POINT/COUNTERPOINT

How to Treat a Chemically Dependent Patient in Recovery

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Most dentists have met a patient who is either a recovering alcoholic or drug addict and in extreme cases a combination of both addictive behaviors. Patients, who tell you about their condition, are asking for your guidance and assistance with pain management during or after their dental treatment. To assist these dedicated patients and enable them to continue their recovery process, there are some factors that must be considered to ensure their comfort and ultimate health.

The purpose of this article is to provide an introduction to treating these patients, in addition to exploring appropriate ways to explain dental issues surrounding their medical condition. It is not intended to provide a way to compel or encourage a patient you *suspect* is an addict/alcoholic to seek recovery. Here are some guidelines to assist you in treating those patients who have already made a personal commitment to abstinence and continued recovery.

Chemical dependency (whether alcoholism or addiction) is a disease and is recognized as such by the American Medical Association. In the professional culture of addictionologists (as well as the social community that has evolved around these patients and others familiar with the process of treatment and recovery from chemical dependency, or CD) they are referred to as a "recovering" person, or a person "in recovery". Dentists can provide a tremendous service to their patients by referring to, and viewing their condition, as a disease rather than a moral failing or a weakness. A patient who is maintaining abstinence from mood altering chemicals during their recovery is indeed a rare breed. A prominent addictionologist has estimated fewer than 10% of the chemically dependent ever seriously attempt recovery. Of that small group, fewer than 10% ever attain longer-term continuous abstinence and sustained recovery. Respecting your patient's commitment to sobriety is vital. Being equipped to treat their dental needs, in a manner that will not tax their susceptibility to relapse, is essential to their continued recovery.

First, it is important to determine a patient's level of commitment to sobriety. A checked item on the dentist's medical history form labeled "Chemical dependency/alcoholism" will give an opportunity for the willing recovering patient to disclose this to us. Asking them about their sobriety or clean time is a way to adequately gauge the depth of their commitment. Begin your conversation by asking the patient about the details of their life-changing event. This not only displays your interest and compassion, it also opens the door to continued discussion. You can start by talking to the patient about their needs and expectations to manage any post-operative pain. In addition, a brief consultation with their addictionologist is generally beneficial. Most drug/alcohol treatment centers have an addictionologist or appropriately trained physician on staff that can provide personalized needs assessment. Most patients (particularly if they've had the benefit of CD treatment) are aware of the need to exercise caution when dealing with analgesics, sedative/hypnotics, or nitrous oxide/oxygen and usually will be happy to provide contact information for their addictionologist.

Patients in sound recovery will generally desire to avoid mood-altering medications at almost any cost. However, if the patient is in pain, or anticipates pain, he/she may be very concerned about suffering. Being human, these patients may become so fearful of pain, they may place their CD recovery at risk by requesting the wrong kind of medications, such as narcotic analgesics, sedative/hypnotics, or nitrous oxide/oxygen. Reassure an anxious patient you will do your best to manage or alleviate their pain without the use of mood-altering drugs. Doing so will go a long way to build trust and also gives them an opportunity to maintain, rather than abandon, their ongoing commitment to sobriety. Despite the protests of some caregivers and patients, neither the recovering alcoholic nor an addict should be treated with narcotics or any other mood-altering chemicals unless absolutely necessary. If potentially harmful treatment with such medications may be (or becomes) necessary, it is always best to consult with their addictionologist prior to treatment.

For local analgesia, CD patients should be treated essentially the same as a non-CD patient. There is however, well-documented evidence that a CD patient may display a higher degree of drug tolerance, even those that have remained abstinent for years.

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Though higher-than-normal doses of anesthetic may be required, precautions regarding the use of local analgesics should never be violated.

