Oral Implications of Chemical Dependency & Substance Abuse for the Dental Professional

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Continuing Education Units: 3 hours


Disclaimer: Participants must always be aware of the hazards of using limited knowledge in integrating new techniques or procedures into their practice. Only sound evidence-based dentistry should be used in patient therapy.

Drug abuse remains a significant epidemic in present day society. According to the 2010 National Survey on Drug Use and Health, nearly 9% of the United States population use illegal drugs. As contemporary dental professionals, it is important that we are educated on the current effects of commonly used and abused drugs or medications including alcohol and tobacco products.

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Overview

There are several reasons why today’s dental clinician needs to be observant when treating patients who may be using drugs, alcohol or tobacco. Medical emergencies during dental treatments spurred by health or drug interactions would be cause for initial concern. Long-term health of the oral cavity is another, but perhaps the most important consideration would be the quality of life and health that could be restored after abuse or addiction.

This course will review the various signs, symptoms and aspects that chemical dependency and substance abuse can have on our patients. We will limit our scope to the effects on the mouth and we will cover more commonly abused drugs. Information will be provided for the clinician to make distinctions, begin safe dialogues, document patient comments and oral findings, and provide resources and follow-up support to your addicted patients.

Focused chairside observation is essential since 50% of patients will reveal less about their lifestyles than they should. Unsubstantiated observations should not cause the clinician to assume the patient has a drug problem. Instead, careful questioning of the patient can reveal drug use and abuse. At the end of each section, we will review various approaches and acceptable means of guidance that a dental professional might employ with a patient regarding that particular drug or substance. While this course is intended to encourage observation and detection of the signs and symptoms of various chemical dependencies and substances, sensitivity for the patient’s right to privacy should be respected. Providing gentle educational explanations about a particular oral condition and posing either straightforward or benign questions to the patient about how or why a particular condition might be arising is the best professional action. If we develop a dialog that promotes trust, we ensure the patient feels safe in our care. Approximately 50% of general dentists provide their patients with tobacco cessation information but fewer get involved with alcohol or drug dependency issues. It is important for the dental professional to have broad-based information regarding substance abuse because a patient suspected of substance abuse can be a challenge. Clinically, it is important to avoid drug treatment interactions or behavioral outbursts in the dental office and support the patient as they attempt to become drug-free. Many times the dental office can serve as a safe and non-threatening source of cessation assistance. Creating referral protocols may help our patients find appropriate professional treatment.

Most scientists consider addiction to be a brain disease caused by persistent changes to cerebral structure and function. Using drugs repeatedly over time changes the brain in ways that persist long after the individual stops using. There are implications for oral health professionals in identifying and managing the patient who is abusing substances. Management issues relevant to delivery of oral care include:

1. Identifying potential drug interactions with substances used during oral care.
2. Offering drug abuse cessation information.
3. Dealing with the erratic behavior of a client who presents to the oral care appointment while under the influence of drugs or alcohol.

Learning Objectives

Upon completion of this course, the dental professional should be able to:
• Differentiate between a social user, substance abuser and addict.
• Describe four stages of substance abuse. Explain the differences between physical and psychological dependence.
• Identify the various forms of tobacco.
• Identify the addiction process for alcohol, prescription medication and illegal drugs.
• Recognize various oral conditions that may be present with chronic tobacco, alcohol, prescription medication and/or illegal drug use.
• Identify commonly abused prescription and illegal drugs.
• Identify various clinician/patient communication strategies for various addictions.
• Use resources to support patients who are interested in cessation.
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Introduction

Drug abuse remains a significant epidemic in present day society. According to the 2010 National Survey on Drug Use and Health, nearly 9% of the United States population (22 million Americans/age 12+) uses illegal drugs. Illegal drugs include marijuana/hashish, cocaine, heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used for non-medical purposes. As contemporary dental professionals, it is important we are educated about the current effects of commonly used and abused drugs or medications including alcohol and tobacco products. We come into contact with patients on a daily basis who range from non-users to addicts. Medical histories may present the opportunity for our patients to reveal their past and present habits regarding drug, tobacco and alcohol use, but up to 50% of patients, when surveyed, say they lie on medical histories due to embarrassment, fear of being judged, loosing insurance benefits or they felt it was just none of the clinician's business. According to this same medical survey, patients, aged 25 to 34, are more likely to lie to their doctors than patients 55 and older. Specifically, younger patients lie about recreational drug use, sexual history, and smoking habits. Men were found to withhold the truth significantly more than women about how much they drink: 24% vs. 15.

The dental setting brings a wide variety of patients for treatment. Drug interactions, systemic reactions and side effects of medications are a few of the considerations we have to take seriously as licensed professionals. The effects drugs, alcohol and tobacco have on teeth and the oral cavity is another health and educational matter of concern. Pairing this with the survey results, our patients are not revealing their true drug, alcohol and tobacco use, presenting a need for a new communication paradigm where sensitivity and awareness need to be honed.

Overview of Substance Abuse

Types of Substance Users

As dental health care provider will come into contact with several different kinds of users of both legal and illegal substances. It is important to understand the types of users because this foundational information may help gain insight into your patient’s lifestyle, then help determine how you may want to approach oral healthcare recommendations to the patient.

The Social User

The first type is the social user. The social user can take or leave a substance and does not make it a focal point in his or her life. The social user never puts themselves or others in harm’s
way using a substance and shows no repetitive pattern. The social user does not use to excess.

The Substance Abuser
The substance abuser may also be a “binge user”, a person who uses to excess at times, but rarely shows a daily pattern of abuse. This type of drug abuser can stop using a substance and return to a somewhat normal life. Although they may not use a drug on a daily basis, they are still susceptible to issues of a drug abuser.

The Addict
The addict is our third and most serious form of substance abuser. Addiction can be defined as a chronic, relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences. It is common for people who fit the profile of an addict to use different substances. An addict may abuse alcohol one decade and then move on to prescription medication. The behavior of moving from one addictive substance to another is called transference.

Stages of Substance Abuse
• Experimentation
• Regular to Risky Use
• Dependence
• Addiction

Experimentation, regular to risky use, dependence and addiction are the stages of substance abuse. These behaviors can be addressed and treated at any stage, despite popular myths that people must hit bottom before they can benefit from help. One role as a dental professional is to recognize symptoms and behaviors that could indicate a substance abuse pattern.

Experimentation
Substance use starts with a voluntary use of alcohol or other drugs. Often the person is trying to erase another emotional problem but there are other causes. An older person may self-medicate by drinking alcohol to cope with depression after losing a spouse. A teenager, angry about a parental divorce, may start smoking marijuana or huffing inhalants. Experimentation may also include a husband taking his wife’s prescription painkiller to cope with recurring back pain.

