NJ Dental Society of Anesthesiology Newsletter

Volume 1 Issue 2 Fall 1995

Autumn Meeting of NJDSA Scheduled

By Robert G Kroll, D.D.S.

Our semi-annual gathering at the Grand Marquis in Old Bridge comes around once again. Yes, it's fall meeting time, and the chosen date is October 11, 1995.

I believe that our speaker, Douglass L. Jackson, D.M.D., M.S., from the University of Minnesota will offer an approach to anesthesiology and pain control from a different and refreshing angle. Dr. Jackson was a research fellow in the Laboratory of Neuropharmacology and is with the Departments of Oral Biology and Restorative Sciences at the University.

The topics on which he will be speaking are:

The Pharmacology of Postoperative Pain Management

A Review of Current and Future Strategies

Diagnosis and Non-Surgical Management of Chronic Orofacial Pain

From his appearances at the scene of the ADSA annual meetings, I have observed Dr. Jackson to be an informed and enthusiastic individual and am looking forward to his visit with us.

In addition, we can expect our usual continental breakfast, a superb lunch, and an expanded group of exhibitors.
Refer to the flier from our component for details as to registration and travel directions.

Tid-Bits From the Central Office at ADSA

Chris LoFrisco, the Executive Director, formerly from Freehold, has been busy organizing the new office headquarters of the ADSA. He tells me:

- We will be represented among a number of organizations meeting at the American Dental Association annual session next

month regarding the safety and regulatory requirements pertaining to the administration of nitrous oxide.

- The ADSA along with the ADA, the AAOMS, the AGD, the AAPD, and the AAP as well as others are attempting to adopt model state regulations for the administration of parenteral conscious sedation. This meeting is scheduled for some time after the ADA annual session.

- The third ADSA Cruise Review Course is set for January 27 to February 7, 1996. The cruise departs from Acapulco with various stops including the Panama Canal. More information is available from the Central Office 800-722-7788 or Aero Travel at 800-733-3084.

- The Winter Review Course is scheduled President's Week at Park City, Utah.

Opportunity Available

The Center for Treatment of the Handicapped had been established at the UMDNJ-New Jersey Dental School eighteen months ago. The Center has functioned not only in the treatment of special patients, but also in providing education for the staff and students. It would now like to expand its services with the addition of a part-time (2 days per week) staff dentist. That person will provide regular services with and without conscious sedation in our department. and treatment under general anesthesia in the adjoining University Hospital.

Qualifications for the position are:

1. Must be licensed to practice dentistry in New Jersey.
2. Must be certified in parenteral conscious sedation.
3. Training, experience and competency in the administration of intravenous and/or gaseous analgesia.
4. Demonstrated ability to successfully manage a broad segment of dental problems for the handicapped.
5. Experience performing dental treatment under general anesthesia in the operating room environment.

If interested, contact Dr. Milton Houpt, Professor and Chairman, Department of Pediatric Dentistry at 201-982-4622 or Dr. Robert Kroll or Dr. Justin Stone at 201-982-7040.

Editor's Addendum

Looking around oft times turns up interesting and reassuring information. Perusal of an abstract that appeared in the Journal of Plast Reconstr Surg 1994 Apr; 93(4): 792 -801 by Courtiss EH, Goldwyn RM, Joffe JM, and Hannenberg AA titled *Anesthetic practices in ambulatory aesthetic surgery relates very closely to what dentists have been doing for years.*

A poll of the American Society for Aesthetic Plastic Surgery brought a response from 76.6% of the members. More than 50% operate in their offices half or more of the time. About one-half never perform aesthetic surgery in the hospital. Local anesthesia with intravenous sedation is widely used in all settings. When employed for office surgery, neither a nurse anesthetist nor an anesthesiologist is present about one third of the time. General anesthesia is used in half of the office surgical units and is administered by dedicated anesthesia personnel. Half the time by an anesthesiologist and half by a nurse anesthetist. Methods of patient monitoring are

similar in the office, in the hospital, and in the free-standing ambulatory surgical facility. Preoperative laboratory evaluation, monitoring, and use of anesthetic agents are similar regardless of the surgical setting.

* * * * * *

For those oral surgeons who may have overlooked the article by Kaufman E, Sheinkman Z, and Magora F. titled *Comparison between intranasal and intravenous midazolam sedation (with or without patient control) in a dental phobia clinic* which appeared in the J Oral Maxillofac Surg 1994 Aug; 52(8): 840-4

Alternative choices for anesthetic management have been presented. Patient controlled sedation (PCS) and intranasal sedation (INS) were compared with the traditional bolus intravenous sedation (BIVS). Appropriate local anesthetic nerve blocks with 2% lidocaine with 1:100,000 epinephrine supplemented with nitrous oxide-oxygen via a nasal mask were given to all patients. The PCS patients received midazolam intravenously through a patient-controlled analgesia pump; the INS patients intranasally; and the BIVS patients 1 mg. boluses as needed. The dosage requirement with PCS was higher than with INS or BIVS. PCS produced more anxiety reduction and was more effective in reducing interfering movements during treatment. No complications were detected in any of the patients.

* * * * * *

A word of caution is sounded by Greco RJ, Johnson P, Scolieri M, Rekhopf PG, and Heckler F in the journal Plast Reconstr Surg 1995 May; 95(6) : 978-84 where they discuss *Potential dangers of oxygen supplementation during facial surgery.*

The use of local anesthesia and intravenous sedation procedures often include the use of supplemental oxygen.
Oxygen- enriched environments increase the combustibility of most materials, and "oxygen-pooling" has been suspected to play an integral role in intraoperative fires.
The authors refer to a personal experience with an intraoperative explosion and fire during a cosmetic blepharoplasty. They noted that the oxygen concentration under surgical drapes consistently reached levels as high as 53.5% compared to that of ambient air (20.9%).
Several suggestions are offered to dilute these concentrations, particularly prior to the use of a possible ignition source.

(Early on we have been alerted to the dangers of using oil on oxygen equipment, particularly under pressure. Let's remember that there are many oil glands around the face and nose and that a rotating bur or cautery unit can be a source of ignition. editor note) .

* * * *

Examining collaborative relationships between anesthesiologists and certified registered nurse *anesthetists in nurse anesthesia educational programs.*
Jorgensen, K.A. and Chamings, P.A.
AANA Journal 62(2):139-48, 1994 Apr.
In a study of collaborative perceptions that Certified Registered Nurse Anesthetists (CRNAs) and anesthesiologists have of each other in nurse anesthesia educational programs, data reflected unequal relationships between CRNAs and anesthesiologists regarding shared responsibility in healthcare decision making. Conclusions from this study show definite philosophical and politicalissues that impact on nurse anesthesia education that can be destructive to these programs as well as to the entire field of anesthesiology. These practices could be indicative of critical deficiencies in the education and clinical practice of both providers. Efforts must be made at all levels to establish better relationships between CRNAs and anesthesiologists.

New Jersey Dental Society of
Anesthesiology
Robert G. Kroll, D.D.S., Editor
90 Cedar Street
Millburn, NJ 07041