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Regarding Out of Office Benzodiazepine Usage

1 message

Jay Littlefield <jaylittlefield09@gmail.com> Fri, Oct 2, 2020 at 2:36 PM
To: stakeholders@tsbde.texas.gov

Dear Board and Stakeholders,

I am writing to provide input on the proposed changes to benzodiazepine usage, specifically, Triazolam.

I am a general dentist representing myself who has been practicing for over 7 years in the State of Texas. I perform minimal conscious level I sedation only and do not provide IV sedation. I will be unable to provide higher levels of sedation due to: 1. There are no courses for graduated dentists to pursue a level II license (I asked around and no one has a course (Canfield, Luce, DOCs, etc..)) 2. IV sedation is just simply not feasible due to the greatly increased requirements,including CE, supplies, and staff.

I have been using Oral Conscious sedation for 7 years with Triazolam exclusively, exactly as was taught at my sedation training courses (the required courses the state board already made mandatory). To this date, I have had no adverse outcomes related to the pre or intraoperative sedation given to my patients, and I have completed well over 400 minimal oral sedation cases. It has proven to be an extremely successful drug for both myself and my patients, and allows me to perform safer, faster dentistry on anxious patients.

I am writing to strongly oppose the board's position to eliminate our ability to prescribe triazolam outside of the office before a visit. The reasons are listed below.

1. As was stated by the board members themselves, there is a complete lack of "adverse outcomes" documented with preoperative prescribing/administration of Triazolam. Why are we creating a solution to a problem that does not exist? One of the members stated that he was aware of a case where a patient took medications preoperatively and was involved in an vehicular accident. This is an understandable risk with preoperative prescribing, however, ALL training that I have ever taken emphasizes the importance of ALWAYS, and without exception, requiring patients to have a driver should they take any medications preoperatively. All of our consent forms and all of our language strongly emphasizes this aspect of the sedation. We do not instruct any patients to take medications preoperatively unless we have a name and phone number for their driver. Furthermore, eliminating our ability to prescribe and have patients take medications before a visit has no bearing on whether patient's will listen to our instructions. If we prescribe the medications and a patient willfully takes the meds before or decides to drive themselves, when they have been explicitly told not to, we cannot be reasonably liable for patients' poor decisions. Please do not punish the 99.99% of responsible patients who can follow instructions as directed for preoperative administration.

2. Triazolam is exceptionally safe and has a relatively consistent onset of action. Several of the board members themselves admitted to prescribing and instructing patients to take triazolam prior to their visit, with no known adverse consequences. For the first two years of my career, I administered all oral sedation in office; however, after the first 100 sedations (approx), I realized that the patients were simply all sitting in the room and we were waiting around for the medications to take effect for an hour or more What I realized is that many of these anxious patients were simply getting MORE anxious waiting around in the office. Bringing the patient to the source of their fear and then having them sit in the dental chair lessens the effect of the oral sedation, in my opinion. Allowing them to take it prior to the visit, 45 minutes to an hour, greatly increases the efficacy and desirable effects of the medication.

3. Triazolam has the shortest half life of all of the benzodiazepine medications that are generally given for oral sedation (https://images.app.goo.gl/eC9Z2uoaUeG9jExD9). If administration of Triazolam preoperatively is eliminated, many doctors will switch to another medication. The unintended consequences of this will be that patients will have drugs in their system for a much longer period of time (e.g Diazepam or Lorazepam). In my opinion, increasing the length of the sedative period for some individuals , such as an older individual where metabolism may be delayed, can extend the half life into the next day if treatment was completed in the afternoon, creating a greater risk for driving or fall complications. Our best bet is to have the patient take the medication with the shortest half life and fastest onset to get them to a sedated state and monitor them very closely during the maximum effect of the drug.

4. Every patient is different. I can think of many patients who have taken Triazolam preoperatively, and they do not reach a minimally sedated state (or even an anxiolytic state) until 1.5-2 hours later. This is not the norm of course, but the only alternative if this is passed, would be to have the patient sit around in the office for 2 hours until they reach a comfortable

level. This is neither practical nor economically feasible. I know of few offices who have the manpower or chairs to let patients sit, unproductively, for 2 hours. I can think of very few who were significantly affected prior to 45minutes/1 hour. The counterpoint to this is that one should be trained and do IV sedation. This is a weak argument- IV sedation training is exceptionally expensive and rather than have doctors rushing to do a poor job monitoring patients under IV sedation for a filling or two, it is far more feasible AND safer to allow administration of preoperative Triazolam for the patient. The cost to administer IV sedation is considerably higher for the patient and this will actually deter many patients from getting the work done in the first place. Additionally, because I live in a rural area, I do not have easy access to a dental anesthesiologist to come to my office. The cost for IV sedation is at least 4-5 fold the cost for oral sedation when I have inquired in the past. This is not a barrier for the doctor, but is a barrier for MANY patients in low income areas like my own.

5. Covid- having patient's come to a public place of business and wait around for a few hours for sedation to kick in, whilst aerosols are being created around them (even if wearing a mask), seems to be a recipe for disaster in my opinion. Our goal, post covid, is to get patients into and out of the office as quickly and efficiently as possible to minimize their time in a public space.

6. Triazolam, whilst technically being used off label for minimal sedation, is often prescribed by physicians as a sleep aid for insomnia. There are many patients of all ages and risk factors taking triazolam as a sleeping aid completely unmonitored. There is not (to my knowledge) a large number of adverse reactions to Triazolam as a sleep aid. Surely if patients are taking a medication alone at home (even if at a different dose) on a nightly basis it can be safely given in the daytime while being monitored by a driver and then fully trained medical professional.

What I would suggest, in lieu of eliminating our ability to prescribe/administer preoperative medications (precisely, those medications taken before a visit), is to have ALL doctors who prescribe triazolam preoperatively or at the office have a sedation license. The main concerns, based on my observation of the meeting prior, were that some doctors were prescribing Triazolam preoperatively without a minimal sedation license. This is easy to fix- require all preoperative administrators to have a minimal sedation license and therefore the required training associated with that.

I thank you for your time and consideration.

Respectfully,
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