic for any patient, consider the following:

Is pain estimated to be mild-to-moderate?

If yes, then consider:

- Acetaminophen 500 – 1000 mg q4h (maximum of 4 g per day) for adults
- Acetaminophen 10 – 15 mg/kg q4h (maximum of 65 mg/kg per day) for children

Is pain estimated to be moderate-to-severe?

If yes, then consider:

1. Is the patient in good health with no contraindications to NSAIDs?
 - If yes, recommend or prescribe an NSAID, such as ibuprofen 400 mg q4h prn or an appropriate dose of flurbiprofen, diflunisal, naproxen, ketorolac, ketoprofen, floctafenine or etodolac.
2. Does the patient have a contraindication to NSAIDs, such as an allergy, gastric bleeding issues or severe asthma?
 - If yes, recommend or prescribe a combination of acetaminophen with codeine or oxycodone.

Is pain estimated to be severe?

If yes, then consider:

- A local anesthetic block with bupivacaine
- A higher dose of an NSAID, such as ibuprofen 600 mg (assuming there are no contraindications)
- Adding codeine 30 – 60 mg to the NSAID or acetaminophen
- Adding oxycodone 5 – 10 mg to the NSAID or acetaminophen (such as Percocet®)

Before prescribing an opioid for any patient, consider the following:

- *Is the patient's pain well-documented?*
- *Is the patient currently taking an opioid?*
- *Does the patient's medical history suggest signs of substance misuse, abuse and/or diversion (see section below on Assessing Risk)?*
- *Given the efficacy of non-opioids, do the benefits of prescribing an opioid outweigh the risks?*

ONLY IN A MINORITY OF SITUATIONS IS AN OPIOID REQUIRED.

If the use of an opioid is determined to be appropriate, then:

- Limit the number of tablets dispensed for any opioid prescription. For most patients, consider the following limits:
 - for codeine 15 mg combinations (e.g., Tylenol#2®): maximum of 36 tablets
 - for codeine 30 mg combinations (e.g., Tylenol#3®): maximum of 24 tablets
 - for oxycodone 5 mg combinations (e.g., Percocet®): maximum of 24 tablets

IN SOME SITUATIONS, PRACTITIONERS MAY CONSIDER EXCEEDING THE SUGGESTED MAXIMUM NUMBER OF TABLETS FOR A SINGLE OPIOID PRESCRIPTION. PRACTITIONERS ARE EXPECTED TO EXERCISE REASONABLE PROFESSIONAL JUDGMENT IN DETERMINING WHEN THIS IS JUSTIFIED, WHICH SHOULD BE DOCUMENTED. SUCH SITUATIONS, HOWEVER, SHOULD BE DEEMED THE EXCEPTION, AND NOT COMMON PRACTICE.

If the patient returns complaining of unmanaged pain, and this is confirmed by history and clinical examination, then:

- Reassess the accuracy of the diagnosis and/or source of the patient's pain.
- Consider non-pharmacologic management of the patient's pain, including direct treatment (e.g., pulpectomy, incision-and-drainage, extraction).
- Consider recommending or prescribing the maximal dose of the NSAID or acetaminophen and discontinuing the opioid.
- Consider prescribing the maximal dose of the NSAID or acetaminophen and the same dose of the opioid.
- Prescribing an increased dose of the opioid should be considered last.

If the patient returns again complaining of unmanaged pain after a second prescription for an opioid, and this is confirmed by history and clinical examination, then:

- Reassess the accuracy of the diagnosis and/or source of the patient's pain.
- Consider non-pharmacologic management of the patient's pain, if appropriate.
- Consider recommending or prescribing the maximal dose of the NSAID or acetaminophen and discontinuing the opioid.
- Consider the risk for opioid misuse, abuse and/or diversion. If this is suspected, consider consulting with the patient's physician (or other primary family health care provider) and/or pharmacist regarding drug history and management of risk.
- Consider prescribing the maximal dose of the NSAID or acetaminophen and the same dose of the opioid.
- If a third prescription for an opioid is issued, then advise the patient that no further prescriptions for an opioid will be issued without consulting with the patient's primary family health care provider and/or a dental specialist with expertise in pain management and referring as appropriate.

