IFDAS MEETING IS COMING UP

The 14th Triennial Dental Congress on Anesthesia, Sedation, and Pain Control sponsored by the International Federation of Dental Anesthesia Societies (IFDAS) takes place this year on October 8–10 in Berlin, Germany. For those of you who have never been to an IFDAS meeting, you really should consider attending. Dentists from all over the world—frequently including such places as Australia, Canada, Cambodia, England, France, Germany, Israel, Italy, Japan, Kuwait, New Zealand, Russia, Scotland, South Korea, and the United States—attend and present presentations on developments in sedation, local anesthesia, management of the medically compromised patient, and emergency medicine. Most interestingly, all of us get to learn what other dentists can—and cannot—provide for their patients in this essential area of dental practice.

In North America and Japan, we take for granted that dentists can and do administer all forms of general anesthesia for dental, oral, maxillofacial, and adjunctive surgical procedures, such as iliac crest bone graft, costochondral graft, free flaps, etc. in clinical settings ranging from dental offices to hospital operating rooms. In many parts of the world, however, dentists are unable to administer even nitrous oxide/oxygen minimal sedation. Oral or intravenous sedation is not part of dental practice in many, if not most, parts of the world.

The UK offers a fascinating, and to me rather unhappy, account of changes to dental anesthesia practice over the years. Dentist-administered general anesthesia was common through the decades until the 1980s. In 1983, operator-anesthesia for deep sedation/general anesthesia was banned. This was followed by the original Poswillo report in 1990 which recommended, among other things, that general anesthesia in the dental office should be practiced with standards equivalent to the hospital operating room. Subsequently, a joint report by the General Dental Council and Royal College of Anaesthetists in 1998 was issued, which recommended that dentists no longer be allowed to administer general anesthesia, but physician anesthetists could still provide this valuable service in dental offices. From January 2002, however, all general anesthesia for dentistry, including so called “chair dental anesthetics,” provided by either dentist or physician anesthetists had to be provided in the hospital operating room. In the UK, dentists can still provide nitrous oxide-oxygen and oral sedation as well as intravenous moderate sedation. However, even today, dentists can essentially only administer a single drug intravenous sedation technique, commonly utilizing midazolam.

The rules in Australasia are somewhat different. General Dental Councils in some areas there still have rules on the books allowing general anesthesia by dentists but there are no training opportunities for dentists to provide full scope anesthesia services in those countries. A handful of dentists from Australia and New Zealand have completed comprehensive training where it is still available, ie, in dental anesthesiology residencies in the United States, Canada, and Japan. Recently, there has been a resurgence of interest in deep sedation techniques in Australia. Led by Dr Doug Stewart, a fairly lengthy postgraduate training program in the use of propofol for moderate and deep sedation has been instituted. Of course, the use of propofol, a drug with a low margin of safety for maintaining consciousness, necessitates training in rescue from general anesthesia. How to provide this training without the benefit of formal general anesthesia training remains an area of considerable concern in that country.

The imperative to preserve the practice of general anesthesia for future generations of dentists would seem to be crucial. Japan was able to cement general anesthesia as the practice of dentistry when, in 2006, it was formally recognized as one of four government-approved specialties of dentistry. Likewise, the same occurred in the province of Ontario, Canada in 2007, but efforts to extend this recognition to the rest of the country have yet to be realized. In the United States, despite multiple reviews over 20+ years by American Dental Association committees that specialty criteria had been met, specialty approval failed only in the final vote by Houses of Delegates, most recently in 2012. Through interactions with IFDAS colleagues at the triennial meetings, an appreciation of the fragile nature of anesthesiology in dentistry throughout the world is evident. It appears that dentistry in the United States has not yet cemented anesthesiology in all its forms as an integral part of the practice of our profession.

The IFDAS meeting, therefore, provides a wonderful opportunity to network with colleagues from other countries and learn what types of advanced pain and anxiety control measures are enjoyed in dental practice around the world. It is fascinating to see countries trying to resurrect dentistry’s greatest gift to mankind: general anesthesia. It is a legacy which all the readers of *Anesthesia Progress* share as we advance pain and anxiety control for dentistry in our own countries. Plan on coming to IFDAS in Berlin in October to share your own personal experiences with your worldwide colleagues. I will be there, and I hope to see you in Berlin.

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