Regular to Risky Use
The transition from regular to risky use and why it happens differs for every individual. The National Institute on Alcohol Abuse and Alcoholism (NIAAA) estimates nearly one-third of Americans engage in risky drinking patterns. As a result, what constitutes “risky behavior” can be difficult to define. If a person’s behavior worries those close to them, the behavior and suspicions should be addressed. There are groups and interventions that may reduce, stop or derail the progression to dependence. The Partnership for a Drug-Free America (www.drugfree.org) has a comprehensive website to educate and provide information for interventions (www.intervenenow.org).

Dependence
In 1990, alcoholism and other chemical dependencies were described by the American Society of Addiction Medicine (ASAM) as primary, chronic, relapsing diseases with genetic, psychosocial, and environmental factors influencing their development and manifestations. Alcohol or drug dependence follows risky behavior. At this stage, alcohol or other drug use may not be compulsive or out of control. Many dependent people are able to work, maintain family relationships and friendships, and limit the use of alcohol or other drugs to certain time periods, such as weekends or evenings. However, it is also difficult for the impaired individual (and for others) to recognize the affects their substance use may be having on themselves, friends, coworkers and family members. Characteristics of dependence include:

• Repeated use of alcohol or other drugs leading to failure to fulfill major responsibilities related to work, family, school or other roles.
• Repeatedly drinking or using drugs in situations that are physically hazardous, such as driving while intoxicated or using heavy machinery when intoxicated.
• Repeated legal, familial and relationship problems surrounding the substance.

Psychological dependence, also referred to as addiction, is a behavioral pattern characterized by drug craving, out of control drug usage, overwhelming desire to obtain a drug supply, drug use causing personal and legal problems, denial about the personal drug use, and continuing to use the drug despite personal and legal difficulties.
Physical dependence is an adaptive state, occurring after prolonged use of a drug, in which discontinuation of the drug causes physical symptoms that are relieved by re-administering the same drug or a pharmacologically related drug.

Both types of dependence can lead to compulsive patterns of drug use where the user’s lifestyle is focused on taking the drug.7

Addiction
Addiction is a medical condition involving serious psychological and physical changes from repeated heavy use of a substance. The symptoms of addiction are uncontrollable alcohol or other drug craving, seeking, and use that persists even in the face of negative consequences. It is a progressive illness that worsens over time if left untreated. Using drugs repeatedly over time changes brain structure and function in long lasting ways that can persist after drug use is stopped. The amount of the drug to cause this change is different for everyone, but it is postulated that after a certain amount of a drug is consumed, it is as if a switch in the brain is flipped from normal to addiction.5

Causative Factors or Etiology
The difference in susceptibility to addiction is considered to be related to genetic influences. Very few people are able to return to occasional use after becoming addicted. Substance abusers often begin taking the drug to achieve a desirable pharmacologic effect. When the drug use is continued to relieve personal problems or used as a coping mechanism, dependence may develop. When the individual becomes dependent on the drug, a genetically associated psychological mechanism leads to an alteration of the brain function. This is a feature of central nervous system (CNS) drugs that leads to addiction.

Tobacco Use & Addiction
The U.S. Surgeon General’s Report on Smoking and Health (1960s) was one of the first public documents linking smoking to increased risk of cardiac and vascular disease. More recent research ties tobacco use to cancers of the mouth, pharynx, esophagus, lung, pancreas, and bladder. Additional health risks include diabetes; respiratory disorders; premature, low birth-weight infants or spontaneous abortions and periodontal disease. More recently, we have learned that those exposed to secondary smoke from tobacco products are at greater risk for these same conditions (Figure 1).

According to the 2010 National Survey on Drug Use and Health, an estimated 69.6 million

![Figure 1. The health consequences linked to smoking and secondhand smoke.](image-url)
Nicotine withdrawal symptoms include irritability, craving, depression, anxiety, cognitive and attention deficit, sleep disturbances, and increased appetite. These symptoms may begin within a few hours after the last cigarette, quickly driving people back to tobacco use. Symptoms peak within the first few days of smoking cessation and usually subside within a few weeks. For some people, however, symptoms may persist for months. Of 35 million smokers who want to quit each year, more than 85% of those who try to quit on their own relapse, most within a week.

Withdrawal is difficult because of the many physical and behavioral effects related to smoking. The withdrawal can be severe. For some smokers, the feel, smell, and sight of a cigarette and the ritual of obtaining, handling, lighting, and smoking the cigarette are all associated with the pleasurable effects of smoking and can make cravings worse. Nicotine replacement therapies such as gum, patches, and inhalers may help alleviate the pharmacological aspects of withdrawal; however, cravings often persist. Behavioral therapies can help smokers identify environmental triggers of craving so they can employ strategies to prevent or circumvent these symptoms and urges.18

Cigars
In 2010, 5.2% of the American population smoked cigars. Cigars are addictive even if the smoke is not being inhaled. High levels of nicotine can still be absorbed into the body. A cigar smoker can get nicotine by two routes: by inhalation into the lungs and by absorption through the lining of the mouth. Either way, the smoker becomes addicted to nicotine. A single cigar can potentially provide as much nicotine as a pack of cigarettes.

Most cigars are composed primarily of a single type of tobacco (air-cured and fermented), with a tobacco wrapper. Cigar smoke is possibly more toxic than cigarette smoke. Cigar smoke has a higher level of cancer-causing substances which originate from the fermentation process of the cigar manufacturing. Nitrosamines are found at higher levels in cigar smoke than in cigarette smoke. Cigar wrappers also have higher concentrations of toxins compared to cigarettes.

Furthermore, many cigars are larger resulting in a longer smoking time and higher exposure to many Americans aged 12 or older reported current use of tobacco. Specifically, 58.3 million (23.0% of the population) are cigarette smokers, 13.2 million (5.2%) smoke cigars, 8.9 million (3.5%) use smokeless tobacco, and 2 million (0.8%) smoke pipes, confirming tobacco is still one of the most widely abused substances in the United States.18

Forms of Tobacco
The following common forms of tobacco will be discussed:

- Cigarettes
- Cigars
- Chewing Tobacco/Snuff

Cigarettes
There are more than 4,000 chemicals found in the smoke of tobacco products. The cigarette is a very efficient and highly engineered drug delivery system. By inhaling tobacco smoke, the average smoker takes in 1–2 milligrams of nicotine (the chemical that causes addiction) per cigarette. Thus, a person who smokes about ½ packs (30 cigarettes) daily gets at least 300 mg “hits” of nicotine to the brain each day. Immediately after exposure to nicotine, there is a “kick” caused in part by the drug’s stimulation of the adrenal glands and the resulting discharge of epinephrine (adrenaline). The rush of adrenaline stimulates the body and causes an increase in blood pressure, respiration, and heart rate.

