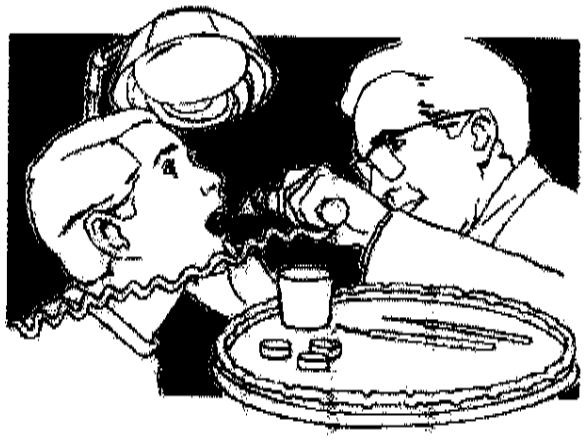

Company Name
Address
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TMJ/ Sleep Apnea Therapy and Research Center
Michael T. Montgomery, D.D.S.
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To TSBDE Stakeholders Meeting on Benzo-Digepins
Fax 512-649-2482
Date 9-26-20
From Michael Montgomery
Pages 3
Email cybermike0@sbcglobal.net

Message

*Your email address does not work (that you sent on the email notification)

TMJ, Facial Pain and Sleep Apnea Center
Michael T. Montgomery, D.D.S.
7551 Callaghan Road, Ste. 210
San Antonio, Texas 78229

9/25/20

I am a dentist whose practice is devoted to facial pain, TMD and sleep apnea. My practice is 25 years old and I taught full time for 14 years. I am a Diplomate of the American Board of Orofacial Pain, a Fellow in the American Academy of Orofacial Pain and have worked in Facial Pain Clinics at two Dental Schools. Insomnia is a significant co-morbidity for bruxism, which is the most common etiologic factor for TMD and a sequela of Obstructive Sleep Apnea (OSA). I use benzodiazepines (mainly Clonazepam, beginning at the lowest dose (.5 mg) and escalating until sleep quality and quantity is normal) or until a maximum dose is reached (2mg). This is my medicine of choice to treat non-obstructive insomnia. The medicine is used at bedtime for sleep and its value is low cost, the ability to titrate to effect, a well matched duration for a sleep cycle, the ability to meet the demands of various degrees of insomnia and minimal side-effects My patients' insomnia is usually chronic and significant in severity, hence, mild over-the-counter meds are usually ineffective and alternative prescription hypnotic medications such as Lunesta and Ambien CR are not generic, hence result in significant cost to the patient. I understand that benzodiazepines are addictive, but using the medications solely at night minimizes abuse. Any medication that improves sleep, whether addictive or not, will result in rebound insomnia which does not imply addiction. In all my years of practice, I cannot recall a patient abusing a hypnotic agent and I have many patients on benzodiazepines for hypnosis, many of these patients have been taking the medications for years. Tolerance and escalation of dose is also something I have not observed. I use the prescription monitoring (PMP) as directed on all patients. Uncommonly, we will use a mild anti-anxiety med such as alpraxolam for significant anxiety-induced diurnal bruxism. These medications are within the scope of my practice and I will vigorously resist any efforts to restrict my practice, which I feel represents an unlawful restriction of trade. Along these lines, I have had numerous encounters with pharmacists, who have questioned my prescriptions and at times have refused to fill them. I have turned all of these pharmacists into their state boards (Texas Board of Pharmacy) and sent complaints to the company corporate headquarters and to their store managers. Instructing pharmacists to determine the appropriateness of medications for all of the specialties and subspecialties of medicine and dentistry is incomprehensible. Such errant jurisdiction suggests that well intentioned efforts to minimize prescription drug abuse is unnecessarily impairing patient care.

Given this history, I am concerned over the legitimacy of the genesis of this discussion, as dentists already have been recently subjected to more stringent regulations concerning the prescription of controlled substances (PMP and additional C-E). It is hard to comprehend that additional measures are either needed or will be fruitful.

Sincerely,
Michael Montgomery
Michael Montgomery, D.D.S.