If the patient returns again complaining of unmanaged pain after a third prescription for an opioid, and this is confirmed by history and clinical examination, then:

- Refer the patient to his/her primary family health care provider or a dental specialist with expertise in pain management for management of pain and assessment for problematic opioid use.
- Avoid prescribing any further opioids until consulting with the patient's primary family health care provider and/or a dental specialist with expertise in pain management and referring as appropriate.
- Consider recommending or prescribing the maximal dose of the NSAID or acetaminophen alone, until an interprofessional consultation has been conducted.

SUMMARY OF APPOINTMENTS

(assuming the same diagnosis and/or source of the patient's pain):

First Appointment

- day of procedure/first appointment
- prescription for an opioid is issued

Second Appointment

- patient returns complaining of unmanaged pain
- possible Second prescription for an opioid

Third Appointment

- patient returns complaining of unmanaged pain
- possible third prescription for an opioid and patient advised that no further prescriptions for an opioid will be issued without consultation/referral

Fourth Appointment

- patient returns complaining of unmanaged pain
- patient referred for pain management and any further prescriptions for an opioid are issued only in consultation with the patient's primary family health care provider and/or a dental specialist with expertise in pain management

Dentists who prescribe an opioid for a patient independently should limit the number of consecutive prescriptions to a maximum of three, using the suggested maximum number of tablets. Further prescribing should take place only in consultation with the patient's primary family health care provider and/or a dental specialist with expertise in pain management.

Management of Chronic Pain

The diagnosis of chronic pain refers to pain that is prolonged, generally of three to six months duration, and subsumes chronic nociceptive pain, central pain and sympathetically maintained pain. These may all cause a "chronic pain syndrome", often with a behavioural or psychosocial component.

CHRONIC PAIN CONDITIONS IN DENTAL PRACTICE	
Primarily of Oral-Facial Origin	Not Primarily or Solely of Oral-Facial Origin
<ul style="list-style-type: none"> • Temporomandibular Disorders <ul style="list-style-type: none"> – Muscular/Myofascial – Intra-articular – Degenerative/Inflammatory • Neuropathic/Neuralgic Pain <ul style="list-style-type: none"> – Trigeminal Neuralgia (Tic Douloureux) – Secondary Trigeminal Neuralgia from Facial Trauma – Postherpetic Neuralgia (Trigeminal) – SUNCT Syndrome (Shortlasting, Unilateral, Neuralgiform Pain with Conjunctival Injection and Tearing) – Unclear But Likely Neuropathic Pain <ul style="list-style-type: none"> ◦ Glossodynia and Sore Mouth (also known as Burning Mouth Syndrome) ◦ Atypical Facial Pain (Atypical Facial Neuralgia, Migratory Odontalgia, etc) 	<ul style="list-style-type: none"> • Tension-Type Headache (Muscle Contraction Type Headache) with facial pain • Secondary Trigeminal Neuralgia from Central Nervous System Lesions • Cervicogenic Headaches with facial pain • Temporal Arteritis • Cluster Headache • Migraine Headache

In dental practice, patients may present with chronic pain primarily of oral-facial origin or as part of, or in conjunction with, another primary pain diagnosis.

If the patient's pain is primarily of oral-facial origin, the dentist or dental specialist may be the primary caregiver. However, if it is not primarily or solely of oral-facial origin, the dentist should collaborate with or refer to a physician or medical specialist, who may assume the responsibility of the primary caregiver.

Even if the patient's pain is primarily of oral-facial origin, the dentist should consider collaborating with other health care professionals, particularly when appropriate pharmacotherapy involves the use of drugs with which the dentist lacks experience or complications begin to exceed his/her competence to manage independently.

CHRONIC PAIN PRIMARILY OF ORAL-FACIAL ORIGIN

The management of acute pain implies the elimination of a causative disease or disorder, whereas the objective with chronic pain is generally management of the patient's symptoms and any related dysfunction. This may involve various modalities, including physical treatment, pharmacotherapy, cognitive/behavioural methods, and complimentary or alternative therapy. In rare cases, surgical intervention may be considered as a last resort.

