Sedation submission
3.8.16

I wish to offer a submission in support of the inclusion of Capnography to the DCNZ regarding the consultation document for sedation.

My comments are based on my experience of sedating approximately 800 patients per year for oral surgery, which I have been doing for the majority of my 37 years in practice. I have taught sedation as part of the New Zealand society for sedation in dentistry for 25 years and in addition attended multiple sedation meetings both in New Zealand and overseas. I have participated on many advisory groups on sedation standards and safety.

I am very aware that increasingly numbers of medically compromised patients are requiring sedation for dental procedures. This is due to a combination of factors including increasing obesity, age, complex medical management of previously life threatening disease and reduced access to public hospital dental care. This corresponds to a greater level of risk in providing dental sedation and therefore requires increased sophistication to safely manage this risk.

Gino Inverso et al, in their recent publication on sedation complications in the JOMS March 2016 stated a 72% increase in the risk of adverse complications per level of increase in the ASA status of the patient. We should therefore embrace every reasonable technology as it becomes available to manage risk just as society has done with seat belts and more recently airbags for motor vehicle safety.

The current consultation document identifies the continuum in sedation. It is well known by experienced practitioners that patients can readily move between the defined levels of sedation. This can occur regardless of what drug dose or combination is used.
I routinely target moderate sedation for my patients but are aware that on occasions they will be in deep sedation with the risk of significant respiratory compromise. Respiratory depression is now well recognised as the most common predisposing state prior to impending sedation morbidity but if recognised early is usually simple to correct.

Capnography identifies respiratory compromise within one breath, which is well before any other monitor. I started experimenting with Capnography over 20 years ago and once the technology became more available have used it routinely on every sedation case for the last 12 years. I regard Capnography as an essential part of my sedation practice with which our team uses to pre-emptively respiratory depression.

Most modern monitors manufactured for the sedation market now have Capnography, pulse oximetry and automatic blood pressure recording available in one economical unit at a comparable price to the original stand-alone pulse oximetry available 20 years ago. I sincerely hope that New

Zealand Dentists providing sedation will appreciate the merit and relative minimal expense to upgrade their monitoring to this level.

Capnography is the recommended standard of care for sedation in both the USA and Australia. These two countries most closely resemble the sedation practice in New Zealand. The New Zealand Society for Sedation in New Zealand has recommended and taught Capnography for the past five years.

It is my opinion that Capnography should be recognised as the standard of care for monitoring respiratory function during intravenous sedation in New Zealand.

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