Smokers have access to numerous media and educational messages which state that tobacco products are unhealthy. Many nicotine-addicted patients want to quit or have attempted to quit. Why is it so hard to quit a habit a person knows may kill them? As with many addictive drugs, it is believed that nicotine affects the release of dopamine into the brain. Dopamine fuels sensations of pleasure and relaxation. Over time, nicotine becomes something a person’s body needs. In other words, after using nicotine for an extended period, the body becomes addicted to the substance. Both mind and body feel a need for the drug and its continued use. Cigarette smoking produces a rapid distribution of nicotine to the brain, peaking within 10 seconds of inhalation. However, the acute effects dissipate quickly, as does the feeling of euphoria, which causes the smoker to continue dosing to maintain the drug’s pleasurable effects and prevent withdrawal.
toxic substances including carbon monoxide, hydrocarbons, ammonia, and cadmium.

Cigar smoking has been linked to cancer of the oral cavity, larynx, esophagus, and lung. It may also cause cancer of the pancreas. Although cigar smokers have lower rates of lung cancer, coronary heart disease, and lung disease than cigarette smokers, they have higher rates of these diseases than those who do not smoke cigars. All cigar and cigarette smokers, whether or not they inhale, directly expose their lips, mouth, tongue, throat, larynx and lungs to smoke and its toxic, cancer-causing chemicals. In addition, when saliva containing the chemicals in tobacco smoke is swallowed, the esophagus is exposed to carcinogens. These exposures probably account for the similar oral and esophageal cancer risks seen among cigar and cigarette smokers.10

**Smoker's Keratosis:** Pigmentation changes, and xerostomia (Figure 2).

**Root Canals:** 28-year study showed cigarette smokers are 70% more likely to need root canal therapy than non-smokers. Smoking impairs the body’s response to infection, exacerbates bone loss throughout the skeleton, induces a chronic systemic inflammatory response, and causes vascular problems. Any of these pathways can potentially affect the health of the tooth pulp and surrounding bone tissue.10

**Sinusitis:** The incidence of acute or chronic inflammation of the nasal lining of both the maxillary and frontal sinuses occurs 75% more often among smokers than non-smokers. This may be attributed to the chemical compounds in the tobacco.

**Ability to Heal:** Nicotine is a vasoconstrictor and reduces blood flow to the tissues, causing delayed wound healing, especially in the mouth where smoke lingers. Dry sockets are four times more prevalent among smokers. Typically dry sockets occur when the addicted smoker returns to their habit too soon after an oral surgery, disrupting the delicate clot in a postoperative extraction socket.

**Leukoplakia:** A precancerous lesion of the oral soft tissue that consists of a white patch or plaque that cannot be scraped off (Figure 3). It is often associated with tobacco use. It can persist in an area with no pain or irritation. These areas can develop into more serious lesions and should be examined carefully during a meticulous oral evaluation. Some leukoplakia will regress if tobacco use is discontinued.

**Oral Implications of Cigarettes & Cigar Use/Abuse**

Various oral conditions result from chronic smoking. Among them are:

**Black Hairy Tongue:** Elongated; black, brown, yellow or white papillae in response to the solid and gaseous wastes of tobacco being trapped on the tongue’s surface. Slowed cell sloughing adds to this syndrome. Food and bacteria may be trapped in the papillae and cause halitosis.

**Stain & Calculus:** While saliva flow is generally reduced in chronic smokers, the act of smoking stimulates serous saliva flow. This can increase calculus production. Stain is generally present. The combination of stain and calculus may compromise the periodontal health of most smokers.

**Gingival and Periodontal Diseases:** Conditions such as necrotizing ulcerative gingivitis (NUG) is prevalent in smokers. Scientific evidence clearly shows smokers have more severe periodontal diseases than do non-smokers. Continued smoking is likely to compromise the success of periodontal therapy. More refractory periodontal patients are smokers (90%) when compared to the general population (25%).

**Additional Oral Changes:** Smokers may also experience candidiasis, nicotine stomatitis, smoker’s keratosis, pigmentation changes, and xerostomia (Figure 2).

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**Figure 2. Nicotine Stomatitis**

Image source: www.doctorspiller.com
Squamous Cell Carcinoma: This is the most common oral cancer linked to cigarette smokers and can occur anywhere in the mouth. It is most commonly found on the lateral borders of the tongue, the ventral surface of the tongue or floor of the mouth. Squamous cell carcinoma has a favorable prognosis if it is detected within two years of onset. If not detected early, approximately 50% will die as a direct result of the cancer or complications (Figure 4).

Other Cancers: Cigarette smoking harms nearly every organ in the body. It has been conclusively linked to cancers of the mouth, pharynx, larynx, esophagus, lung, stomach, pancreas, cervix, kidney, and bladder as well as acute myeloid leukemia. Tobacco related cancer accounts for about one-third of all cancer deaths. The overall rates of death from cancer are twice as high among smokers as non-smokers, with heavy smokers having rates that are four times greater than those of non-smokers. Foremost among the cancers caused by tobacco use is lung cancer. Cigarette smoking has been linked to about 90% of all cases of lung cancer, the number one cause of cancer deaths among both men and women.

Chewing Tobacco/Snuff
Chewing tobacco, (dip, snus or snuff) is ground up tobacco, placed and held in the vestibule and chewed, not smoked. Nicotine is absorbed through the oral mucosa and into the bloodstream. Because of this rapid absorption, it is much harder for the snuff chewer to quit as compared to the smoker.

There are several forms:
- **Chewing tobacco** consists of loose tobacco leaves, sweetened and packaged in pouches.
- **Plug.** This is chewing tobacco that has been pressed into a brick shape, often with the help of syrup, such as molasses, which also sweetens the tobacco. A piece is cut off or bitten off of the plug and held it between the cheek and gum. Tobacco juices are spit out.
- **Twist.** This is flavored chewing tobacco that has been braided and twisted into rope-like strands. Twist is held between the cheek and gum, tobacco juices are expectorated as nicotine is absorbed.
- **Snuff.** This is finely ground or shredded tobacco leaves. It’s available in dry or moist forms and is packaged in tins or tea bag-like pouches. A pinch of snuff is placed between the lower lip and gum or cheek and gum. Dry forms of snuff can be sniffed into the nose. Using snuff is also called dipping.
- **Snus.** Snus (pronounced snoos) is a newer smokeless, spitless tobacco product that originated in Sweden. It comes in a pouch that is placed between the upper lip and gum. It is left in place for less time, about a half-hour without having to spit, then is discarded.
- **Dissolvable tobacco products.** These are pieces of compressed powdered tobacco, similar to small hard candies. They dissolve in the mouth, requiring no spitting of tobacco juices. They’re sometimes called tobacco lozenges, but they’re not the same as the nicotine lozenges or gum used to help one quit smoking.
In a 2010 study, 3.5% of Americans used chewing tobacco regularly. It seems chewing tobacco is not a male dominated habit. Among both males and females, the average ages at first use of smokeless tobacco were similar in 2009 and 2010 (18.7 and 19.1 years for males, 19.3 and 19.9 years for females).²

**Oral Implications of Chewing Tobacco Use/Abuse**

The use of smokeless tobacco products poses oral health risks. The more common manifestations are discussed below:

**Leukoplakia:** These can lead to aggressive oral cancers if left unchecked. The lesion pictured here is a very early lesion with a very thin coating of leukoplakia which should resolve with cessation of snuff use.

