LETTER TO THE EDITOR

Anesthesia Progress recently published an article titled “Comparing the Efficiencies of Third Molar Surgeries With and Without a Dentist Anesthesiologist.”¹ The introduction of this retrospective analysis refers to an article published by Bennett et al² in the *Journal of the American Dental Association* that asked the question as to the safety of deep sedation or general anesthesia in the dental office. In that article, the authors provide OMSNIC data, which has been shared at numerous meetings of the American Association of Oral and Maxillofacial Surgeons and American Dental Society of Anesthesiology. The numbers reported that of an estimated 39.4 million anesthetics administered over a 14-year period, there were 113 cases that resulted in death or brain injury, which is an occurrence of 1 injury per approximately 350,000 anesthetic procedures or 1 injury every 6.4 weeks. Oral and Maxillofacial Surgery National Insurance Company (OMSNIC) insures an estimated 80% of practicing surgeons. The authors, therefore, estimated that if the 20% of oral and maxillofacial surgeons not insured by OMSNIC had a comparable occurrence, the potential anesthetic morbidity and mortality would approach 1 occurrence every 5.4 weeks. Unfortunately, as Bennett et al stated, a national safety center in which anesthetic outcome is assessed is not available.

Oral and maxillofacial surgery (OMS) has striven to provide optimal care for its patients. The numbers reported above have been provided over the years in conjunction with anesthetic safety presentations in which the specialty has openly assessed adverse outcomes and processes to take to avoid such in the future. Missing from those numbers is what transpires in the non-OMS offices. From the information available, Bennett et al estimated that the occurrence of morbidity and mortality in all dental offices exceeds 1 every 4 weeks. Reebye et al¹ incorrectly quoted Bennett et al in attributing the occurrence of more than 1 death or brain injury every 4 weeks to OMS, in which the statement reflected an estimated occurrence in all dental offices. This was probably a conservative estimate, and the occurrence per week of anesthetic morbidity and mortality associated with enteral and parenteral sedation and general anesthesia in non-OMS offices is probably comparable to that which occurs in OMS offices with a significantly

smaller number of anesthetics administered. Unfortunately, without any national data reserve reporting death or brain injury as well as adverse anesthetic events, the dental profession cannot completely learn from these occurrences to minimize their occurrence in the future.

The authors chose to report the numbers in the manner reflected of occurrences per week. When reported as an occurrence of 1 per every 350,000 anesthetics, the perception is different than when reported as 1 every 5.4 weeks. The first numbers reflect the safe delivery of anesthetic care; the latter asks if there is anything that can be done to optimize care. The article wanted to put the focus on the need to not be complacent but to continue to advance the delivery of anesthesia, which the OMS specialty is doing with the focus on advancing simulation training and team development.

Nobody desires to minimize the tragedy associated with an adverse outcome. The goal of patient care is to do no harm. Patient safety is critical to patient care. The dental patient is getting older, more medically compromised, and taking more medications. Dental education, however, is minimizing the importance and time allotted to biomedical sciences and their application in the didactic and clinical curriculum, yet there are those who are encouraging and facilitating individuals with inadequate medical foundation to provide anesthetic services with little training. We always applaud individuals to assess what and how they provide care. Reebye retrospectively assessed the care that he provided. As the article correctly stated, there is bias in a retrospective data assessment, and a prospective study would be required to provide any recommendation to determine if the difference in the anesthetic delivery system is both of clinical significance and not just statistically significant. We feel that the article by Reebye et al¹ incorrectly used the morbidity and mortality data from our publication to establish a foundation against the OMS surgical anesthetic team. Various practice models exist within dentistry for the delivery of anesthesia from sedation to general anesthesia. Safe deep sedation and general anesthesia is provided in OMS offices daily. It is important, however, for all dentists to understand that safe anesthesia practice is dependent on the following: appropriate patient selection; selection of an appropriate anesthetic depth; use of appropriate monitoring (considering beneficial or necessary redundancy in

respiratory monitoring)³; equipping the office with the appropriate emergency medications, supplies, and instrumentation (including cognitive aids to provide recall in crisis situations); and a well-trained surgical/anesthetic team⁴ that routinely participates in simulated emergencies.

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