Prescription Drug Abuse and Prevention

America is in the midst of a prescription opioid epidemic. It is estimated that 6.5 million Americans and 2.5% of the population age 12 years and older are current nonmedical users of psychotherapeutic drugs. Of these, 4.3 million, or 66.2%, reported the use of pain relievers for nonmedical purposes.\(^1\)

As oral and maxillofacial surgeons (OMSs) and lawful prescription drug prescribers, we know that when used as prescribed, prescription opiates enable individuals with acute and chronic pain to lead productive lives and recover more comfortably from invasive procedures. We also recognize, however, that acute pain medication prescribed following oral and maxillofacial surgery may frequently be the first exposure many American adolescents have to opioid prescriptions, and that roughly 12% of all immediate release opioid prescriptions in the US are related to dental procedures.\(^2\) Dentists, including OMSs who primarily manage acute pain, have a responsibility to ensure we do not exacerbate a growing public health risk while ensuring our patients receive the relief they need following complex dental procedures.

Over the past decade, a number of approaches have been proposed to address this issue. The AAOMS provides the following positions in response to several of these proposals.

**Prescription Drug Monitoring Programs**

Prescription drug monitoring programs (PDMPs), if properly funded, implemented and updated by dispensers, are valuable tools for detecting a practice known as “doctor-shopping” and preventing the diversion of prescription opioids. AAOMS believes that federal and state efforts to develop these programs should be supported and properly funded. AAOMS further believes that in order to prove useful in preventing abuse and diversion, dispensers should enter data into a PDMP in real time. In addition, if the prescription is for a period of less than 7-days, it should not be mandatory to check a PDMP for acute pain patients who receive an opioid following an invasive surgical procedure, as the risk of abuse and diversion is low in these instances. Furthermore, because checking the PDMP is an administrative task, the AAOMS believes that approved auxiliary personnel should be authorized to access the system on the doctor’s behalf.

**Continuing Education**

The training received during their residencies implicitly qualifies OMSs to manage their patients’ pain and in particular acute pain following invasive procedures. Nevertheless, AAOMS encourages our members to be aware of public health trends that may impact patient care and supports voluntary provider participation in continuing education (CE) programs that focus on drug abuse and responsible prescribing practice. AAOMS is working with the National Institute on Drug Abuse (NIDA) to develop an education course to help prescribers, including oral and maxillofacial surgeons, talk to adolescents about substance use and abuse. We also helped develop and encouraged our members to participate in the Substance Abuse and Mental Health Services Administration’s (SAMHSA) online training on “Safe Opioid Prescribing for Acute Dental Pain.” Prescribing, while important, is but a small part of the overall care that is provided to each patient. A significant increase in CE requirements in this one topic would be overly burdensome and could possibly prevent a practitioner from obtaining needed CE in other critical areas of patient care. AAOMS believes that to be most effective, CE should be managed at the state level and be customized so that it is relevant to each type of prescribing situation. AAOMS further believes that provider specialty organizations, such as the AAOMS, should be included as accepted practitioner training organizations for CE requirements. Finally, there remains a need beyond prescriber CE to educate patients and the public at large about opioid abuse and diversion. AAOMS supports such collaborative education efforts that include governmental agencies, non-profit organizations and prescriber organizations.
Prescribing Guidelines

The AAOMS appreciates the development of prescribing guidelines, which may be helpful to some practitioners as they determine the proper course of post-operative treatment for their patients. AAOMS recognizes and encourages our members who provide chronic pain management to consider the CDC Guideline for Prescribing Opioids for Chronic Pain. AAOMS also supports efforts currently underway by several OMS residency training programs to develop and utilize acute prescribing guidelines. If government entities seek to develop prescribing guidelines, we encourage them to recognize the unique care provided by OMSs by involving them in the development process, and to avoid a one-size-fits-all approach as patient pain management needs vary from patient to patient. AAOMS encourages provider and/or patient discretion by allowing them to partially fill a prescription with the option to acquire the remaining amount only when necessary. Implementation of such a practice will not only reduce the risk of a patient’s overdose or addiction, but also significantly lessen the risk of diversion of unused medications. AAOMS also supports additional pain management strategies, such as the use of long-acting local anesthetics during surgery of the dentoalveolar complex and nonsteroidal anti-inflammatory drugs (NSAIDS) either preoperatively and/or postoperatively for acute pain control in conjunction with the judicious use of opioids or as a substitute.

Supporting Practitioner Judgement

Only the treating practitioner, not subjective policy, can determine a patient’s medical needs. It is the position of the AAOMS that the patient-practitioner relationship must be upheld, allowing the practitioner to have the final say regarding the management of a patient’s pain including drug types, dosage and treatment duration. Practitioners should be informed of the latest public health trends, including possible alternatives to opioid pain treatment; but in the end, practitioners should be trusted to treat their patients according to their best professional judgement. As with any issue, should a practitioner be shown to be practicing contrary to the standard of care, the practitioner should be referred first for peer review, followed by prescription writing counseling/continuing education and then, if necessary, punitive remediation.

References:

2. JADA. July 2011; 142(7): 800–810.
3. CDC Guideline for Prescription Opioids for Chronic Pain. Recommendations and Reports. 65(1); 1-49. March 2016.

Reaffirmed March 2017, AAOMS Committee on Government Affairs

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