Temporomandibular Disorders

For muscular/myofascial pain, in general, the most effective first line of therapies are the physical and cognitive/behavioural modalities. If parafunctional habits are contributing to the patient's symptoms,

a stabilizing-type oral appliance may be helpful. If sleep disordered breathing is suspected, a referral for a sleep assessment, followed by appropriate management, may be considered.

In severe cases of muscular/myofascial pain or if nocturnal parafunction is contributing to the symptomatology, a muscle relaxant may be prescribed, such as cyclobenzaprine, orphenadrine, tizanidine or methocarbamol. Generally, these drugs are prescribed for short periods of two to four weeks, but occasionally a longer course is appropriate with regular monitoring. If additional pain management is necessary, acetaminophen or an NSAID may be recommended. **Benzodiazepines are generally not recommended for long-term use because of their significant potential for misuse, abuse and/or diversion.**

For intra-articular, degenerative or inflammatory disorders, the physical and cognitive/behavioural modalities may again be considered. Although the evidence for their use is weak, stabilizing-type oral appliances may be helpful.

For mild to moderate pain management, acetaminophen is the drug of choice. Daily adult dose should be tailored to the minimum necessary to manage the pain (maximum of 4 g per day). The risks of hepatotoxicity, nephropathy, anemia and thrombocytopenia increase with duration of use.

NSAIDs are a useful adjunct, both for their analgesic effect and, when appropriate, anti-inflammatory activity. All NSAIDs risk gastrointestinal bleeding and cardiovascular thrombotic events, including stroke and myocardial infarction. With celecoxib, the gastrointestinal risks are lessened, but there is evidence that the cardiovascular risks may be increased, especially in patients with a history of myocardial infarction or cerebral vascular accident. Although adverse effects are not always related to dose or duration, long duration in particular increases risk.

Unlike acute pain, pharmacologic management of chronic temporomandibular pain implies long-term use, which may result in drug tolerance, escalating dosage and increased risks of adverse effects. **Opioids are rarely indicated.**

For more detailed information about the management of temporomandibular disorders, refer to the Guidelines on the Diagnosis and Management of Temporomandibular Disorders & Related Musculoskeletal Disorders, which is available on the College's website at www.rcdso.org.

Neuropathic/Neuralgic Pain

For neuropathic/neuralgic pain, whether (apparently) primarily of oral-facial origin or not, collaboration with a physician or medical specialist is advisable to confirm that it is not part of a more generalized/systemic pain disorder and rule out a central space occupying lesion. Brain and/or base of skull imaging are recommended. In addition, if the dentist is not experienced in prescribing the appropriate drugs, she/he should transfer the responsibility of principal prescriber to the patient's physician or an appropriate medical or dental specialist, while maintaining a collaborative role in the patient's care. At minimum, the dentist or dental specialist's role includes monitoring for a local/dental cause or contributing disorder.

Generally, neuropathic/neuralgic pain is best managed pharmacologically, although other adjunctive modalities are often helpful. Anticonvulsants are usually the drugs of choice for neuropathic/neuralgic pain, including carbamazepine, gabapentin and pregabalin. Prior to prescribing carbamazepine or related agents, liver function tests are mandatory to establish a baseline, with follow-up testing periodically. Certain antidepressants, particularly the tricyclic amines, are also useful in selected situations. **Opioids are rarely indicated, except for the most severe cases, unresponsive to the first line of therapy.**

When prescribing anticonvulsants and/or antidepressants, these drugs should be started at a low dose and then slowly increased until relief is accomplished, while not exceeding the maximum dose. Similarly, these drugs must not be discontinued abruptly, but rather patients should be weaned from them carefully. Again, the dentist should consider collaborating with the patient's physician, particularly when appropriate pharmacotherapy involves the use of drugs with which the dentist may lack experience or when complications begin to exceed his/her competence to manage independently.

CHRONIC PAIN NOT PRIMARILY OR SOLELY OF ORAL-FACIAL ORIGIN

For pain that is not primarily or solely of oral-facial origin, in general, the dentist or dental specialist is not the primary care provider. Possible exceptions to this rule include cases involving tension-type headache when a muscular/myofascial temporomandibular disorder is a significant component. In such cases, the College's Guidelines for the Diagnosis and Management of Temporomandibular Disorders & Related Musculoskeletal Disorders are applicable.