**Verrucous Carcinoma:** The longer snuff is used, the thicker and whiter the leukoplakia becomes and the more likely the lesion is to transform into an aggressive form of squamous cell carcinoma known as verrucous carcinoma. In most cases, cessation of the habit prior to the development of the cancer results in the disappearance of the lesion and a return to normal mucosa.²⁴

**Periodontal Disease:** When tobacco products are held in the mouth, the patients may have less time to perform daily oral hygiene, allowing bacteria to flourish. Typically bleeding is an indicator of gingival inflammation. With nicotine use and abuse, vasoconstriction in oral tissues can lead to reduced bleeding upon probing which may give a false clinical indication. Keep this in mind while probing smokers.

**Dental Caries:** If the user chooses a tobacco product flavored or sweetened with a fermentable carbohydrate, there is an increase in caries, especially near the placement site.

**Gingival Recession:** Due to the irritating nature of the tobacco itself as well as the toxic chemicals release, there is a higher incidence of recession, especially adjacent to the placement site (Figure 6).

**Other Implications**

Smokeless tobacco contains approximately 28 carcinogens. It has been linked to reproductive health problems including reduced sperm count and abnormal sperm cells. Women who use smokeless tobacco during pregnancy are at an increased risk for preeclampsia, a condition that may include high blood pressure, fluid retention, and swelling; premature birth, and low birth weight babies.

**Dental Clinician/Patient Communication Regarding Tobacco Use**

Patients look to dental professionals for cessation assistance, but their addiction and enjoyment of tobacco far outweigh the best intentions of a caring clinician. We must be mindful that our efforts to educate don’t come across as judgment or lecture. We must consider any existing oral conditions that may cause harm to the patient. For suggestions on how to approach your patients who smoke about smoking cessation options, take the continuing education course at the dentalcare.com website: *Understanding Nicotine Addiction and Tobacco Intervention Techniques for the Dental Professional*.

Preventative oral cancer screenings are an annual standard of care. Documentation of such exams should also be standard procedure in all hygiene recare protocols. Use of early detection oral cancer techniques and products may be helpful. They include: visible light fluorescent...
wands that excite certain atypical compounds in the tissues, toluidine blue staining, vital staining, DNA-evaluation, and saliva-based oral cancer diagnosis. Brush and scalpel biopsies are the most effective.\footnote{12}

Smoking will reduce both mucous and serous saliva production. With compromised salivary flow and the effects of nicotine on the body, calcium uptake to teeth via saliva may also be inhibited in both smokers and chewing tobacco users. Educating the patient about the benefits of in-office and home therapeutic doses of calcium-phosphate fluoride varnishes and toothpastes will help to protect tobacco users and abusers from new or recurrent decay. A caries assessment evaluation is now considered the standard of care by the American Dental Association and should be incorporated into dental hygiene department protocols for patients with substance abuse issues (Figure 7). Assessing the patient’s lifestyle and habits with regard to their risk for decay and need for therapeutic doses of calcium phosphate fluoride varnishes and toothpastes is essential. There are various sources of additional information on varnish and toothpastes protocols for review.

It is important for the clinician to have resources for patients interested in smoking cessation. Since smoking and tobacco use affects so many patients’ health worldwide, a failure to suggest smoking cessation options and opportunities may not only affect your patients’ oral health, but may affect their lifespan as well. The American Dental Hygienists’ Association established guidelines for a smoking cessation program (http://www.askadviserefer.org/) within the dental office. As part of the ‘Ask-Advise-Refer’ campaign, clinicians can refer their patients to quit lines as well as to web-based and local cessation programs. Quit lines are telephone-based tobacco cessation services. Most are accessed through a toll-free number and provide callers with services including educational materials, referral to formal cessation programs and individualized telephone counseling. They are a significant resource universally available to dental clinicians. Evidence has revealed that quit lines are convenient, effective and preferred by smokers.\footnote{7}

In 2000, a National Youth Tobacco Survey (NYTS) was administered anonymously to school-aged children. From a sample of 35,828 students (grades 6 to 12 in 324 schools) the patterns of tobacco counseling used among physicians and dentists were reported by these students. The intent was to determine the association between “provider advice to quit” and “cessation activities among current smokers”. Thirty-three percent of adolescents who visited a physician (in this study) reported the physician counseled them about the dangers of tobacco, while only 20% reported that a dentist provided a similar message. Among students who smoked in 2010, 16.4% received advice to quit from a physician and 11.6% received advice to quit from a dentist.\footnote{23} Researchers concluded physician and dentist practice patterns on smoking cessation are well below recommended guidelines and failure to suggest smoking cessation may represent a missed opportunity to affect adolescent smoking behavior.

Quitting smokeless tobacco may cause short-term problems, especially for those who have used heavily for many years. These temporary changes can result in nicotine withdrawal symptoms that include cravings, anger/irritability, anxiety, depression or weight gain. Tobacco cessation programs for chew users need to be carefully supported. Many times health education via photographs and the invasiveness nature of oral cancers surgeries are enough to motivate the user to quit. There are many resources to support tobacco chew cessation including:

http://www.cancer.org/cancer/cancercauses/smokeless-tobacco

from the American Cancer Society. In addition, the following are suggested to assist in living a dip free lifestyle:

• Limited contact with other dippers, especially in early weeks of quitting.
• Do not buy, carry, or hold dip cans for others.
• Do not let people dip in your home. Post a small “No Tobacco” sign by your front door.
• Ask others to help you remain tobacco-free. Give them specific examples of things that are helpful (such as not dipping around you) and things that are not helpful (like asking you to buy chew for them).
Prior to being surveyed; 23.7% had binged (5+ drinks within 2 hours); and 6.8% drank heavily (5+ drinks on 5+ occasions). In the 12-17 age range, 14.7% had consumed at least one drink in the 30 days prior to being surveyed; 8.8% had binged; and 2.1% drank heavily.

