The article regarding female pediatric dentists and their possible inclination to treat special needs patients (J Dent Child 2004;71:218-221) emphasizes once again the access problem for this group of children and adult patients. While I agree with the authors' statement that there is no one single answer to this problem, I do believe there is one answer that would have a huge impact—pediatric specialty programs need to graduate individuals who are well-trained and confident in intramuscular (IM) conscious sedation, which currently is not the case!

Many of these special needs patients cannot be treated without some form of sedation. Oral sedation cannot achieve the necessary depth of sedation and IV sedation not only requires a great deal of skill, it requires a calm, cooperative patient. Mentally handicapped patients are often agitated, moving, and resisting. IM sedation administration requires much less skill than IV and can be accomplished even with a patient with cerebral palsy kicking and screaming. Additionally, the adverse reactions with IM sedation are much less profound and serious than with IV sedation.

The advent of benzodiazepines, especially Versed, has added a measure of safety to sedation significantly over that of the DPT cocktail (Demerol-Phenergan-Thorazine) used in the past. Versed has very little respiratory depressive effects, which has always been the major concern with narcotics (Demerol). Versed also has a reversal agent (Romazicon). Many of my anesthesiologist friends encouraged me to add Ketamine to the regimen for a greater success rate. Ketamine got a bad reputation many years ago when clinicians were using it as a short-acting general anaesthetic. We use subanesthetic doses of 50 to 100 mg, with 5 to 10 mg of Versed and 25 mg Phenergan for its antiemetic affect. We sedate and treat patients with severe mental retardation and cerebral palsy. While some patients will be somewhat refractory, which makes it difficult to complete the work, the only adverse results we ever deal with are vomiting (usually with nitrous oxide use) and airway blockage by a large, relaxed tongue. In over 1,400 cases, we have never dismissed and rescheduled a special needs patient because the sedation was inadequate to complete the work. I believe Versed-Ketamin-Phenergan administered IM could be the "gold standard" for conscious sedation in pediatric dentistry and that all pediatric dentistry graduates should be well-trained in its use.

One problem is that very few teachers have experience with IM conscious sedation. When we go through dental school and get to the pharmacology class, we learn some general information, but graduate believing there is another entire level of knowledge we never got. That's not true! The fact is that there is no magic formula with each drug, and being competent in clinical pharmacology requires experience. You learn the basic action and interactions of a drug and then you must use them to acquire the subtle "feel" for a drug. All patients react differently to different doses and combinations and only after using certain drugs repeatedly does a clinician get a "feel" for how a drug or drug combination works. If our pediatric dentistry residents could do 20 to 25 cases with an experienced clinician and learn what the possible adverse reactions can be, how to deal with them, and how to provide basic life support in general, they would be prepared to use this technique and see many special needs patients in their offices.

Access to dental care for mentally handicapped patients will not improve significantly until more dentists can sedate in their offices. Taking patients with special needs to the operating room every 6 months would be very costly and is not practical. In fact, there is no reason that family practice doctors should not learn this in dental school. A "normal" patient going to the hospital gets sedated for a 15-minute debridement or a few sutures or almost any procedure, no matter how simple. Getting 3 or 4 crown preparations or restorations can be very uncomfortable, take hours, and is much more of an ordeal for the patient than many of these minor medical procedures for which they sedate or put to sleep, yet very few dentists are beginning to use oral sedation, most use nothing. If dentists routinely sedated for that, the number of patients seeking care would sky rocket! There is no reason every graduating dentist should not be able to deliver oral and IM sedation with skill and confidence. The positive impact on the oral health of Americans would be tremendous!

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