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patient arrive to the visit by his or her self, and can they take care of their own apartment or house"?

Dentists need also consider the urgency (medically necessary versus elective), and invasiveness of the planned procedure. A denture adjustment or examination or prophylaxis without local anesthesia is roughly analogous to a haircut in terms invasiveness; rescheduling is rarely indicated. Conversely, a 3-hour multiple extraction using 15 through 20 milliliters of local anesthetic is a physiological challenge.

Finally, many dental patients are in pain or anxious. This contributes to the elevated BP found the day of the visit and precipitates more emergencies than the operation itself. Fortunately, most dentists can offer some type of sedation. Studies and personal experience have shown sedation can lowers BP 20 through 30 millimeters of mercury, just as effectively as administering antihypertensive medications.[4]

A multicenter randomized clinical trial looking at what adverse effects might occur if dental treatment were performed on patients with elevated BP would be interesting. It would be expensive, need to enroll thousands of patients because of the few anticipated adverse events, and may not pass the scrutiny of many universities' institutional review boards. I doubt it would find the outcome postulated by some that patients with elevated BP are more likely to have a stroke, myocardial infarction, or increased intraoperative bleeding if allowed to complete the planned dental treatment.

Canceling an elective, invasive procedure on a frail patient not seen by his or her physician for over 1 year, especially with BP in the 180/110 mm Hg range and dyspnea or chest pain walking to the chair is reasonable. Any intraoperative or immediate postoperative complication in such cases would be hard to defend. However, with no known benefit, the risks and costs of canceling and rescheduling secondary to isolated elevated BP readings in most patients unwarranted. This practice should stop. ■

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AUTHORS' RESPONSE

We greatly appreciate Dr. Bavitz's kind words and his interest in hypertension in dentistry for over 20 years. We completely agree that encouraging dentists to obtain accurate blood pressure (BP) measurements will educate patients about the importance of hypertension while contributing to diagnosing new office hypertension in patients that may not have access to BP measurements. We also appreciate his support in using a simple functional capacity assessment concurrently with BP measurement for especially complex dental procedures, rather than simply canceling the procedure due to elevated office BP measurements. We agree that a multicenter randomized trial would be useful, but likely not practical, owing to the cost. We would suggest that for complex elective dental procedures that patient should correctly measure home BP twice daily, when awakening and at bedtime the week before the procedure. This would importantly assess hypertension control and if it is elevated in office before the procedure, while normal at home, then white-coat anxiety would be the source of elevation and easily treated by sedation. ■

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OPIOID AND ANTIBIOTIC PRESCRIBING

We thank Roberts and colleagues for a wonderful March JADA study titled "Antibiotic and Opioid Prescribing for Dental-Related Conditions in Emergency Departments: United States, 2012 Through 2014 (Roberts RM, Bohm MK, Bartoces MG, Fleming-Dutra KE, Hicks LA, Chalmers NI. *JADA*. 2020;151[3]:174-181.e1) using IBM MarketScan Research Databases in Treatment Pathways data that draw attention to opioid prescribing in hospital emergency departments (EDs) for dental problems. We have published in JADA about ED visits for dental problems and found that over 1.4 million occur each year in the United States.[1] Inserting this context into the Roberts and colleagues' study finding that about 40% of dental-related ED visits result in an opioid prescription and about 55% result in an antibiotic prescription help quantify the issue.

Problematically, physicians have limited knowledge of oral health and prescribe opioids and antibiotics to postpone the need for dental intervention. Importantly, as we write this letter to the editor, dentists around the country are being advised to stop elective care in response to the COVID-19 crisis. Many dental offices are choosing to practice aerosol-free dentistry, which essentially means postponing dental services.

During this crisis, we must pay heed to Roberts and colleagues' study, which shows that, when direct emergency dental care is inaccessible, clinicians frequently resort to antibiotics and opioids. Prescribing both have consequences, but opioids have been identified as a gateway drug for heroin[2] and fentanyl[3] and are associated with persistent use and abuse.[4] 2018 was the first in several years that opioid-related mortality actually fell in the United States.[5,6] Dentists and physicians must be very cautious to prevent a trend reversal and consequent worsening of the opioid crisis in 2020 and beyond. ■

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PREVENTIVE ORAL HEALTH SERVICES

In an article published in the April issue of JADA titled "Impact of a Medicaid Policy on Preventive Oral Health Services for Children With Intellectual Disabilities, Developmental Disabilities, or Both" (Kranz AM, Ross R, Sorbero M, Kofner A, Stein BD, Dick AW. *JADA*. 2020;151[4]:255-264.e3), the authors analyze the use of preventive oral health services (POHS) in medical offices for children with intellectual disabilities, developmental disabilities, or both (IDD).[1] This study concluded that children younger than 3 years with IDD in states with Medicaid policies that allowed for administration of POHS in medical offices were more likely to receive those services than children in states without these types of policies for POHS. This study emphasizes the importance of state Medicaid policies including accommodations for the administration of POHS in medical offices for children with IDD. It is imperative that state Medicaid policies also accommodate for adults with IDD, especially in states without Medicaid dental benefits for adults.

Poor oral health can be easily prevented through simple oral hygiene practices, such as brushing, flossing, and consistent dental follow-ups.[2] Despite the ease in poor oral health prevention, there is still a high rate of poor oral health seen in adults with intellectual disabilities.[1] Many adults with special health care needs (SHCN) are unable to afford private dental insurance and are often enrolled in Medicaid; however, in states like Alabama where dental coverage is not included for adults on Medicaid, these patients are often left without a dental home to provide these important POHS.[2] Low Medicaid reimbursement rates also often deter dentists from seeing patients enrolled in Medicaid in states with Medicaid policies that do provide dental coverage for adults.

These obstacles emphasize the need for creating alternative routes for administration of POHS in medical offices for adults with IDD during regular visits. With advances in medical care, many children with SHCN are able to live longer, contributing to a rise in adults with SHCN, so this expansion of POHS for adults is an important endeavor.[2] This article by Kranz and colleagues calling for improvements in minimizing barriers for Medicaid-insured children with IDD in receiving POHS is timely and should be followed by a call for mimicking these same improvements for adults with IDD, especially in the wake of the COVID-19 pandemic and the decrease in discretionary spending available for most of the US population. Now, more than ever, the cost efficiency of providing preventive services is paramount. ■

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