**Alcohol Use & Addiction**

In 2009, 51.9% of Americans age 12 and older had used alcohol at least once in the 30 days prior to being surveyed; 23.7% had binged (5+ drinks within 2 hours); and 6.8% drank heavily (5+ drinks on 5+ occasions). In the 12-17 age range, 14.7% had consumed at least one drink in the 30 days prior to being surveyed; 8.8% had binged; and 2.1% drank heavily.
Ethyl alcohol, or ethanol, is the intoxicating ingredient found in beer, wine, and liquor. Alcohol is produced by the fermentation of yeast, sugars, and starches. It is a central nervous system depressant that is rapidly absorbed from the stomach and small intestine into the bloodstream. A standard drink (12 ounces of beer, 8 ounces of malt liquor, 5 ounces of wine, or 1.5 ounces (a “shot”) of 80-proof distilled spirits or liquor (gin, rum, vodka, or whiskey) equals 0.6 ounces of pure ethanol.

Alcohol affects every organ in the body as well as damage a developing fetus. Intoxication can impair brain function and motor skills; heavy use can increase risk of certain cancers, stroke, and liver disease. Alcoholism or alcohol dependence is a diagnosable disease characterized by a strong craving for alcohol, and/or continued use despite harm or personal injury. Alcohol abuse, which can lead to alcoholism, is a pattern of drinking that results in harm to one’s health, interpersonal relationships, or ability to work. The National Institutes of Health reports 15% of the people living in the United States are considered “problem drinkers.” Within this population, 5%-10% of the men and 3%-5% of the women could be labeled as alcoholics (Figure 8).

**Oral Implications of Alcohol Use/Abuse**

**Excessive Bleeding or Bleeding Disorders:** Alcoholism may damage the liver and bone marrow resulting in excessive bleeding during dental treatment. If excessive bleeding is observed, treatment should be stopped and digital pressure applied. Referral for medical evaluation and necessary blood coagulation tests should be requested before treatment progresses.

**Effectiveness of Drugs:** The drugs used in dentistry that are metabolized in the liver include amide local anesthetics and benzodiazepines. These drugs can have a reduced effect in the alcohol abusive patient. They can metabolize faster as compared to a routine patient. Dental anesthetics may not work as well at the injection site in the alcohol abuser and may be carried into the bloodstream more rapidly. Repeated doses may need to be reduced, or the interval between doses prolonged, to prevent excessive blood levels.

**Periodontal Disease:** Several biological explanations exist for the detrimental effect that alcohol may have on the periodontium. Studies have shown neutrophilic phagocytosis is associated with periodontal disease. Alcohol also impairs neutrophil function, contributing to bacterial overgrowth which may lead to periodontal inflammation. Additionally, alcohol may have a direct toxic effect on periodontal tissue. Finally, high alcohol intake increases monocyte production of inflammatory cytokines (tumor necrosis factor-alpha (TNF-α), interleukins-1 and 6), in the gingival crevice which is associated with periodontitis.

**Oral Cancer:** Alcohol drinking has been associated with oral cancer. Evidence suggests that this is because alcohol breaks down into acetaldehyde which can bind to the proteins in the oral cavity. This can trigger an inflammatory response in the body. In the most severe cases, cancerous cells can develop. Oral cancer most often appears on the lips or tongue but can occur under the tongue, on the palate or on the gingiva. An oral cancer screening should be performed at each dental exam.

**Dental Caries:** Heavy drinkers may experience dry mouth at night and neglect both personal and professional oral health care. They may also consume higher levels of refined carbohydrates to satisfy their “munchies.” Heavy drinking can also lead to frequent vomiting and the vomit is extremely acidic. All of these might increase their risk of developing dental caries.

**Xerostomia:** Because alcohol will dehydrate the patient, their salivary flow may be compromised. An enlargement of the parotid salivary glands may be a sign of a chronic alcohol use problem. Educating the patient about the benefits of in-office and home therapeutic doses of calcium-phosphate fluoride varnishes and toothpastes will help to protect these patients from new or recurrent decay. Have the patient do a Caries Assessment Evaluation to discover their proper protocol for varnish and toothpaste regimens (see Figure 7).

**Blood Pressure:** When treating an alcohol dependent patient, the clinician should consider the possibility of increased blood pressure and monitor vital signs at each appointment.
by administering injectable/topical anesthetics or performing scaling which could induce prolonged bleeding. Some dental offices now keep an alcohol breathalyzer on hand to test the patient’s blood levels to determine if treatment is contraindicated. Protocols for dealing with patients suspected of being under the influence of alcohol should be established in the office. The office personnel may consider testing the patient’s blood alcohol levels, having the patient sign-off to have or not have treatment, gently suggesting the appointment be rescheduled for another day or dismissing the patient.

Patients with signs of oral-related pathology should be educated about oral cancers and conditions that can persist and may be related to alcohol consumption. Many patients withhold from their medical history and patient interview an accurate picture of the amount of alcohol or drug use. Providing an overview of associated lifestyle habits can infer to the patient's inherent risks of alcohol indulgence without getting invasive or too personal. Proper documentation of clinical findings and suspected lifestyle should be documented in the patient’s chart for future reference.

Dental Clinician/Patient Communication Regarding Alcohol Use
Patients may not openly admit they have an alcohol problem. Many times this is omitted from a medical history and only occasionally will it come up in conversation if a patient is seeking help or guidance. The dental clinician must be competent at recognizing signs, especially if a patient is “under the influence”. Use the senses: the smell of alcohol on breath or the odor of alcohol upon opening the bloodstream during scaling; has a red face or bloodshot eyes; has hypertrophy of parotid glands; exhibits slurred speech; or demonstrates impaired or inappropriate behavior.

When alcohol abuse is suspected in the dental patient, management depends on whether or not the patient is intoxicated, shows signs of alcohol abuse or reports substance abuse on the health history. A patient who comes to the appointment in an inebriated state should be rescheduled and accompanied to their home by a responsible person. This can become a delicate situation for which the dental office would become liable if they were to treat this patient...
If an alcohol dependant patient presents for dental treatment and wants to discuss their current dependency, it is important to provide a safe accepting environment in which to deliberate. Having support materials on hand within your dental office from a resource such as Alcoholics Anonymous (AA) can provide a tie to that support system without the patient having to do research themselves. Keeping a printed list (or marking it in your web browser) is another convenient means to help an alcohol dependant patient seek help. Placing brochures or AA meeting lists inside the oral hygiene take-home bags will keep this information discrete. Make sure the patient approves of the information before providing it as a take along (Figure 9).