For surgical and endodontic treatment, pre- and peri-operative use of steroids and non-steroidal anti-inflammatory drugs (NSAIDS) has reached wider acceptance among dentists. While dental literature has been less than definitive as to the clinical significance of such techniques (especially in endodontics), the prudent and appropriate use of such medications carries a low risk relative to a full-blown relapse back into CD. The use of steroids may be justified in an attempt to preempt a need for post-op use of mood-altering analgesics in this population of dental patients. Dosage and regimen is identical to use of such methods with a non-CD patient. It has been my personal experience that such methods may be very beneficial, even if it is conjectured the perceived benefit is due (in part or whole) to a placebo effect. Post-operative use of a tapering steroid regimen, ibuprofen or the newer COX-2 antagonists, (Vioxx or Celebrex) in concert with acetaminophen, will manage mild to moderate pain and cover the vast majority of scenarios common in a dental practice. Intra-operative use of longer-acting local analgesics, like Marcaine and Duranest, provide a slower progression of post-op pain and allow time for easier compliance with p.o. medications and applying ice to the site. On occasion the re-injection with Marcaine to facilitate numbness again, and to allow the patient to "stay ahead of the pain", is useful. It is also good to remind patients that mood-altering drugs are not an option for them and that they must limit their activity while maintaining strict compliance with post-op instructions. This kind of reassurance goes a long way to illustrate your knowledge of the modern medical model of CD and the recovery process.

Dentists are often tempted to believe the pronouncements from drug manufacturers, other doctors, or even recovering CD patients that certain drugs are "safe" or "non-addictive". Unfortunately, this has been a common mantra since the development of Demerol in the 1940s and remained a popular claim among some clinicians through the emergence of Librium, Valium and benzodiazepines. A conversation with an addictionologist will reveal all of these drugs, including partial-agonist opiates like Talwin, Nubain, Stadol, and Ultram; as well as Ambien (for insomnia) or even other seemingly innocuous mild sedatives such as the antihistamine Benadryl, have a very high potential for initiating a relapse into CD. Prescribing these drugs should be completely avoided unless used in direct consultation with the patient's addictionologist. In today's litigation-prone society, even the legal ramifications may be considered as a rationale for choosing not to prescribe.

Treatment of emergent needs involving pain must rely upon prompt and definitive care. Pain can often be a potent trigger for drug- or alcohol-seeking behavior in recovering patients. If possible, every effort should be made to see the patient, establish an accurate diagnosis and institute treatment at that setting. In the classic toothache scenario, it is inappropriate to simply prescribe a narcotic analgesic and antibiotic, presuming the presence of pain justifies the mis-prescription of a drug contra-indicated for a patient in recovery. As with any patient, if you can go the extra mile, and institute a timely pulpotomy/pulpectomy or extraction, the patient will most likely be very appreciative of your efforts. Your caring actions may result in the patient referring their family, friends or co-workers to you.

Management of anxiety can pose a difficult problem. Prior to their recovery, many CD patients arrived for their dental treatment after drinking alcohol or taking various anxiolytic or analgesic medications (either prescribed or illicit), and/or under the administration of nitrous oxide/oxygen analgesia. It has been my experience that it is best to defer to the recommendation provided by the patient's addictionologist for the treatment of dental anxiety. This is especially true in the case of a CD patient early in their recovery. Anxiety is a common and almost ubiquitous complaint and secondary to withdrawal from the patient's drug of choice. This phenomenon is referred to as *protracted withdrawal.* Reassurance, coupled with a willingness to proceed slowly and with much explanation, will reap greater rewards in both management of dental anxiety and establishing trust with your patient.

Recovering patients with a *bona-fide* diagnosis of dentophobia carry their own set of problems—far beyond the scope of this article. These patients should be referred back to their addictionologist for psychiatric/psychological counseling and treatment of their phobia in concert with a dentist who is familiar with desensitization and other techniques to which phobic disorders are amenable. Caution should be the watchword here, though these patients are very rare.

Patients in recovery from chemical dependency require our attention and respect. As with developmentally disabled or severely handicapped patients, dentists should not feel compelled to treat recovering CD patients if doing so is outside their comfort zone. However, knowledge of the special needs of recovering CD patients and a willingness to continually deliver care that will not endanger their commitment will go a long way to reflect positively on both you and the entire dental community.

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