Almost **89** Americans die each day from prescription opioid overdoses

Up to **12%** of patients develop opioid use disorder after being prescribed opioids

Adolescents prescribed opioids are **33% more likely** to misuse opioids later in life

The majority of opioids prescribed to adolescents for surgical dental extractions are not used

Nearly **80%** of heroin users started by misusing prescription opioids

Prescription opioid misuse costs the U.S. **$78.5 billion** each year

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**PRESCRIPTION OPIOIDS
A GROWING PUBLIC HEALTH CRISIS**

Medical and dental providers have relied on opioids to help treat acute and chronic pain, but misuse and abuse of opioids have become significant public health issues. Patients exposed to opioids are at increased risk of developing physical tolerance, dependence, addiction, and death from overdose. Nationally, deaths from opioid overdose have been increasing across all regions and demographics, and accounted for 66% of all overdose deaths in 2016. In particular, the rate of overdose deaths from prescription opioids increased by more than 11% in one year.

Many factors contribute to the opioid epidemic, but medical and dental providers have a critical role in reducing unnecessary and potentially harmful exposure to opioids. Dental providers in particular are essential to mitigating exposure in adolescents—dentists are the most frequent prescribers of opioids for adolescents. Adolescents prescribed opioids are 33% more likely to misuse opioids later in life. Additionally, the majority of opioids prescribed to adolescents for surgical dental extractions are unused, and leftover prescription opioids fuel non-medical use.

In the absence of a Centers for Disease Control and Prevention (CDC) guideline for opioid prescribing for acute pain, the American Dental Association (ADA) recommends that dental providers follow relevant guidance in the CDC’s chronic pain guideline. Current clinical recommendations are to use non-opioid analgesics as first-line therapy to reduce unnecessary exposure to opioids and mitigate long-term harms. The ADA has a range of resources available for providers and patients related to opioid prescribing and use on its website.
NON-OPIOID ANALGESICS

In 2016, the CDC released guidelines for clinicians prescribing opioids, suggesting a variety of tactics to reduce patient reliance on opioids, including the management of non-cancer pain with non-opioid pharmacological treatment. Non-opioid analgesics are a potential alternative to opioids for effectively managing pain and potentially cause fewer side effects with a lower risk of addiction.

Non-opioid analgesics provide an alternative pain management strategy, and current evidence suggests comparable pain reduction to opioids. Additionally, there is some evidence of improved physical function for patients using non-opioid analgesics compared to those using opioids. Research specific to oral surgery has found that non-steroidal anti-inflammatory drugs (NSAIDs) were either similar or more effective at reducing patients' pain, and resulted in fewer adverse events. This means that patients are able to manage pain with non-opioid medications similarly to opioids, with potentially better physical function.

Despite the advantages of non-opioid analgesics, they are not without risks. For example, the use of NSAIDs can damage the gastrointestinal tract, and acetaminophen presents risk of toxicity and liver damage. It is critical that providers evaluate patients’ medical history and weigh the analgesic benefits against the potential harms for any pain medications considered.

Current evidence and clinical guidelines from the ADA and CDC recommend that dental providers consider use of non-opioid analgesics as a first-line pain management strategy. These guidelines also suggest that dental providers consider prescribing combinations of NSAIDs and acetaminophen for oral surgery pain, including use of medications immediately prior to surgery, unless contraindicated. Contraindications include, but are not limited to:

- **NSAIDs**: Known drug hypersensitivity, history of gastrointestinal bleeding, aspirin-sensitivity asthma, severe renal disease
- **Acetaminophen**: Known drug hypersensitivity, severe liver disease related to high doses

Current guidelines note that providers should adjust dosing for patients with renal impairment and those who consume more than two alcoholic drinks per day. Providers may also refer patients to the FDA's Taking Acetaminophen Safely video for additional information. In the event that an opioid prescription is warranted, the following guidance has been adopted from the CDC's 2016 Guideline for Prescribing Opioids for Chronic Pain and the Bree Collaborative's Dental Guideline on Prescribing Opioids for Acute Pain Management.