**Prescription Medication Use & Addiction**

Prescription drug abuse is the intentional use of a medication without a prescription, in a way other than as prescribed, or for the experience or feeling it causes (for the “high”). It is a problem that deserves attention, especially from healthcare professionals. While prescription drugs can be powerful healing tools, they also pose serious health risks related to their abuse.¹⁷

In 2010, approximately 7 million people (2.7% of the U.S. population) were current users of psychotherapeutic drugs taken non-medically.¹⁷ The medications most commonly abused are:

- Pain relievers – 5.1 million
- Tranquilizers – 2.2 million
- Stimulants – 1.1 million
- Sedatives – 0.4 million

Prescription and over-the-counter medications account for most of the commonly abused drugs by high school seniors (Figure 10). Nearly 1 in 12 high school seniors reported non-medical use of Vicodin; 1 in 20 reported abuse of OxyContin. When asked how prescription narcotics were obtained for non-medical use, 70% of 12th graders said they were given to them by a friend or relative.¹⁷

There are several factors that contribute to prescription drug abuse:

- **Misperceptions about their safety.** Because these medications are prescribed by doctors, many patients assume the medications are safe to take under any circumstances. This is not the case. Prescription drugs act directly or indirectly on the same brain systems affected by illicit drugs. Using a medication other than as prescribed can lead to a variety of adverse health effects, including overdose, addiction or death.

  - **Increasing availability.** Between 1991 and 2010, prescriptions for stimulants increased from 5 million to nearly 45 million and for opioid analgesics from about 75.5 million to 209.5 million.
  - **Motivations to abuse.** Patients may use prescription drugs to get high; to counter anxiety, pain, or sleep problems; or to enhance cognition. Whatever the motivation, prescription drug abuse comes with serious risks.¹⁷

### Commonly Abused Prescription Drugs

**Opioids (used to treat pain):** Prescription opioids act on the same receptors as heroin and can be highly addictive. People who abuse them sometimes alter the route of administration (e.g., snorting or injecting) to intensify the effect; some even report moving from prescription opioids to heroin. It is estimated that approximately 1.9 million people in the U.S. meet abuse or dependence criteria for prescription opioids. Abuse of opioids either alone or with alcohol or other drugs, can depress respiration or lead to death. Unintentional overdose deaths involving prescription opioids have quadrupled since 1999 and now outnumber those from heroin and cocaine combined (Figure 11). Injecting opioids increases the risk of HIV and other infectious diseases through use of unsterile or shared equipment. Non-injection drug use can also increase these risks through drug-altered judgment and decision making.

**CNS Depressants (used to treat anxiety and sleep problems):** These drugs are addictive and, in chronic users or abusers, discontinuing them

![Figure 9. Examples of informative brochures available from Alcoholics Anonymous.](image-source)

Image source: Alcoholics Anonymous pamphlet library
without a physician’s supervision can bring about severe withdrawal symptoms, including seizures, which can be life-threatening.

**Stimulants (used to treat ADHD and narcolepsy):** Misuse of stimulants can cause addiction and other health consequences. These include psychosis, seizures, and cardiovascular complications.  

**Oral Implications of Prescription Medication Use/Abuse**

Oral implications of prescription medication use and abuse are vast depending on the specific drug being used/abused. Common implications include xerostomia, clenching/grinding, caries and periodontal disease. A routine, thorough oral exam is recommended. Identifying the particular prescription drug will reveal more complete oral implications.

**Identifying the Prescription Drug Abuser**

The dental office can be a target for a prescription drug abuser as they may be seeking prescriptions from the office. Paying special attention to medications listed on the medical history may not be sufficient for the patient suspected of abusing prescription drugs as the patient may downplay
Marijuana increases dopamine, which creates the good feelings or “high” associated with its use. A user may feel the urge to smoke marijuana again, and again, and again to re-create that experience. Repeated use could lead to addiction – a disease where people continue to do something, even when they are aware of the severe negative consequences at the personal, social, academic, and professional levels.

Cannabis may be smoked as a cigarette or in a pipe, as well as added to foods. A favorite way to use marijuana is through a “bong” in which the smoke is sucked through a layer of water that cools and removes some of the tar and irritants. Marijuana use is reported to have risen in recent decades in both adults and children. It is reported that as many as 60% of Americans have experimented with cannabis at some point in their lives.²

When marijuana is smoked, tetrahydrocannabinol (THC) rapidly passes from the lungs into the bloodstream, which carries the chemical to the brain and other organs throughout the body.

Contrary to common belief, marijuana is addictive. Estimates from research suggest that about 9% of users become addicted to marijuana; this number increases to 17% among those who start young. People who use marijuana may also experience a withdrawal syndrome when they stop using the drug. It is similar to what happens to tobacco smokers when they quit – people report being irritable, having sleep problems, and weight loss-effects which can last for several days to a few weeks after drug use is stopped. Relapse is common during this period, as users also crave the drug to relieve these symptoms.³

Oral Implications of Marijuana Use/Abuse Periodontal Disease: Smoking marijuana may contribute to periodontal disease in a way similar to tobacco smoking. A recent study of individuals who reported smoking cannabis at ages 18, 21, 26 and 32 years of age in New Zealand investigated the relationship between marijuana and oral health. When measurements of oral health between ages 26 and 32 in the group reporting high cannabis use were
If you think a patient may be inappropriately asking you for drugs, consider the following questions:

- How often does this patient present?
- Has the patient told you that he has moved, but doesn’t want you to talk to his previous doctor?
- Is the patient paying with cash?
- Does the person have a last known address?
- Have you had trouble contacting the patient between visits?
- Are your prescription pads disappearing?
- Does the patient say that only a particular drug will work, or that no other drug he has tried has worked?
- Does the patient refuse to go to one primary care physician?
- Does the patient frequently report losing medications?
- Does the patient demand drugs with high street value?
- Does the patient have prescriptions from multiple doctors or have prescriptions filled at multiple pharmacies?
- Is the patient cooperating with the full treatment plan-physical therapy, alternative medicines, etc.?

Figure 12. Questions to Identify the Drug-seeking Patient.

Figure 13. Illicit drug use among persons age 12 or older (2010)
Substance Abuse and Mental Health Services Administration (SAMHSA)
Xerostomia: Heavy use may cause xerostomia in the mouth and dryness in the throat, irritation of oral tissues, edema, and erythema of the uvula. As an added detriment, the xerostomia may increase the caries rate.

Tissue Changes: The high temperature of the burning product on the oral tissues causes some tissue change and cellular disruption. Additionally, oral leukoplakia/erythroplakia, leukoedema and hyperkeratotic lesions have been documented. Candida has been reported to be higher in marijuana users compared with tobacco users.

Other Effects of Marijuana: In addition to oral effects, cannabis smoking has been implicated in cardiovascular disease. A recent systematic review reports atrial fibrillation, increased heart rate, and a risk for postural hypotension in healthy men who used marijuana. In older adults cardiovascular changes led to angina attacks from lack of oxygenated blood in cardiac muscle.

Methamphetamine

Methamphetamine (meth) abuse has increased significantly as the National Survey on Drug Use and Health reports. Between 2002 and 2004, the percentage of meth users who were dependent on the drug increased from 27.5% to 59.3%. It is estimated there are 12.3 million Americans over the age of 12 who have used the drug at least once, with the majority of users between ages 18-34 years. Meth can be made from inexpensive medications or simple over-the-counter chemicals (lye, muriatic and sulfuric acids) that are easily obtained at stores. Street names include Speed, Ice, Chalk, Crank and Crystal.