Otherwise, the dentist's or dental specialist's role is complementary to the physician or medical specialist, principally in monitoring and/or controlling the oral-facial and/or dental component of the patient's complaint.

It should be recognized that chronic pain may be a function of psychosocial and/or physical factors, and that a history of trauma (either psychological or physical) may precipitate and/or perpetuate pain in general. In addition, it should be acknowledged that addiction to any substance, including opioids, may be precipitated by the experience of pain.

Management of Risk for Opioid Use

In some instances, the prescription of opioids may be deemed necessary to manage a patient's pain. However, opioids are often prescribed in excess of what is required. Many factors may contribute to the over-prescribing of opioids in dentistry, including:

- habit or convenience;
- lack of knowledge regarding the efficacy of non-opioid analgesics;
- patient demands and expectations;
- inadequate patient history regarding alcohol and other substance use;
- desire to avoid conflicts or complications.

Dentists should not prescribe opioids to manage potential postoperative pain without regard to the possibility for problematic opioid use. While dentists typically prescribe a limited quantity of opioids for acute pain (e.g., 24 tablets), excess tablets may remain after the patient's condition has been successfully managed. These excess tablets may then become a source for recreational drug abuse or diversion by the patient, a relative or a friend.

It should be emphasized that a dentist has no obligation to prescribe any drug, including opioids, if he or she does not believe it is clinically appropriate, even if the patient has been prescribed them in the past and despite any demands or expectations. In appropriate instances, a dentist must have the clarity of purpose and conviction to refuse a patient's request for opioids when it appears to be unjustified or suspect, in order to protect him or her from unnecessary medication and abuse potential, and to limit the diversion of these drugs to the streets.

The dentist should strive for adequate pain management, while simultaneously assuming the responsibility of limiting the potential for drug misuse, abuse and/or diversion.

ASSESSING RISK

When prescribing opioids, a dentist must have current knowledge and ensure comprehensive documentation of the patient's pain condition and general medical status. This should include a review of the patient's alcohol and other substance use and screening for sleep apnea.

If additional assessment is desirable regarding a patient's risk for opioid misuse, abuse and/or diversion, various screening tools may help with this determination. Examples include the CAGE-AID Questionnaire adapted to include drugs and the Opioid Risk Tool (refer to Appendix 1).

A discussion about potential benefits, adverse effects, complications and risks assists the dentist and patient in making a joint decision on whether to proceed with opioid therapy.

Before prescribing opioids, the dentist should ensure the patient's expectations are realistic. The goal of analgesic therapy is rarely the elimination of pain, but rather the reduction of pain intensity.

PATIENT EDUCATION

It is recommended that dentists advise patients on the safe use and storage of opioids by communicating the following:

- Read the label and take the drug exactly as directed. Take the right dose at the right time.
- Follow the other directions that may come with the drug, such as not driving, and avoiding the use of alcohol.
- Store opioids in a safe place out of the reach of children and teenagers, and keep track of the amount of drugs.
- Never share prescription drugs with anyone else, as this is illegal and may cause serious harm to the other person.
- Return any unused drugs to the pharmacy for safe disposal, in order to prevent diversion for illegal use and to protect the environment. Drugs must not be disposed of in the home (e.g., in the sink, toilet or trash).

In addition, dentists should advise patients about what to do if they miss a dose, and remind them that crushing or cutting open a time-release pill destroys the slow release of the drug and may lead to an overdose with serious health effects.

