Parameters of Care:
AAOMS Clinical Practice Guidelines
for Oral and Maxillofacial Surgery
(AAOMS ParCare) Sixth Edition 2017

ANESTHESIA IN OUTPATIENT FACILITIES

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THIS SECTION IS 1 OF 11 CLINICAL SECTIONS INCLUDED IN AAOMS PARCARE 2017, WHICH IS VIEWED AS A LIVING DOCUMENT APPLICABLE TO THE PRACTICE OF ORAL AND MAXILLOFACIAL SURGERY. IT WILL BE UPDATED AT DESIGNATED INTERVALS TO REFLECT NEW INFORMATION CONCERNING THE PRACTICE OF ORAL AND MAXILLOFACIAL SURGERY.

INTRODUCTION

Criteria and parameters in this section refer specifically and exclusively to methods used by Oral and Maxillofacial Surgeons to control the pain and anxiety of patients treated in outpatient facilities (eg, dental school surgery units, ambulatory surgery centers, Oral and Maxillofacial Surgeons' offices, and other facilities where Oral and Maxillofacial Surgery is performed).

Pain and anxiety control, using various techniques of regional (local) anesthesia, all forms of sedation, and general anesthesia, have been an integral part of the practice of Oral and Maxillofacial Surgery since the inception of the specialty. Anxiety, fear, and pain are concerns because each is inherent in the patient's reaction to the proposed treatment. All three must be controlled satisfactorily during the perioperative period to permit safe and effective completion of the surgical procedure. These anesthesia criteria have been developed to maximize safety and minimize risk for patients.

The practitioner's selection of a particular technique for controlling pain and anxiety during a specific procedure has to be individually determined for each patient, considering the risks and benefits for each case.

Techniques seldom used or applicable to very few patients are not included in this section. This category includes hypnosis, acupuncture, transcutaneous electrical nerve stimulation, and specific medications and techniques for controlling acute or chronic pain. Behavior modification techniques (biofeedback) and psychiatric management also have been excluded from this section.

In the future, new indications or new anesthetic agents and techniques may lead to changes in equipment. As new pieces of equipment and their techniques for use are evaluated for safety and efficacy and accepted for patient care and treatment, their inclusion in this document will be considered.

DEFINITIONS OF SEDATION AND ANESTHESIA

The following definitions are taken from the American Society of Anesthesiologists (ASA) *Continuum of Depth of Sedation Definition of General Anesthesia and Levels of Sedation/Analgesia* (approved by the ASA House of Delegates on October 13, 1999, last amended on October 15, 2014).

Minimal Sedation is a drug-induced state during which patients respond normally to verbal stimulation. Although cognitive function and physical coordination may be impaired, airway reflexes and ventilatory and cardiovascular functions are unaffected.

Moderate Sedation/Analgesia is a drug-induced depression of consciousness during which patients respond purposefully** to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

Deep Sedation/Analgesia is a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully** following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

General Anesthesia is a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

Because sedation is a continuum, it is not always possible to predict how an individual patient will respond. Hence, practitioners intending to produce a given level of sedation should be able to rescue*** patients whose level of sedation becomes deeper than initially intended. Individuals administering moderate sedation/analgesia should be able to rescue*** patients who enter a state of deep sedation/analgesia, whereas those administering deep sedation/analgesia should be able to rescue*** patients who enter a state of general anesthesia.

** Reflex withdrawal from a painful stimulus is NOT considered a purposeful response.

*** Rescue of a patient from a deeper level of sedation than intended is an intervention by a practitioner proficient in airway management and advanced life support. The qualified practitioner corrects adverse physiologic consequences of the deeper-than-intended level of sedation (such as hypoventilation, hypoxia, and hypotension) and returns the patient to the originally intended level of sedation. It is not appropriate to continue the procedure at an unintended level of sedation.