J Oral Maxillofac Surg
77:1322-1323, 2019

COMMENT ON "INVESTIGATION OF AN OPIOID PRESCRIBING PROTOCOL AFTER THIRD MOLAR EXTRACTION PROCEDURES"

To the Editor:—Substantial change to deeply ingrained and long-standing habits is never easy; individuals in the behemoth of a major university dental school are especially hard to budge. Tompach et al[1] should be commended for a common-sense and evidence-based approach that has accomplished not just a token reduction in opioid prescribing but a seismic shift in the culture of managing acute pain at the University of Minnesota School of Dentistry in a remarkably short time.

We, as a specialty, should take heed. The literature as far back as the 1980s showed no clear advantage of opioids over nonsteroidal anti-inflammatory drugs (NSAIDs) when treating pain after third molar removal. Recent work has concluded that opioid medication is not the most effective or longest lasting of the available options for acute dental pain relief and that opioids are associated with higher rates of acute adverse events. Habit and vigorous marketing efforts by Big Pharma should not overshadow randomized, double-blind pain studies. The high vulnerability of adolescent and young adult third molar patients to future opioid abuse and addiction after even a first exposure is becoming clearer.[2,3] In 2018 the US Food and Drug Administration contraindicated opioid-containing cough and cold remedies for patients younger than 18 years.[4] Avoiding opioids for pain management, especially in the young patient, should be a priority.

Dr Ken Hargreaves' efforts while at the University of Minnesota showing the superiority of NSAIDs for acute dental pain management[5] convinced me in the mid 1990s to change my prescribing habits from hydrocodone-acetaminophen to flurbiprofen in my suburban oral surgery practice. This change was made cautiously at first, but I eventually came to the subjective conclusion that fewer patients called postoperatively with complaints of pain when taking NSAIDs than when taking opioids. (This change in prescribing habits was not fueled by concerns of addictive risks, which I had recently learned as a resident were insignificant when opioids were used for legitimate pain management.) For well over 20 years, both my prescriptions for opioids and postoperative pain calls from patients have been few and far between.

This anecdotal experience shows that a private oral surgery practice can function quite well for decades without habitually prescribing opioids. The idea that hydrocodone with acetaminophen is the gold standard for managing pain after third molar removal should be put to rest. Even a backup prescription for an opioid for "breakthrough pain" gives a clear message—not supported by the literature—that the opioid is superior for pain relief. The patient holding that backup opioid prescription is put unnecessarily at risk, and if it is filled and not used, more opioids will have become available for possible diversion.

Oral surgery, as a specialty, should take the lead on this issue and adjust prescribing habits away from opioids to reflect documented best practices of efficacy and safety to best serve our patients. The alternative may come as intrusive regulatory mandates that constrain our ability to make individual choices for patient care.

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https://doi.org/10.1016/j.joms.2019.03.027

HYPERCEMENTOSIS AND CEMENTOBLASTOMA: IMPORTANCE OF THE HISTOPATHOLOGIC ANALYSIS FOR THE CORRECT DIAGNOSIS

To the Editor:—We have read with great interest the recently published article by Borges et al,[1] "Conservative Treatment of a Periapical Cementoblastoma: A Case Report," describing a 33-year-old woman who underwent a conservative approach (endodontic treatment). After 7 years of follow-up, no recurrence was detected and the tooth maintained its masticatory function. It is noteworthy that this case shows excellent documentation of the clinical, imaging, and surgical procedures; however, we believe that, considering the common

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