

## Official but unformatted

### Clinical Guideline on Appropriate Use of Nitrous Oxide for Pediatric Dental Patients

#### Originating Council

Council on Clinical Affairs

#### Adopted

2005

#### Purpose

The American Academy of Pediatric Dentistry (AAPD) recognizes nitrous oxide/oxygen inhalation as a safe and effective technique to reduce anxiety, produce analgesia, and enhance effective communication between a patient and health care provider. The need to diagnose and treat, as well as the safety of the patient and practitioner, should be considered before use of nitrous oxide. By producing this guideline, the AAPD intends to assist the dental profession in developing appropriate practices in the use of nitrous oxide/oxygen analgesia/anxiolysis for pediatric patients.

#### Methods

This guideline is based on a review of the current dental and medical literature related to nitrous oxide/oxygen analgesia/anxiolysis in pediatric patients. A MEDLINE search was conducted using the terms "nitrous oxide", "analgesia", "anxiolysis", "behavior management", and "dental treatment."

#### Background

Dentists have expertise in providing anxiety and pain control for their patients. While anxiety and pain can be modified by psychological techniques, in many instances, pharmacological approaches are required.<sup>1</sup> Analgesia/anxiolysis is defined as diminution or elimination of pain and anxiety in a conscious patient.<sup>2</sup> The patient responds normally to verbal commands. All vital signs are stable, there is no significant risk of losing protective reflexes, and the patient is able to return to pre-procedure mobility. In children, analgesia/anxiolysis may expedite the delivery of procedures that are not particularly uncomfortable, but require that the patient not move.<sup>2</sup> It also may allow the patient to tolerate unpleasant procedures by reducing or relieving anxiety, discomfort, or pain. The outcome of pharmacological approaches is variable and depends upon each patient's response to various drugs; however, the clinical effect of nitrous oxide/oxygen inhalation is more predictable among the majority of the population.

Nitrous oxide is a colorless and virtually odorless gas with a faint sweet smell. It is an effective analgesic/anxiolytic agent causing central nervous system (CNS) depression and euphoria with little effect on the respiratory system.<sup>3</sup> It has rapid uptake, being absorbed quickly from the alveoli and held in a simple solution in the serum. Nitrous oxide is relatively insoluble, passing down a gradient into other tissues and cells in the body, such as the CNS. It is excreted quickly from the lungs. As nitrous oxide is 34 times more soluble than nitrogen in blood, diffusion hypoxia may occur. Studies<sup>4-6</sup> have shown that children become desaturated more rapidly than adolescents; administering 100% oxygen to the patient for 3-5 minutes once the nitrous oxide has been terminated is important.<sup>4</sup> Nitrous oxide causes minor depression in cardiac output while peripheral resistance is slightly increased, thereby maintaining the blood pressure.<sup>3</sup> This is of particular advantage in treatment of patients with cerebrovascular system disorders.

Nitrous oxide is absorbed rapidly, allowing for both rapid onset and recovery (2-3 minutes). It causes minimal impairment of any reflexes, thus protecting the cough reflex.<sup>3</sup> It generally is acceptable to children and can be titrated easily. Most children are enthusiastic about the administration of nitrous oxide/oxygen; many children report dreaming or being on a "space-ride".<sup>7</sup> However, for some patients the feeling of "losing control" may be troubling and claustrophobic patients may find the nasal hood confining and unpleasant.<sup>8</sup> The decision to use nitrous oxide/oxygen analgesia/anxiolysis must take into consideration alternative behavioral guidance modalities, dental needs of the patient, the effect on the quality of dental care, the patient's emotional development, and the patient's physical considerations.

The objectives of nitrous oxide/oxygen inhalation include:

1. reduce or eliminate anxiety;

## Official but unformatted

2. reduce untoward movement and reaction to dental treatment;
3. enhance communication and patient cooperation;
4. raise the pain reaction threshold;
5. increase tolerance for longer appointments;
6. aid in treatment of the mentally/physically disabled or medically compromised patient;
7. reduce gagging;
8. potentiate the effect of other sedatives.

Disadvantages of nitrous oxide/oxygen inhalation may include:<sup>3</sup>

1. lack of potency;
2. dependant largely on psychological reassurance;
3. interference of the nasal hood with injection to anterior maxillary region;
4. patient must be able to nose breathe;
5. nitrous oxide pollution and potential occupational exposure health hazards.

### Recommendations

#### *Patient selection*

Indications for use of nitrous oxide/oxygen analgesia/anoxiolysis include:

1. a fearful, anxious, or obstreperous patient;
2. certain mentally, physically, or medically compromised patients;
3. a patient whose gag reflex interferes with dental care;
4. a patient for whom profound local anesthesia cannot be obtained;
5. a cooperative child undergoing a lengthy dental procedure.

