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Literature Abstract

Trends in death associated with pediatric dental sedation and general anesthesia

The authors attempted to quantify pediatric mortality in relation to dental anesthesia by reviewing media reports gathered from the Lexis-Nexis Academic database and a private foundation website. Deaths of US-based children (\leq 21 years of age) who died after receiving anesthesia for a dental procedure in a dental office, ambulatory surgery center, or hospital from 1980 to 2011 were reviewed. Providers of anesthesia were classified as general/pediatric dentist, oral surgeon, or anesthesiologist. The results showed that 47% (n = 21) of the deaths reviewed occurred in children 2 to 5 years of age; 70.5% (n = 31) of deaths occurred in an office setting; and 56.8% (n = 25) of deaths occurred with a general/pediatric dentist. Most deaths, 68% (n = 17), were associated with sedation anesthesia in comparison to local anesthesia or general anesthesia. An external body reviewed 11 cases to determine whether a deviation from standard practice contributed to the cause of death; adverse rulings were made in 9 cases. Due to the limitation of the study scope, the authors commented that the findings might not be representative of all pediatric dental deaths. However, they opined that some of the pediatric deaths could have been prevented by reducing the need for dental procedures through aggressive preventive care, or through better observance of standards of care when rendering treatment to patients who require general anesthesia.

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