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Sedation and General Anesthesia:
A World of Contrasts and Similarities

I just returned from Belgrade, Serbia, having attended the biannual meeting of the European Academy of Pediatric Dentistry (EAPD). This was a first, in that, the main Congress was a joint symposium of the EAPD and the AAPD. The topic was *Transatlantic Perspectives on Sedation and General Anesthesia*. The European perspectives were presented by Dr. Marie Therese Hossy, professor and chair of pediatric dentistry at Kings College in London and Dr. Monty Duggal, professor and chair of pediatric dentistry at Leed’s Dental Institute in the United Kingdom. Dr. Bobby Thikkurissy, professor and director of the pediatric dental residency program at Cincinnati Children’s Hospital and I, in private practice using in-office sedation for over 33 years, gave the United States perspective.

The European model for in-office sedation and general anesthesia (GA) is quite different than the U.S. model. For the most part, in Europe, there are significantly more restrictions to providing in-office sedation and advanced behavior management techniques. For our European colleagues, the ability to do in-office sedation using nitrous oxide and an oral or IV sedation is essentially not allowed. As you can imagine, this has shifted a significant number of general anesthetics to provide dental care to very young and/or medically compromised patients. In the U.K., relative to pediatric dentistry, general anesthesia can only be delivered by a physician in a hospital that must have pediatric intensive care services. This even further limits their options in smaller communities.

The majority of the GA cases are of an urgent nature and are primarily limited to extractions. Their availability to do comprehensive restorative care during that case is much more unlikely and, if granted, will usually require a second GA.

The U.K. presenters were the first to admit that their system is broken. The overall cost to their National Health Care Services for pediatric dental care is exploding and their ability to focus on prevention is compromised due to the overwhelming burden of just treating dental disease.

From my personal experience, the U.S. model is also quickly eroding. The availability to utilize hospital; or surgery center-based GA is getting squeezed. This primarily relates to the medical/dental reimbursement levels for our public assistance patients and the increasing insurance deductibles for many families. In the U.S., this is putting increased pressure to provide in-office sedation services, which also has its challenges. There are a host of factors influencing the challenges facing in-office sedation. Leave it to say that discussion would require another article.

In the U.S., with these issues on the table, I can tell you the AAPD is focusing on a number of ways we can help both our members and the patients we treat.

This past year, we have completely updated our comprehensive course *Safe and Successful Sedation of the Pediatric Dental Patient*. Besides the curriculum, we have added additional video clips that visually highlight important topics. When it comes to training in the management of office medical emergencies, the state-of-the-art is high fidelity mannequin simulators. The Academy has an outstanding hands-on course to receive the ultimate experience. An assistant’s role is critical during in-office sedation. There is also a course specifically for them to enhance patient safety and fulfill many state regulatory requirements. In addition to our live courses we are expanding our web-based offerings through our *Education Passport*. I encourage you to utilize these resources. Here are a few of those one-hour webinars:

- Clinical Use of Capnography in Pediatric Procedural Sedation
- Pediatric Behavior Management: A Little Art, A Little Science, & A Little Medicine
- Pediatric Sedation Emergencies: Can They Be Avoided?

Also, the entire AAPD Annual Session recording and slides for the past several years are a comprehensive resource for virtually all topics.

In the regulatory area, the AAPD has devoted significant resources to assist our state members. As we all know, politics are local. Therefore it is critical that your state pediatric chapter have an active AAPD Policy Public Advocate (PPA). This is the most effective way the AAPD can assist with regulatory issues within your individual state. Your PPA is a member selected by your state chap-
ter that works strongly with a host of resources the AAPD provides. It is targeted specifically for policy and regulatory matters within your state, in addition to supporting AAPD on national issues. Each PPA meets face-to-face annually for training and networking with all other states PPAs. While in Washington, D.C., all the PPAs and a significant number of members and residents meet with their state congressmen and senators to ask for support on a variety of issues. This past year we continued to request corrections in the Affordable Care Act that have had a negative impact on dental care for children. We again asked for support for Title VII funding for education and loan repayment funds for our members going into academics.

In addition, the PPAs have regular conference calls and can contact the appropriate resource at the AAPD for any assistance.

We ask that each state PPA is also active in their State ADA Chapter to further leverage our members’ voices.

Things change, and unfortunately, if I were to predict the future as it pertains to sedation and GA in the United States, I would say that an increase in regulations is highly likely. Therefore, it is critical for all members to take an active role in your states, allowing us all to provide the optimal care for our patients.