Review of the patient's medical history should be performed prior to the decision to use nitrous oxide/oxygen analgesia/anoxiolysis. This assessment should include:

1. allergies and previous allergic or adverse drug reactions;
2. current medications including dose, time, route, and site of administration;
3. diseases, disorders, or physical abnormalities and pregnancy status;
4. previous hospitalization to include the date and purpose.

Contraindications for use of nitrous oxide/oxygen inhalation may include:

1. some chronic obstructive pulmonary diseases;
2. severe emotional disturbances or drug-related dependencies;
3. first trimester of pregnancy<sup>9</sup>;
4. treatment with bleomycin sulfate.<sup>10</sup>

Whenever possible, appropriate medical specialists should be consulted before administering analgesic/anoxiolytic agents to patients with significant underlying medical conditions (eg, severe obstructive pulmonary disease, congestive heart failure, sickle cell disease<sup>11</sup>, acute otitis media or recent tympanic membrane graft<sup>12</sup>).

#### *Technique of nitrous oxide/oxygen administration*

Nitrous oxide/oxygen must be administered only by appropriately licensed individuals, or under the direct supervision thereof, according to state law. The practitioner responsible for the treatment of the patient and/or the administration of analgesic/anoxiolytic agents must be trained in the use of such agents and techniques and appropriate emergency response.

Selection of an appropriately-sized nasal hood should be made. A flow rate of 5-6 liters/minute generally is acceptable to most patients. The flow rate can be adjusted after observation of the reservoir bag. The bag should pulsate gently with each breath and should not be either over- or underinflated. Introduction of 100% oxygen for 1-2 minutes followed by titration of nitrous oxide in 10% intervals is recommended. During nitrous oxide/oxygen analgesia/anoxiolysis, the concentration of nitrous oxide should not routinely exceed 50%. Nitrous oxide concentration may be decreased during easier procedures (eg, restorations) and increased during more stimulating ones (eg, extraction, injection of local anesthetic). During treatment, it is important to continue the visual monitoring of the patient's respiratory

## Official but unformatted

rate and level of consciousness. The effects of nitrous oxide largely are dependent on psychological reassurance. Therefore, it is important to continue traditional behavior guidance techniques during treatment. Once the nitrous oxide flow is terminated, 100% oxygen should be delivered for 3-5 minutes.<sup>3</sup> The patient must return to pre-treatment responsiveness before discharge.

### *Monitoring*

The response of patients to commands during procedures performed with anxiolysis/analgesia serves as a guide to their level of consciousness. Clinical observation of the patient must be done during any dental procedure. During nitrous oxide/oxygen analgesia/anxiolysis, continual clinical observation of the patient's responsiveness, color, and respiratory rate and rhythm must be performed. Spoken responses provide an indication that the patient is breathing.<sup>2</sup> If any other pharmacologic agent is used in addition to nitrous oxide/oxygen and a local anesthetic, monitoring guidelines for the appropriate level of sedation must be followed.<sup>13</sup>

### *Adverse effects of nitrous oxide/oxygen inhalation*

Nitrous oxide/oxygen analgesia/anxiolysis has an excellent safety record. When administered by trained personnel on carefully selected patients with appropriate equipment and technique, nitrous oxide is a safe and effective agent for providing pharmacological guidance of behavior in children. Acute and chronic adverse effects of nitrous oxide on the patient are rare.<sup>14</sup> Nausea and vomiting are the most common adverse effects, occurring in 1-10% of patients. A higher incidence is noted with longer administration of nitrous oxide/oxygen, fluctuations in nitrous oxide levels, and increased concentrations of nitrous oxide.<sup>3</sup> Fasting is not required for patients undergoing nitrous oxide analgesia/anxiolysis. However, the practitioner may recommend that only a light meal be consumed in the 2 hours prior to the administration of nitrous oxide.<sup>15</sup> Diffusion hypoxia can occur as a result of rapid release of nitrous oxide from the blood stream into the alveoli, diluting the concentration of oxygen. This may lead to headache and disorientation and can be avoided by administering 100% oxygen after nitrous oxide has been discontinued.<sup>3</sup>

### *Documentation*

Informed consent must be obtained from the parent and documented in the patient's record prior to administration of nitrous oxide/oxygen. The practitioner should provide instructions to the parent regarding pre-treatment dietary precautions, if indicated. In addition, the patient's record must include indication for use of nitrous oxide/oxygen inhalation, nitrous oxide dosage (ie, percent nitrous oxide/oxygen and/or flow rate), duration of the procedure, and post-treatment oxygenation procedure.

### *Facilities/personnel/equipment*

All newly installed facilities for delivering nitrous oxide/oxygen must be checked for proper gas delivery and fail-safe function prior to use. Inhalation equipment must have the capacity for delivering 100%, and never less than 30%, oxygen concentration at a flow rate appropriate to the child's size, and must have a fail-safe system that is checked and calibrated regularly according to the practitioner's state laws and regulations.<sup>13</sup> If nitrous oxide/oxygen delivery equipment capable of delivering more than 70% nitrous oxide and less than 30% oxygen is used, an in-line oxygen analyzer must be used. The equipment must have an appropriate scavenging system.