Patient information pamphlets and other educational materials regarding opioid use are available on the internet, including:

- **Are you thinking about taking opioids (painkillers) for your pain?**
<http://nationalpaincentre.mcmaster.ca/documents/AreYouThinkingAboutTakingOpioidsEnglishJan2014.pdf>
- **Unintended Consequences: Sometimes medications end up in unusual places... Like Trail Mix Parties**
<http://nationalpaincentre.mcmaster.ca/documents/UnintendedConsequencesAug2012.pdf>
- **Youth and prescription painkillers: What parents need to know**
http://knowledgex.camh.net/amhspecialists/resources_families/Documents/YouthandMisuse%20E.pdf

DETECTING PROBLEMATIC OPIOID USE

When prescribing opioids, dentists must be alert for behaviour that suggests patients are experiencing problems with the appropriate use of opioids or have an opioid use disorder (as described in the Diagnostic and Statistical Manual of Mental Disorders [DSM-5] of the American Psychiatric Association.) Such a disorder may include seeking opioids for non-medicinal use or diversion purposes.

It may be difficult to determine whether a patient is experiencing problems with opioid use. Indicators of an opioid use disorder include:

- **escalating the dose** (e.g., requesting higher doses, running out early);
- **altering the route of delivery** (e.g., biting, crushing controlled-release tablets, snorting or injecting oral tablets);

- **engaging in illegal activities** (e.g., double-doctoring, prescription fraud, buying, selling and stealing drugs).

The following chart lists indicators of problematic opioid use or an opioid use disorder.

Dentists may take practical steps to help prevent problematic opioid use:

- If the patient is not well known to you, ensure her or his identity has been verified; for example, by requesting two or three pieces of identification (e.g., health card, driver's licence, birth certificate).
- Verify the presenting complaint and observe for indicators of problematic opioid use.
- Screen for current and past alcohol and drug (prescription, non-prescription, illicit) use. Consider using screening tools (refer to Appendix 1).
- Consider whether the patient may be experiencing problems with opioid use or have an opioid use disorder if she/he:
 - requests a specific drug by name and/or states that alternatives are either not effective or s/he is “allergic” to them;
 - refuses appropriate confirmatory tests (e.g., x-rays, etc.);
 - indicates losing previous filled prescriptions or spillage of drugs.
- Ask to speak with the patient's primary family health care provider and/or pharmacist.
- Ask the patient if she/he has received any opioids in the last 30 days from another practitioner and look for any signs of evasiveness.

Under the Controlled Drugs and Substances Act, 1996, and its regulations, a person who has received a prescription for a narcotic, such as an opioid, shall not seek or receive another prescription or narcotic from a different prescriber without telling that prescriber about every prescription or narcotic that he or she has obtained within the previous 30 days.

MANAGING THE HIGH-RISK PATIENT

Dentists who are considering prescribing opioids or other drugs with abuse potential for patients with a history of problematic opioid use or an opioid use

INDICATOR	EXAMPLES
Altering the route of delivery	<ul style="list-style-type: none"> – Injecting, biting or crushing oral formulations – Biting, chewing, swallowing or injecting topical preparations (e.g., sustained-release analgesic patches)
Accessing opioids from other sources	<ul style="list-style-type: none"> – Taking the drug from friends or relatives – Purchasing the drug from the “street” – Double-doctoring
Unsanctioned use	<ul style="list-style-type: none"> – Multiple unauthorized dose escalations – Binge rather than scheduled use
Drug seeking	<ul style="list-style-type: none"> – Recurrent prescription losses – Aggressive complaining about the need for higher doses – Harassing staff for faxed scripts or fit-in appointments – Nothing else “works”
Repeated withdrawal symptoms	<ul style="list-style-type: none"> – Marked dysphoria, myalgias, GI symptoms, craving
Accompanying conditions	<ul style="list-style-type: none"> – Currently addicted to alcohol, cocaine, cannabis or other drugs – Underlying mood or anxiety disorders not responsive to treatment
Social features	<ul style="list-style-type: none"> – Deteriorating or poor social function – Concern expressed by family members
Views on the opioid medication	<ul style="list-style-type: none"> – Sometimes acknowledges being addicted – Strong resistance to tapering or switching opioids – May admit to mood-leveling effect – May acknowledge distressing withdrawal symptoms

Attribution: Prescribing Drugs (Policy Statement # 8 – 12), 2012, College of Physicians and Surgeons of Ontario

disorder should clarify the conditions under which they will prescribe, including consultation with the patient's physician. The physician may consider, in appropriate circumstances, monitoring for indicators of problematic opioid use (e.g., urine drug screening) and the utility of a treatment agreement.

