Health policy and the dental implant practitioner

By Arun Garg, DMD

In 2007, when the American Heart Association changed the recommenda-
tions for antibiotic prophylaxis for routine dental care in patients with
valvular heart disease, some dentists scoffed, others rejoiced. The policy
change was the first of its kind since the organization began recommend-
ing prophylaxis for routine dental procedures 50 years earlier.

Considering the fact that an estimated 2 percent of the U.S. popula-
tion carries the diagnosis of mitral valve prolapse, a relatively benign
heart-valve disorder that had, until 2007, required administration of anti-
biotics in advance of any dental procedure (including routine clean-
ing), this was indeed a noteworthy change.

The use of antibiotics for the intended prevention of endocarditis in individuals at higher risk (those with valvular pathology) had far reaching effects on antibiotic resis-
tance rates, the cost of medical and dental care, the number of emer-
gency visits for allergic reactions to medications, even overall compli-
ance with routine teeth cleaning visits.

Some dentists chose to ignore the revised recommendations, respond-
ing that the risks of bacterial endo-
carditis were outweighed by the benefits of antimicrobial admin-
istration, regardless of population effects. Other dentists were not
aware that the recommendations had even been changed. Most have
complied with the current recom-
mandations and do not insist on
antibiotic prophylaxis unless so indi-
cated by evidence-based research.

Health policy has, in many ways, changed the way that dentists and
dental implant practitioners prac-
tice. The influences of various medical societies will continue to have an impact for dental implant practitioners in the years to come
given the expanding use of elec-
tronic health records, the institu-
tion of government-driven health
reform programs and the paradigm
shift from practitioner instinct to
evidence-based decision making.

These policy changes are intend-
ed for the betterment of societal health care as a whole, however,
they do not always reflect a con-
scious among medical and dental
societies nor are they always readily applicable to the patient directly in
front of us.

A hotly contested topic between orthopedic surgeons, dentists and
infectious disease experts involves
the extent to which antibiotic pro-
phylaxis prior to specific dental
procedures is required to prevent
bacterial seeding of the joint in
patients who have received total
joint replacements.

Previously, the three groups
aligned and supported antibiotic
prophylaxis for individuals who
had had joints replaced within two
years and those at higher risk, due
to medical conditions, however, a
more recent publication from the
American Association of Orthopaed-
ic Surgeons (AAOS), put forth in
February 2009 and revised in June
2010, states that all patients with
total joint replacements should be
given antibiotic prophylaxis for spe-
cific medical and dental procedures
for the rest of their lives.

The impetus, consequences and
controversy of this change are still
being widely debated. In response to
the AAOS statement, the American
Academy of Orthopedic Medicine issued
a pointed rebuttal debunking the
reasoning behind the AAOS state-
ment paper and reminded practi-
tioners to make their own clini-

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page 16A
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Yet will that seemingly harmless decision undermine antimicrobial compliance improvement efforts elsewhere?
Hospitals and other large health-care facilities are initiating programs known as “antibiotic stewardship programs” to facilitate responsible and appropriate antimicrobial use in a particular health care institution. And while these programs are most often undertaken in larger health-care settings, the reality is that application of certain principles at the micro level will enhance antibiotic effectiveness in the general population provided all practitioners (and patients) use antimicrobial agents appropriately.

The relevance of antimicrobial stewardship at the hospital level does trickle down to the individual provider in the dental implant practice. Every antibiotic prescribed conveys a risk of allergic reaction, drug-drug interaction, antibiotic-associated diarrheal illness, decreased population effectiveness and increased cost to the health-care system.

Nonetheless, when indicated, a single dose of preoperative antibiotics or a course administered for a wound infection is absolutely essential.

Limiting antibiotic use to those cases supported by evidence-based practice (and espoused by consensus statements from multiple organizations) will help reduce the amount of antibiotic resistance within the population. Individual practitioners will ultimately be the ones responsible for effecting change at the population level.

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