**Non-Opioid Analgesics**

- Acetaminophen

**Common NSAIDs**

- Aspirin
- Celecoxib
- Diclofenac*
- Etodolac
- Fenoprofen*
- Ibuprofen
- Indomethacin
- Ketoprofen*
- Ketorolac
- Meclofenamate**
- Mefenamic acid
- Naproxen
- Piroxicam

* Approved for adult use only
** Not approved for use in patients under 14 years old

**MANAGING SEVERE PAIN**

The current evidence base supports clinical recommendations for use of non-opioid analgesics for first-line therapy to manage acute pain, including pain from surgical dental procedures. Patients experiencing severe pain that cannot be effectively treated with non-opioid medications and/or short-term opioids should be seen and evaluated for alternative treatment strategies. The ADA has resources and the CDC provides guidelines for managing chronic non-cancer pain.
Based on current evidence and clinical guidelines, dental providers should only consider opioids if the expected benefits for pain management and function outweigh the risks. If use of opioids is warranted, clinical guidelines recommend discussing potential risks and treatment expectations with patients using plain-language and easily understood patient education tools—including considerations of culturally appropriate messages and patients’ health literacy needs. Discussions may include the risk of combining opioids with other medications, illicit drugs, or alcohol, and what to do with unused medications. The Bree Collaborative asserts that opioids should not be prescribed if a patient or parent has stated they do not want an opioid prescription. Clinical guidelines recommend the following approach to opioid prescribing:

**EVALUATE** treatment goals and your patient for current or past use of opioids, benzodiazepines, sedative-hypnotics, and anxiolytics. This includes checking your state’s prescription drug monitoring program, if applicable.

**COORDINATE** care with other providers if your patient has been or is currently prescribed opioids, benzodiazepines, sedative-hypnotics, or anxiolytics.

**ASSESS** your patient for a history of substance use disorder and risk of relapse.

**COMMUNICATE** treatment goals, expectations, and potential risks with patients. Consider providing written guidance or other patient education materials.

The decision process to the right is an example of how the CDC and Bree Collaborative clinical guidelines may inform opioid prescribing and is not a clinical recommendation.

*Based on guidelines from the CDC and Bree Collaborative*
If opioids are determined to be the most appropriate pain management strategy for a patient, the following considerations from the CDC and Bree Collaborative clinical guidelines may help guide prescribing during dental preoperative, intraoperative, and postoperative periods. As per current clinical recommendations, dental providers should aim to prescribe opioids in the lowest effective dose and quantity necessary—recognizing that a 3-day supply is usually sufficient, and more than 7 days is almost never needed. The following is a summary of clinical recommendations from the Bree Collaborative and is not intended as a clinical guide. To access the full clinical recommendation, visit the Bree Collaborative website.

**PREOPERATIVE**

*Prescribe the lowest effective dose of opioids* and the lowest quantity necessary

*Do not exceed 12 opioid tablets* for people younger than 25 years undergoing minor oral surgery

*Avoid prescribing codeine or tramadol* to anyone under age 18, and do not prescribe to anyone under age 12

*Avoid multiple acetaminophen-containing preparations* when prescribing opioids in combination with non-opioid analgesics (acetaminophen can be hepatotoxic at more than 3 to 4 grams per day, or even less for patients with alcoholism or liver disease)

*Do not prescribe opioids in combination* with benzodiazepines, sedative-hypnotics, or anxiolytics

*Coordinate care* by checking your state’s prescription drug monitoring database (if available), and conferring with your patient’s primary care provider.

**INTRAOPERATIVE**

*Use preemptive analgesia* such as long-acting anesthetic injections, unless contraindicated

*Consider a corticosteroid burst* to reduce edema and pain after oral surgery; corticosteroid initiation has been studied most often in the intraoperative period, but has also been studied starting in the preoperative and postoperative periods

**POSTOPERATIVE**

*Prescribe the lowest effective dose of opioids* and the lowest quantity necessary

*Prescribe opioids in combination with first-line therapy*, avoiding multiple acetaminophen-containing preparations

*Do not exceed 12 opioid tablets* for people younger than 25 years undergoing minor oral surgery

*Avoid prescribing codeine or tramadol* to anyone under age 18, and do not prescribe to anyone under age 12

*Do not prescribe opioids in combination* with benzodiazepines, sedative-hypnotics, or anxiolytics

*Recommend* complementary pain management strategies such as ice on the affected area

*Discuss medication disposal* options with patients for any unused prescriptions.
REFERENCES