A treatment agreement may be an effective tool, especially for a patient who is not well known to the dentist or at higher risk for problematic opioid use.

A treatment agreement is a formal and explicit written agreement between a practitioner and a patient that sets out terms regarding adherence to the therapy. An agreement may state that:

- the patient agrees that only one practitioner will prescribe opioids;
- the patient will use the drug only as directed;
- the patient acknowledges that all risks of taking the drug have been fully explained;
- the patient will use a single pharmacy of his or her choice to obtain the drug.

A treatment agreement helps to establish the dentist's expectations of a patient before prescribing begins and the circumstances in which it may stop. The consequence for not meeting the terms of the agreement should also be clear: the dentist may decide not to continue prescribing opioids.

DEALING WITH A SHORTAGE OF INTERPROFESSIONAL SUPPORT

The College recognizes that at times, dentists may be faced with the prolonged management of a patient's pain in undesirable circumstances, especially when there is a shortage of interprofessional support; for example, the patient does not have a physician (or other primary family health care provider) or the referral to another practitioner with expertise in pain management is not possible for an extended period of time.

The paramount responsibility of dentists is to the health and well-being of patients, which is an expression of the core ethical value of beneficence. This requires dentists to maximize benefits and

minimize harm for the welfare of patients. In some situations, determining what may be beneficial versus harmful is difficult. Nevertheless, dentists must attempt to provide care in a way that upholds these principles as best as possible.

Traditional interprofessional support may not always be available. Even in such situations, the principles of patient management described in this document still apply.

When dealing with a shortage of interprofessional support, dentists should make reasonable attempts to leverage whatever resources are at hand. For example, a dentist may consider:

- referring the patient to Health Care Connect, which helps Ontarians who are without a family health care provider to find one. People without a family health care provider are referred to a family doctor or a nurse practitioner who is accepting new patients in their community (<http://www.health.gov.on.ca/en/ms/healthcareconnect/public/>);
- consulting with an experienced colleague regarding patient management;
- consulting with the patient's pharmacist to verify the patient's history of prescription drugs and discuss options/alternatives;
- consulting with the local public health unit regarding available resources in the community;
- consulting with the College.

Additional Issues

USE OF ANALGESICS FOR PEDIATRIC PATIENTS

Acetaminophen is usually considered the drug of choice for pediatric patients. It should be administered in a dose of 10-15 mg/kg q4-6h, up to a maximum of 65 mg/kg per day. Ibuprofen can also be used in a dose of 10 mg/kg, q6-8h.

ASA is contraindicated for pediatric patients, because it can potentially induce Reye's syndrome.

Health Canada has recommended that codeine only be used in patients aged 12 and over. This is due to the potential of the rare complication of ultra-rapid metabolism of codeine leading to morphine overdose.

CONTENT OF PRESCRIPTIONS

Dentists must provide the following information with a prescription:

- name of the patient;
- full date (day, month and year);
- name of the drug, drug strength and quantity or duration of therapy;
- full instructions for use of the drug;
- refill instructions, if any;
- printed name of prescriber;
- address and telephone number of dental office where the patient's records are kept;
- signature of prescriber or, in the case of electronically produced prescriptions, a clear and unique identifier, which signifies to the dispenser that the prescriber has authorized the individual prescription.

For prescriptions that vary from common practice, dentists should consider providing additional information for the pharmacist.

If the prescription is for a monitored drug, as defined in the Narcotics Safety and Awareness Act, 2010, dentists must also provide their registration number, as well as an identifying number for the patient (e.g., health card number) and the type of identifying number it is (e.g., health card).

Dentists should be aware that pharmacists are responsible for confirming the authenticity of each prescription, which may require direct confirmation with the prescriber before the prescription is filled.

CLARITY OF PRESCRIPTIONS

Dentists must ensure that all written and verbal prescriptions are clearly understandable.

Written prescriptions must be legible. It is recommended that dentists use the generic name of the drug to ensure prescriptions are clear and consider including more information, when appropriate (e.g., include both brand name and generic name, and the reason for prescribing the drug). When writing prescriptions, dentists must pay particular attention to the use of abbreviations, symbols and dose designations, and should avoid using abbreviations, symbols, and dose designations that have been associated with serious, even fatal, medication errors.

