



Death Following Sedation

Ten years ago I wrote an article describing a fictional event, the death of a two year old child following sedation with chloral hydrate (*J Dent Child* 55(2):123, 1988.) Although the account was fictional, it was based on a real event. A child had died because an excessive dose of a drug was administered for conscious sedation prior to routine dental treatment. However, the child was not properly monitored, and when a problem developed, inadequate measures were performed to manage the resulting emergency situation. If the proper dose of the drug had been administered, or if proper monitoring had occurred during the procedure, a tragic result could have been averted. Correct drug dosage and monitoring are just two of many requirements that are included in the Academy's Guidelines for the Elective Use of Conscious Sedation, Deep Sedation and General Anesthesia in Pediatric Dental Patients. These guidelines are distributed annually to members of the Academy as a section of the Reference Manual published each November, and they must be observed whenever sedation is used.

Last year, in an editorial titled "Accidents Will Happen", I discussed the necessity of following the Academy's sedation guidelines. Now, once again, it is necessary to address this very important topic because, tragically, this past year there were at least four children who died in dentists' offices following what were to have been routine sedation experiences. The available information indicates that these deaths occurred with poorly trained or inexperienced practitioners who did not follow the Academy's Sedation Guidelines.

When the guidelines were first drafted in 1985, they were designed to protect children. They have served that purpose well, and I am not aware of a single documented mortality when the guidelines were observed. Since their original drafting, the guidelines were refined three times and, generally, are observed by pediatric dentists. It is now our responsibility to promulgate those guidelines to general practitioners who treat children with sedation.

Although their numbers are relatively small, there are still many children who cannot be managed with non-pharmacologic methods. Some practitioners are uncomfortable with the use of drugs. Rather than receive retraining, they refer patients for treatment with general anesthesia or they rationalize a delay in treatment. General anesthesia might be appropriate for some, but properly used conscious sedation is the method of choice for others. The pediatric dentist should be expert in the use of drugs for behavior management, rather than ignore this important aspect of a pediatric dental practice.

Sedation is a valuable tool in dentistry, yet it is like a loaded gun. When used correctly, it can serve and protect. When used inappropriately, it can shoot to kill!