J Oral Maxillofac Surg
77:2177-2178, 2019

Of Dry Sockets and Preemptive Opioids

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Removal of third molars is accompanied by the ever-present reality of patients occasionally developing localized alveolar osteitis—dry socket. Because telephone prescriptions for schedule II drugs are technically permitted but for practical purposes virtually impossible, should hydrocodone be provided to all patients at the time of surgery "just in case" symptoms of dry socket develop? If so, are you convinced that hydrocodone actually helps dry socket pain better than nonsteroidal anti-inflammatory drugs (NSAIDs), such as ibuprofen? Thirty-plus years of clinical experience in private practice have convinced me that oral analgesics are largely ineffective for dry socket and that localized treatment is the only satisfactory remedy for it—not just satisfactory but usually dramatic. If symptoms start on a weekend, and the patient already has hydrocodone, the patient might take it instead of "bothering" the oral-maxillofacial surgeon. In addition, although pain will usually continue mostly unabated despite the opioid, the patient (and referring dentist) might consider this acceptable. A willingness to meet patients after hours for localized care accompanies a philosophy of optimizing pain management. Would you want to see your own child suffer through a weekend with dry socket while taking hydrocodone with little or no relief, but with acceptance, because "after all, I have Vicodin"? A localized dressing would all but eliminate the pain, which might inconvenience the provider but would provide a superior outcome while avoiding the considerable risks of opioid usage.

Mounting evidence has indicated that exposure to prescription opioids, even from a first prescription, can precipitate abuse and addiction in the developing brain of the young patient. The brain has enhanced neuroplasticity during growth, which continues until about age 25 and can contribute to permanently altered brain chemistry after exposure to opioids; leaving the person forever predisposed to abuse and addiction.[1] Vicodin (hydrocodone-acetaminophen; Knoll Pharmaceutical Company, Whippany, NJ) is a gateway drug that can prime patients for future addictions according to the chief of addiction medicine at Stanford University School of Medicine.[1] She described her treatment of a heroin addict whose opioid abuse had started while he was an average upper-middle-class high school student after hydrocodone-acetaminophen had been prescribed by a dentist after third molar removal.[1] The first hydrocodone-acetaminophen he took triggered a desire to keep taking it, although his pain was tolerable without it. He soon found sources of illegal pills at school and online and changed to heroin as pills became more difficult to obtain even from the internet.[1] Findings in mid-2018 that a filled opioid prescription after third molar removal almost tripled the risk of persistent opioid use has raised concerns. These concerns paled a few months later with the report of a 15-fold increase in medically diagnosed opioid abuse-related disorders in patients aged 16 to 25 years receiving an opioid prescription from a dentist compared with that seen in controls not exposed to opioids.[2] Overall, just less than 6% of these adolescent and young adult patients developed a medically diagnosed opioid abuse problem within 12 months of receiving the opioid prescription and about two thirds of these abuse-related diagnoses were within 90 days.[2] No significant difference in persistent opioid use or abuse was seen for patients prescribed more than 20 pills compared with those prescribed 20 or fewer pills.[2] Persistent opioid use was found in 4.8% of surgical patients aged 13 to 21 years versus 0.1% of a nonsurgical comparison group.[3] In 2018, the Food and Drug Administration contraindicated the use of opioid-containing cough and cold remedies for patients younger than 18 years old, citing concerns of abuse and addiction in this vulnerable population. Those in our own specialty have publicly shared heartbreaking accounts of loved ones lost to opioid addictions that started with legitimate prescriptions to manage postoperative pain.[4,5]

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Conflict of Interest Disclosures: The author does not have any relevant financial relationship(s) with a commercial interest.

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Received June 2 2019
Accepted June 5 2019

0278-2391/19/30804-3
https://doi.org/10.1016/j.joms.2019.06.173

Consistent findings in the reported data have indicated that opioids are not as effective as NSAIDs—with or without acetaminophen—for treating acute dental pain; thereby providing an alternative superior to opioids. This supports a decision to all but eliminate opioids from office oral-maxillofacial surgery, although an evidence-based leap of faith might be necessary to break habits formed during dental school and residency. Pain management is a process, not just pills. A 2017 American Association of Oral and Maxillofacial Surgeons White Paper recommended NSAIDs for first-line analgesic therapy, along with a multimodal approach to pain management, and numerous adjuncts for managing pain after third molar removal that are available in the current data. Even if none of these adjuncts are used, the use of an NSAID remains the best evidence-based and safest first-line pharmacologic method of acute dental pain management.

If you provide an opioid prescription for breakthrough pain, are you clearly advocating NSAIDs to your patients, or are you recommending they use hydrocodone-acetaminophen in the first days after surgery by strongly implying or overtly stating that opioid is a better analgesic? The optimum effectiveness of an opioid-minimizing philosophy for third molar patients comes when the prescriber embraces the conclusion—and presents it to patients unequivocally—that opioids are not expected to provide an advantage over NSAIDs in managing acute dental pain. A provider's acceptance of the demonstrated efficacy of NSAIDs, coupled with a straightforward discussion about the risk of future misuse and addiction, will largely allay the dwindling concerns some patients might have about not being provided an opioid. In recent years, I have seen patients, and especially parents, increasingly resolute to eschew opioids altogether, before any conversation with me about pain management. Most are relieved to hear opioids are not part of my standard prescribing protocol.

The specter looms of encountering a referring dentist who, from a sincere protective instinct for their patients, questions one's decision not to prescribe opioids. If you are convinced opioids should not be made available—in any quantity—to the adolescent or young adult in any but the rarest and most unusual circumstances, are you willing to possibly forgo future referrals from a dentist who might consider routine opioids necessary for proper pain management? However, concerns about how a referring dentist perceives pain management and prescribing protocols are usually more imagined than real. Open and transparent dialog with referring dentists will help them understand a sincere commitment to provide the best and safest pain management for their patients.

Our primary focus is the safety of our patients. The message of opioid risk is reaching the public, and the same should hold true for the providers responsible for protecting it. Considering all we have learned in recent years, would prescribing hydrocodone for your 17-year-old daughter after third molar removal give you pause in any way? It would for me. It behooves us to make use of our current knowledge to best serve our patients.

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