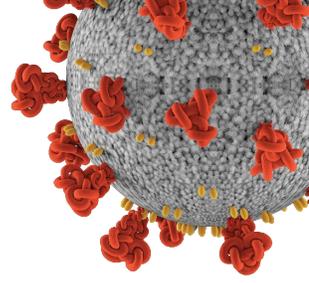


Peer-to-peer Perspectives in the COVID-19 Era

Sedation for Emergency Extractions

Sept. 10, 2021



Concerned surgeon

My state has an emergent/urgent treatment-only restriction active in response to COVID-19. What should I do if a patient presents with a painful, swollen, infected #31, temperature 37° C, no coronavirus exposure risk and requests sedation for the emergency extraction? Testing is not available.

Against sedation use at this time

Patients presenting to OMSs with complaints and dental surgical needs in the time of COVID-19 during a government-mandated restriction should be assessed and managed with consideration of the ADA treatment guidelines and the general concept of limiting risk of spread of the SARS-CoV-2 virus. This patient clearly qualifies for immediate surgical treatment, but anesthesia services are questionable.

Nonsurgical management with appropriate antibiotic and analgesic therapy should be considered if, based on the OMS's judgment, there is significant likelihood that it may provide resolution of the acute infection.

Nonsurgical management also may be preferred if the patient has an increased risk of morbidity or mortality associated with coronavirus infection to avoid unintentionally exposing the patient.

If immediate surgical management is preferred, then potential for aerosol generation and anesthetic technique should be considered. Rotary handpiece use with irrigation creates aerosols that will contain viral particles if the patient is an asymptomatic carrier. If there is a potential need for rotary drill use, there must be availability of appropriate PPE and environmental infection control measures. The indications for ambulatory sedation are to improve comfort and tolerance of dental procedures. Dental anxiety is one of the most common fears, and although office-based OMS operator-administered anesthesia is extremely safe, there are multiple sources for further aerosol generation.

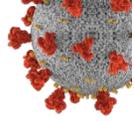
Additionally, there is an extremely small, albeit real, chance of complications requiring hospitalization. Supplemental oxygen flow from a nasal cannula or nasal hood and positive pressure ventilation, supraglottic device placement or intubation also may cause sputum and respiratory secretions containing viral particles to be aerosolized. In addition to viral spread, there also is a concern for appropriate NPO status when a patient presents without advance notice where preoperative instructions would otherwise have been given.

Anesthesia services also require an additional person to accompany the patient as an escort, potentially exposing another person to the presence of unknown viral particles. To limit the potential spread of the virus, sedation services should generally not be provided – and even nitrous oxide administration should be used with caution. Behavioral management techniques should be performed as much as possible to alleviate the patient's fear and anxiety during emergent treatment.

Supportive of sedation in certain circumstances

As states relax mandates related to elective surgeries, OMSs are rapidly entering yet another period of uncertainty. Ethical considerations are likely to challenge society. The first challenge could be called the “Monday morning quarterback.” This pertains to how OMSs judge colleagues regarding their decisions during mandated practice limitation periods set forth by local authorities.

Another challenge pertains to how OMSs perform during the intermediary period when they do not have rapid point-of-care testing for SARS-CoV-2, or a vaccine has not been developed. This will likely provide another opportunity to judge colleagues' decisions until, as a collective society, a zenith of practice is reached where OMSs have confidence in the information available to perform their craft



in a manner that is universally accepted as safe, conscientious and evidence-based to an acceptable degree of certainty.

What do OMSs do until then?

This is a difficult question – and without sounding cliché – it is complicated.

In a recent AAOMS webcast, Dr. Tom Dodson emphasized the risk versus uncertainty when considering the potential for being infected by SARS-CoV-2. More importantly, he emphasized “local conditions” and “situational appropriate assumptions.” While surgeons have vastly differing perspectives, it would behoove all to remember the importance of local conditions and situational-appropriate assumptions. The decisions made in New York City, Seattle and New Orleans may vary drastically with the decisions made in a rural part of a state where there may be 10 counties with either zero or one COVID-19-positive patient.

From the perspective of reducing exposure risk to the OMS team members, the decision to sedate is based on an assessment of the ability to comfortably administer local anesthetic effectively and to perform the necessary procedure. If a procedure could be performed faster with sedation, then that also is a consideration. If an infected site will be difficult to achieve profound local anesthesia, then there may be an indication to consider sedation. If the patient would have a difficult time mentally tolerating what needs to be done, then sedation may be considered.

Hyperventilating, crying (i.e., increased nasopharyngeal secretions) or loudly verbalizing, distressed patients who exude higher volumes of respiratory droplets toward breathing spaces are not without an increased risk of viral spread. There are reasonable anesthetic considerations that are not only appropriate but arguably decrease the risk the procedure poses to the well-being of OMS team members.

Take into consideration the patient who lives in a remote and underserved area of the state and has significant pain and swelling from a partially erupted third molar. She drives an hour to the nearest medium-sized town and visits the ER. The local OMS is called and is unable to see her because she is unable to pay. The patient is then transferred to another emergency department in the nearest metropolitan area. A local OMS agrees to see her at the office. She arrives NPO, is sedated and has her painful third molar and the other three impacted third molars removed. One is asymptomatic while the remaining two were asymptomatic but grossly carious. The judgment was that one anesthetic and one surgery was the best option even though only one third molar was considered an urgent procedure.

The information provided in this document is intended for educational purposes only. In no event shall AAOMS be liable for any decision made or action taken or not taken by anyone in reliance on the information contained in this resource. For practice, financial, accounting, legal or other professional advice, professional advisers should be consulted.

© American Association of Oral and Maxillofacial Surgeons, 2021