Meth is a highly addictive synthetic amine that stimulates the release and blocks the re-uptake of serotonin, dopamine and norepinephrine in the brain. The action of these neurotransmitting monoamines is to stimulate the reward centers of the brain and give the characteristic “high” of the substance. Lack of appetite frequently accompanies this drug’s effect. The high can last 14 hours. During the high, the user is typically impaired and unable to care for themselves or others. Long-term use leads to depletion of these neurotransmitters, resulting in emotional depression.

Oral Implications of Meth Use/Abuse

Dental Caries: Meth mouth, or crank decay, is commonly observed in methamphetamine users. The cause of meth mouth is multifactorial. Meth users commonly experience drug-induced cravings for high-calorie carbonated beverages. As a result, soft drinks containing high amounts of sugar and caffeine are often consumed to prolong the high and assuage the cravings. Reports indicate that Mountain Dew™ is commonly ingested by meth users; as much as several liters per day. The drug produces extreme xerostomia, reducing the amount of protective saliva and buffering capacity around the teeth. As a result of these behaviors, the oral bacterial levels can drastically increase, exacerbating the decay. The caustic nature of the drug, poor oral care and high sugar diet result in increased decay. This devastation can occur rapidly in as little as one year. Conventional dental treatment is frequently of little value. Often, the caries are so significant and rampant that full-mouth extractions are indicated (Figure 14).

Periodontal Disease: Methamphetamine users have an increased incidence of periodontal disease. The drug causes vasoconstriction of the vessels that supply blood to the oral
tissues. With repeated use of the drug and repeated vasoconstriction, the blood vessels are permanently damaged and the oral tissues die. In addition, lack of proper daily oral hygiene further exacerbates the declining periodontal health.

**Bruxism:** Methamphetamine can cause users to feel anxious and nervous, resulting in clenching and grinding of the teeth. Signs of bruxism, including fractures of the teeth and severe attrition, are common. The vasoconstriction can also affect the vitality of the teeth, increasing the likelihood of enamel fractures.

**Oral Ulcers and Infection:** Oral ulcerations and infections are common among methamphetamine users. When smoked or snorted, the caustic ingredients of the drug bathe the oral cavity and irritate and burn the oral tissues. This leads to significant oral ulcerations and infections. This is also brought on by the severe dry mouth that accompanies the use of meth. Xerostomia is caused by the vasoconstriction and reduction of salivary gland function. The tongue and lining of the mouth can become raw and irritated without the surfactant action of saliva. This can lead to secondary infections and limited ability to speak and eat.6

**Local Anesthesia and Sedation:** The clinician must be sure the meth patient has not used several days prior to deep sedation and dental injections need to be closely monitored.

For more advanced clinical information about the oral implications of meth abuse, please see the following course on dentalcare.com: *Methamphetamine: Implications for the Dental Team.*

**Cocaine**

Cocaine is a powerfully addictive stimulant that directly affects the brain. Cocaine was labeled the drug of the 1980s and 1990s because of its extensive popularity and use during that period. However, cocaine is not a new drug. In fact, it is one of the oldest known psychoactive substances. Coca leaves, the source of cocaine, have been chewed and ingested for thousands of years, and the purified chemical, cocaine hydrochloride, has been an abused substance for over 100 years. In the early 1900s, for example, purified cocaine was the active ingredient in most of the tonics and elixirs that were developed to treat a wide variety of illnesses.

Cocaine is generally sold on the street as a fine, white, crystalline powder known as coke, C, snow, flake, or blow. Street dealers generally dilute it with inert substances such as cornstarch, talcum powder, sugar, or with active drugs such as procaine (a chemically related local anesthetic) or amphetamine (another stimulant). Some users combine cocaine with heroin – in what is termed a “speedball.”

There are two chemical forms of cocaine that are abused: the water-soluble hydrochloride salt and the water-insoluble cocaine base (or freebase). When abused, the hydrochloride salt, or powdered form of cocaine, can be injected or snorted. The base form of cocaine has been processed with ammonia or sodium bicarbonate and water, and then heated to remove the hydrochloride to produce a substance that can be smoked. The term “crack,” which is the street name given to freebase cocaine, refers to the crackling sound heard when the mixture is smoked.15

The National Survey on Drug Use and Health (NSDUH) estimates that in 2008 there were 1.9 million cocaine users and approximately 359,000 were current crack users. Adults aged 18 to 25 years have a higher rate of current cocaine use than any other age group, with 1.5% of young adults reporting past month cocaine use. Overall, men report higher rates of current cocaine use than women.2

Users generally take cocaine in “binges,” during which the cocaine is used repeatedly and at increasingly higher doses. This can lead to increased irritability, restlessness, panic attacks, and paranoia—even a full-blown psychosis, where the individual loses touch with reality and experiences auditory hallucinations. With increasing dosages or frequency of use, the risk of adverse psychological or physiological effects increases.10

**Oral Implications of Cocaine Use/Abuse**

**Dental Caries:** Cocaine users experience an increased rate of tooth decay for a variety of
reasons: the drug contributes to xerostomia, the user does not seek regular professional care or perform regular personal oral care, and they may rub the drug directly onto the gingival tissue resulting in tooth erosion.

**Gingival and Periodontal Diseases:** Xerostomia and lack of routine oral hygiene care lead to an increased rate of periodontal diseases. Bruxing may also contribute to disease.

**Bruxism and TMJ:** Clenching and grinding contribute to the destruction of the supporting structures leading to cervical abrasion, occlusal wear and TMJ disorders.

**Gingival Lesions:** The user may rub the drug on the gingival tissue resulting in gingival lesions.

**Nasal and Oropharynx:** Regularly snorting cocaine can lead to loss of sense of smell, nosebleeds, problems with swallowing, hoarseness, and an overall irritation of the nasal septum, which could result in a chronically inflamed, runny nose.

**Other Oral Effects:** Other manifestations include oral candida infections, perforation of palate, bilateral cleft lip and palate in fetus, angular cheilitis, halitosis, glossodynia, erosive lichen planus, corrosion of gold restorations, and excessive hemorrhage after tooth extraction.\(^7\)

**Local Anesthesia:** The administration of a local anesthetic with vasoconstrictors may result in an acute rise in blood pressure which could lead to cardiac arrest. There is also a risk of convulsions associated with the combination of lidocaine and cocaine potentiates. Use of epinephrine-impregnated retraction cords is also contraindicated. It is advisable to postpone any dental treatment at least 6 to 24 hours after the use of cocaine.\(^1\)

**Dental Clinician/Patient Communication Regarding Illegal Drug Use**

Patients may not admit they have a drug dependency. The dental clinician must be competent at recognizing signs, especially if a patient is "under the influence".