The practitioner who utilizes nitrous oxide/oxygen analgesia/anxiolysis for a pediatric dental patient shall possess appropriate training and skills and have available the proper facilities, personnel, and equipment to manage any reasonably foreseeable emergency. Training and certification in basic life support (BLS) are required for all clinical personnel. These individuals should participate in periodic review of the office's emergency protocol, the emergency drug cart, and simulated exercises to assure proper emergency management response.

An emergency cart (kit) must be readily accessible. Emergency equipment must be able to accommodate children of all ages and sizes. It should include equipment to resuscitate a non-breathing, unconscious patient and provide continuous support until trained emergency personnel arrive. A positive-pressure oxygen delivery system capable of administering >90% oxygen at a 10 L/min flow for at least 60 minutes (650 L, "E" cylinder) must be available. When a self-inflating bag valve mask device is used for

## Official but unformatted

delivering positive pressure oxygen, a 15 L/min flow is recommended. There should be documentation that all emergency equipment and drugs are checked and maintained on a regularly scheduled basis.<sup>13</sup> Where state law mandates equipment and facilities, such statutes should supersede this guideline.<sup>13</sup>

### *Occupational safety*

In an effort to reduce occupational health hazards associated with nitrous oxide, the AAPD recommends exposure to ambient nitrous oxide be minimized through use of effective scavenging systems and periodic evaluation and maintenance of the delivery and scavenging systems.<sup>16</sup>

### **References**

1. American Dental Association. Position statement: The use of conscious sedation, deep sedation and general anesthesia in dentistry. <http://ada.org/prof/resources/positions/statements/useof.asp> Accessed February 16, 2005.
2. American Society of Anesthesiologists. Practice guidelines for sedation and analgesia by non-anesthesiologist: A report by the American Society of Anesthesiologists task force on sedation and analgesia by non-anesthesiologists. *Anesthesiology*. 1996;84:459-471.
3. Paterson SA, Tahmassebi JF, Paediatric dentistry in the new millennium: 3. Use of inhalation sedation in paediatric dentistry. *Dent Update*. 2003;30:350-356,358.
4. Patel R, Lenczyk M, Hannallah RS, McGill WA. Age and onset of desaturation in apnoeic children. *Can J Anaesth*. 1994;41:771-774.
5. Patel R, Norden J, Hannallah RS. Oxygen administration prevents hypoxemia during post-anesthesia transport in children. *Anesthesiology*. 1998; 69: 616-618.
6. Kinouci K, Tanigami H, Tashiro C, Nishimura M, Fukumitsu K, Takauchi Y. Duration of apnea in anesthetized infants and children required for desaturation of hemoglobin to 95%. *Anesthesiology*. 1992; 77:1105-1107.
7. Hogue D, Ternisky M, Iranour B. The response to nitrous oxide analgesia in children. *J Dent Child*. 1971;38:129-133.
8. Stach DJ. Nitrous oxide sedation: Understanding the benefit and risks. *Am J Dent*. 1995;8:47-50.
9. Rowland AS, Baird DD, Shore DL, Weinberg CR, Savitz DA, Wilcox AJ. Nitrous oxide and spontaneous abortion in female dental assistant. *Am J Epidemiol*. 1995;141:531-537.
10. Fleming P, Walker PO, Priest JR. Bleomycin therapy: A contraindication to the use of nitrous oxide-oxygen psychosedation in the dental office. *Pediatr Dent*. 1988;10:345-346.
11. Ogundipe O, Pearson MW, Slater NG, Adepegba T, Westerdale N. Sick cell disease and nitrous oxide-induced neuropathy. *Clin Lab Haematol* 1999;21:409-412.
12. Fish BM, Banerjee AR, Jennings CR, et al. Effect of anaesthetic agents on tympanometry and middle-ear effusions. *J Laryngol Otol (England)*. 2000;114:336-338.
13. American Academy of Pediatric Dentistry. Clinical Guideline on the Elective use of Minimal, Moderate, and Deep Sedation and General Anesthesia in Pediatric Dental Patients. *Pediatr Dent*. 2004;26(7):95-103.
14. Donaldson D, Meechan JG. The hazards of chronic exposure to nitrous oxide: An update. *Br Dent J*. 1995. 119;178:95-100.
15. Hosey MT. UK National Clinical Guidelines in Paediatric Dentistry. Managing anxious children: The use of conscious sedation in paediatric dentistry. *Int J Paediatr Dent*. 2002;12:359-372.
16. American Academy of Pediatric Dentistry. Policy on minimizing occupational health hazards associated with nitrous oxide. *Pediatr Dent*. 2004;26(7):48-49.