

Is it Time to Relegate Routine Opioid Prescriptions to the Oral Surgery Archives?



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The end of the 1970s ushered in what became an accepted standard of care for most of medicine and dentistry, including oral and maxillofacial surgery: Hydrocodone with acetaminophen was introduced as Vicodin (Knoll Pharmaceutical, Whippany, NJ) in 1978 and rapidly embraced by providers to treat all types of pain. Curiously, centuries-old concerns about opioid addiction were largely set aside, and hydrocodone-acetaminophen combinations became the most-prescribed drugs in the United States by the early 2000s and remain in the top 10. However, it was aggressive and effective marketing by Big Pharma and other external forces, instead of valid supporting data, that prompted the routine prescription of opioids for acute pain.¹ Hydrocodone-acetaminophen became the gold standard for pain management after oral surgical procedures despite no references in the literature showing opioids were more effective than nonsteroidal anti-inflammatory drugs (NSAIDs), as well as failure of pharmaceutical manufacturers to substantiate marketing claims of the nonaddictive nature of their new opioid formulations.

Studies dating back to the 1980s, most using third molars for their pain model, have consistently shown the superiority of NSAIDs over opioids for acute dental pain management.² Will anything be accomplished by additional comparisons of opioids to NSAIDs for management of acute dental pain? Should more studies expose the vulnerable, neuroplastic brain of the adolescent and young adult patient to opioids in the interest of science? Would you feel comfortable with your child in the opioid group of another third molar pain study? Perhaps we should accept the general inferiority of opioids for dental analgesic effectiveness—along with their undesirable immediate side effects and risk of

abuse and addiction²—and set them aside for future third molar pain research. A focus on identifying the best combination of non-opioid pain management techniques (which include additional adjunctive treatments along with oral analgesics, as stated by the 2017 American Association of Oral and Maxillofacial Surgeons White Paper on opioid prescribing) would better serve our specialty and ultimately the public that depends on us for safe and effective treatment.

Many other decades-long assumptions held about the superiority of opioids to treat acute pain are not holding up to scientific study. For instance, in the emergency department setting, for patients presenting with acute extremity pain, no statistically significant or clinically important differences in pain reduction were found at 2 hours after single-dose treatment with ibuprofen and acetaminophen or with 3 different opioid and acetaminophen combination analgesics.³ A growing number of opioid-sparing treatments and prescribing protocols are being described in the current oral-maxillofacial, orthopedic, and other surgical literature. The writing is on the wall: Opioids prescribed after oral surgery can be curtailed substantially.

Should repeated findings that patients of all ages, especially adolescents and young adults, are susceptible to abuse and addiction when exposed to prescription opioids be dismissed as retrospective, epidemiologic, and/or anecdotal? With so much smoke, can there possibly be no fire? How many of our youth claim “it won’t happen to me” only to find addiction does not discriminate by socioeconomic status? No one takes the first prescribed opioid intending to become addicted, yet many of the nearly 1,000 weekly US opioid overdose deaths started with pills

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prescribed legitimately.⁴ Of the almost 50,000 US opioid overdose deaths in 2017, how many began with an opioid prescription from an oral surgeon after third molar removal? Fifty thousand? Certainly not. Zero? Certainly not, either. What is an acceptable percentage of patients developing abuse or addiction problems to justify exposing the young brain to prescription opioids? Is the finding of 6% developing subsequent opioid-related abuse⁵ flawed and the problem overstated? Would 3% be acceptable? One percent? Are your patients less vulnerable than those in recent studies—immune from opioid abuse because of your highly specialized training? Have any of your patients been sparked to addiction by a good-faith prescription from your hand? Because addiction occurs downstream and its occurrence is often not shared because of privacy concerns, how often would the oral surgeon (or any other prescriber) become aware?

Prescribing guidelines from professional organizations and regulatory agencies recommend NSAIDs for first-line analgesia. These guidelines generally allow exceptions if the clinical judgment of the provider determines a deviation from the standard is indicated. If such clinical judgment routinely defaults to “the way I have always done it: with opioids,” one should consider the following: Are the reasons for prescribing opioids to manage postsurgical pain in a patient without contraindications for an NSAID evidence based or based on habit dating back to residency training? Does reluctance to eliminate regular opioid prescriptions come from hoping to avoid inconveniencing patients, practice partners, or yourself with after-hours pain calls? Is any such reluctance evidence based, or is it habit based? Are opioid prescriptions written begrudgingly, fearing the sting of a “1-star rating” on social media from patients aghast you did not provide opioids? If opioids are prescribed, do your patients really hear and process your recitation of precautions, or do they become overwhelmed with the circumstances of surgery and fill whatever prescription is written, remember little of what was said, and use an opioid if provided? If you suggest the route to optimum pain management begins with hydrocodone by providing a prescription for it, many patients will take it despite concerns of abuse and addiction garnered from the popular press. They may obediently—albeit reluctantly—fill an opioid prescription and use it carefully as directed, having received a take-home message that opioids are most effective, trusting their doctor not to prescribe in a way that could harm them. That single,

well-intended prescription can precipitate misuse or addiction.^{4,5}

Imagine opioids were superior to NSAIDs for third molar pain (which is not supported by the reported data)² but put the developing brain at a 6% risk of subsequent opioid abuse (which is supported by the reported data⁵). Which would parents choose for their child: a few days of modestly elevated pain or a 1-in-16 chance of starting what could become a lifelong struggle with addiction, however long that life may last? Fortunately, that choice is not necessary because NSAIDs have consistently been shown to outperform opioids for acute dental pain.

History suggests we carefully examine what is already known before trying something “new” and be open to casting aside unfitting or unsafe treatments if subsequent experience so dictates. With the benefit of hindsight, the collective medical community now considers routine opioid prescriptions a well-intended, multifactorial mistake of unwarranted and regrettable enthusiasm for a product that caused considerable unintended consequences.¹ The US Food and Drug Administration will not act to recall opioids because they are too deeply ingrained in our culture of pain management and remain useful for pain relief in selected circumstances. Each oral and maxillofacial surgeon is left to decide whether present data warrant the definitive personal action of eliminating opioids—in any quantity—from one’s standard prescribing protocol, especially after third molar removal in the young patient. This would entail a paradigm shift in pain management for most oral and maxillofacial surgeons. Is it worth it?

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