When abuse is suspected, management depends on whether or not the patient is high, shows signs of abuse or whether they are seeking help with a drug problem. As with alcohol, protocols for dealing with patients should be established in the office.

Patients with signs of oral-related pathology should be educated about the conditions. Proper documentation of clinical findings and suspected lifestyle should be included in the patient’s chart.

If a drug dependent patient presents for dental treatment and chooses to discuss their current dependency, provide a safe accepting environment for discussion. Having support materials on hand from a resource such as Narcotics Anonymous (NA) can provide a link to that support system. Further communication suggestions are available at Partnership for a Drug Free America and National Clearinghouse for Alcohol and Drug Abuse Information.\(^7\)

**Conclusion**

Substance abuse is a national concern. The dental professional must be aware of the indications of substance use, have the knowledge to recognize and treat dental concerns, and provide the patient with cessation information.
1. A dental clinician needs to be observant when treating patients who use drugs, alcohol or tobacco to ___________.
   a. avoid potential medical emergencies
   b. promote long term health of the oral cavity
   c. increase the quality of life
   d. All of the above.

2. Surveyed patients in the __________ years of age group, were more likely to lie or withhold information on their medical history regarding drug use, sexual history, and smoking habits, than patients 55 years or older.
   a. 17-24
   b. 25-34
   c. 35-45
   d. 46-54

3. Men are more likely to lie about how much they drink on a medical history form.
   a. True
   b. False

4. The Stages of Substance Abuse are _____________.
   a. Experimentation, Regular to Risky Use, Dependence, Addiction
   b. Try, Buy, High, Fly
   c. Experimentation, Psychological Dependence, Physical Dependence, Addiction
   d. None of the above.

5. Psychological dependence _____________.
   a. is a behavioral pattern characterized by drug craving and overwhelming desire to obtain a drug supply despite the consequence
   b. is a state where discontinuation of the drug causes physical symptoms that are relieved by administering the same or similar drug
   c. causes problems for the user because they can stop using drugs whenever they want
   d. All of the above.

6. Tobacco is one of the most widely abused substances in the United States.
   a. True
   b. False

7. Cigarette smokers are _______ more likely to need root canal therapy than non-smokers.
   a. 20%
   b. 50%
   c. 70%
   d. 100%
8. If not detected early, approximately _______ of people diagnosed with Squamous Cell Carcinoma will die as a result of the cancer or from complications associated with it.
   a. 10%
   b. 25%
   c. 50%
   d. 80%

9. Other names for chewing tobacco include ____________.
   a. Plug
   b. Snuff
   c. Snus
   d. All of the above.

10. ____________ is now considered the Standard of Care by the American Dental Association and should be incorporated into your dental hygiene department protocols for substance user and abuser patients.
    a. Caries assessment evaluation
    b. Electric powered toothbrushes
    c. Water flossers
    d. All of the above.

11. Oral implications of alcohol abuse include ____________.
    a. increased bleeding
    b. reduced effect of local anesthetics
    c. increased periodontal disease
    d. All of the above.

12. Common reasons for the increased use of prescription drugs are ____________.
    a. sensitivity to alcohol
    b. misperceptions about their safety
    c. increasing environmental availability
    d. B and C

13. Cannabis smoking may contribute to ____________.
    a. periodontal disease
    b. caries
    c. xerostomia
    d. All of the above.

14. Methamphetamine users experience dental caries due to ____________.
    a. Xerostomia produced by the drug
    b. Frequent ingestion of high sugar, high caffeine soft drinks
    c. Caustic nature of the drug
    d. All of the above.

15. The dental clinician should use which of the following skills when treating a patient who has a substance abuse problem?
    a. Be aware of the indicators of substance abuse.
    b. Have the knowledge to recognize and treat dental concerns.
    c. Provide the patient with cessation information.
    d. All of the above.
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7. Frieda P. Substance Abuse: Considerations for the Oral Health Professional When the Client is Suspected to be Abusing Substances. (August 2012). Tennessee Dental Hygienists Association Continuing Education.

Additional Resources
• American Council for Drug Education
• Center for Disease Control
• Center for Substance Abuse Prevention
• Community Anti-Drug Coalitions of America
• Council for Prevention of Alcohol and Substance Abuse
• Department of Health and Human Services
• Freevibe
• Methamphetamine Treatment Project
• Narconon International
• National Clearinghouse for Alcohol and Drug Info
• National Institute on Drug Abuse (NIDA) or www.drugabuse.gov
• NIDA for Teens
• Office of Community oriented Policing
• Office of National Drug Control Policy
• Ohio Parents for Drug Free Youth
• Ohio Department of Alcohol and Drug Addition
• Ohio Resource Network
• Oregon Meth Watch
• The Partnership for a Drug-Free America
• Street Drugs
• Substance Abuse and Mental Health Services
• U.S. Drug Enforcement Administration
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Jill Obrochta received her Bachelor’s of Science Degree at Loyola University in 1985 and her Certificate in Tissue and Anesthesia at UCLA in 1991. Initially practicing Dental Hygiene in the Chicago area, she polished the “business edge” to her career. Establishing herself in a niche area of dental research, Jill developed easy-to-follow dental practice protocol for Infection Control Compliance within the insurance industry in accordance with OSHA and the Center for Disease Control.

She expanded her career into the field of academics. By securing a position with a highly dynamic dental education company, she was part of a national team of dental hygienists that were dedicated to research and lecturing the current trends to other dental professionals.

In 1999, she co-founded the Ft. Lauderdale-based dental continuing education foundation, transcenDENTALStudyGroup.org. This unique continuing education venue, offers dental professionals an opportunity to stay clinically current with a special focus on Stress Relief, Psychological Balance and Self! TranscenDENTAL's success gained notoriety in RDH magazine for offering continuing education credits with a unique motivational flair. Jill also co-writes and has co-hosted several Health-Channel Television Shows for Today's Health/CNBC, and local Cable & You-Tube™ Television.

Jill went on to establish a professional education company, Dental Enhancements.com, providing a unique blend of dental education, motivation, practice growth solutions, and 5-star customer services philosophies that culminate into the most exquisite & unique dental patient experience!
Over the past 2 decades she has researched and developed innovative dental team workshops, such as: OSHA made Easy™, Perio Fitness, Dental Branding & Internet Marketing, Winning Influences in the Now Economy (W.I.N.E.™), and many other powerful practice growth solution seminars.

She is a charismatic dental speaker, with an approachable style that makes learning uniquely memorable and fun! Jill has coached dental teams from coast-to-coast, as well as presented inspirational workshops at many National Dental Conferences and to the Dental Hygiene Society of Switzerland.

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