According to medication safety literature, the use of verbal prescriptions (spoken aloud in person or by telephone) introduces a number of variables that can increase the risk of error. These variables include:

- potential for misinterpretation of orders because of accent or pronunciation;
- sound-alike drug names;
- background noise;
- unfamiliar terminology;
- patients having the same or similar names;
- potential for errors in drug dosages (e.g., sound-alike numbers);
- misinterpretation of abbreviations.

In addition, the use of intermediaries (e.g., office staff) has been identified as a prominent source of medication error.

Dentists must have protocols in place to ensure that verbal prescriptions are communicated in a clear manner. The more direct the communication between a prescriber and dispenser, the lower the risk of error. Accordingly, if dentists use verbal prescriptions, it is recommended that they communicate the verbal prescription themselves. If this is not possible, it is recommended that dentists consider asking a staff person who has an understanding of the drug and indication to communicate the prescription information, unless the prescription is a refill.

When verbal prescriptions are used, it is recommended that the accuracy of the prescription be confirmed

using strategies such as a ‘read back’ of the prescription and/or a review of the indication for the drug. It is recommended that the read back include:

- spelling of the drug name;
- spelling of the patient’s name;
- dose confirmation expressed as a single digit (e.g., “one-six” rather than “sixteen”).

In addition, to reduce the risk of error due to patients having the same (or similar) names, it is advisable to communicate at least one additional unique patient identifier to the dispenser.

SECURELY ISSUING WRITTEN PRESCRIPTIONS

In issuing prescriptions for opioids, dentists should consider taking the following precautions:

- If using a paper prescription pad:
 - write the prescription in words and numbers;
 - draw lines through unused portions of the prescription;
 - keep blank prescription pads secure.
- If using desk-top prescription printing:
 - use security features, such as watermarks;
 - write a clear and unique signature.
- If faxing a prescription:
 - confirm destination and **fax directly to the pharmacy**, ensuring confidentiality;
 - destroy paper copy or clearly mark it as a copy.

SAFEGUARDING THE DENTAL PRACTICE

Securing and Monitoring In-Office Drugs

Opioids require increased storage security than other drugs. It is recommended that drugs stored in a dentist’s office be kept in a locked cabinet and out of sight. Dentists are advised to avoid storing drugs in any other location, including their homes, and never leave drug bottles unattended or in plain view.

A drug register must be maintained that records and accounts for all opioids, as well as other narcotics, controlled drugs, benzodiazepines and targeted substances, that are kept on-site. The register should

also be kept in a secure area in the office, preferably with the drugs, and reconciled on a regular basis.

Whenever drugs in the above-mentioned classes are used or dispensed, a record containing the name of the patient, the quantity used or dispensed, and the date should be entered in the register for each drug. Each entry should be initialled or attributable to the person who made the entry. In addition, this same information should be recorded in the patient record, along with any instructions for use.

When dispensing monitored drugs for home use by patients, dentists are also required to record an identifying number for the patient and the type of identifying number it is in the drug register, as well as in the patient record.

Dentists are required to report within 10 days of discovery the loss or theft from their office of controlled substances, including opioids and other narcotics to the Office of Controlled Substances, Federal Minister of Health.

Staff Education

Dentists should use staff training sessions and meetings to discuss the dangers of drug and substance abuse, to remind staff of the safeguards and protocols in the office to prevent misuse of supplies, and to provide information about resources that are available to dental professionals to assist with wellness issues.

It should be emphasized that there is no provision for dentists or their staff to access in-office supplies of opioids or other drugs that normally require a prescription for their own use or by their family members.

Dentists should take reasonable precautions to prevent the unauthorized use of in-office supplies of opioids or other drugs by staff and other individuals with access to the office.

Appendix 1

SCREENING TOOLS: THE CAGE-AID QUESTIONNAIRE AND THE OPIOID RISK TOOL

THE CAGE QUESTIONNAIRE ADAPTED TO INCLUDE DRUGS (CAGE-AID)
1. Have you felt you ought to cut down on your drinking or drug use?
2. Have people annoyed you by criticizing your drinking or drug use?
3. Have you felt bad or guilty about your drinking or drug use?
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)?
Score: _____ /4 2/4 or greater = positive CAGE, further evaluation is indicated

Attribution: Wisconsin Medical Journal. Brown, R.L. & Rounds, L.A. (1995). Conjoint screening questionnaires for alcohol and drug abuse. Wisconsin Medical Journal, 94,135–140.

OPIOID RISK TOOL		
	Female	Male
Family history of substance abuse		
– Alcohol	<input type="checkbox"/> 1	<input type="checkbox"/> 3
– Illegal drugs	<input type="checkbox"/> 2	<input type="checkbox"/> 3
– Prescription drugs	<input type="checkbox"/> 4	<input type="checkbox"/> 4
Personal history of substance abuse		
– Alcohol	<input type="checkbox"/> 3	<input type="checkbox"/> 3
– Illegal drugs	<input type="checkbox"/> 4	<input type="checkbox"/> 4
– Prescription drugs	<input type="checkbox"/> 5	<input type="checkbox"/> 5
Age (mark box if between 16 and 45)	<input type="checkbox"/> 1	<input type="checkbox"/> 1
History of preadolescent sexual abuse	<input type="checkbox"/> 3	<input type="checkbox"/> 0
Psychological disease		
– Attention deficit disorder, obsessive-compulsive disorder, bipolar, schizophrenia	<input type="checkbox"/> 2	<input type="checkbox"/> 2
– Depression	<input type="checkbox"/> 1	<input type="checkbox"/> 1
Scoring: Low risk: 0–3 points Moderate: 4–7 points High: 8+ points		

Attribution: Lynn R. Webster, MD; Medical Director of Lifetree Medical, Inc., Salt Lake City, UT 84106

Appendix 2

ADDITIONAL RESOURCES AND REFERENCE MATERIALS AVAILABLE ON THE INTERNET

Are you thinking about taking opioids (painkillers) for your pain?, 2014

National Pain Centre, McMaster University

<http://nationalpaincentre.mcmaster.ca/documents/AreYouThinkingAboutTakingOpioidsEnglishJan2014.pdf>

Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain, 2010

National Pain Centre, McMaster University

<http://nationalpaincentre.mcmaster.ca/opioid/>

Controlled Drugs and Substances Act, 1996

Government of Canada

<http://laws-lois.justice.gc.ca/eng/acts/c-38.8/>

Diagnosis & Management of Temporomandibular Disorders & Related Musculoskeletal Disorders (Guidelines), 2009

Royal College of Dental Surgeons of Ontario

<http://www.rcdso.org/save.aspx?id=67cf07e5-ee36-4f7d-a45f-57ce198ba0d5>

Health Care Connect

Government of Ontario, Ministry of Health and Long-Term Care

<http://www.health.gov.on.ca/en/ms/healthcareconnect/public/>

Narcotics Safety and Awareness Act, 2010

Government of Ontario

http://www.e-laws.gov.on.ca/html/source/statutes/english/2010/elaws_src_s10022_e.htm

Ontario's Narcotic Strategy

Government of Ontario, Ministry of Health and Long-Term Care

<http://www.health.gov.on.ca/en/pro/programs/drugs/ons/>

Prescribing Drugs (Policy Statement # 8 – 12), 2012

College of Physicians and Surgeons of Ontario

http://www.cpso.on.ca/CPSO/media/uploadedfiles/policies/policies/policyitems/prescribing_drugs.pdf?ext=.pdf

Unintended Consequences: Sometimes medications end up in unusual places... Like Trail Mix Parties, 2014

National Pain Centre, McMaster University

<http://nationalpaincentre.mcmaster.ca/documents/UnintendedConsequencesJan2014.pdf>

<http://nationalpaincentre.mcmaster.ca/documents/UnintendedConsequencesAug2012.pdf>

Youth and prescription painkillers: What parents need to know, 2013

Centre for Addiction and Mental Health

http://knowledgex.camh.net/amhspecialists/resources_families/Documents/YouthandMisuse%20E.pdf



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