CE DOJO · CANNABIS & DENTISTRY

Chairside Cannabis Decision Algorithm

Use is not impairment. Screen the patient in front of you, act on what you measure, individualize, document.

1 TRIGGER — ANY OF 3

Odor (most common, least informative) · **disclosure** on the health history or at check-in · **an unexplained finding** (resting tachycardia, red eyes, a patient who seems off). Vape pens and edibles are odorless, so odor alone is not the way in. Any team member reports it to the dentist BEFORE treatment, every time.

2 PROTECT PRIVACY

Move the patient to an operatory. No cannabis conversation at the front desk or in the waiting room.

3 HISTORY

"We ask everyone. Used cannabis today? When and how?" Note edibles (they peak late) and any medical card plus issuing state.

4 VITAL SIGNS — THE STRONGEST ELEMENT

Record HR and BP with the time. Read against the patient's own baseline. Median pulse in cannabis cases runs 91 bpm against 71 in controls. Sedation case? Vitals are mandatory.

5 EYE EXAM — PENLIGHT, ~25 SECONDS

Lack of convergence. Pen tip slowly to the bridge of the nose. **Normal:** both eyes track inward and cross, holding to ~2 in. **Abnormal:** one or both eyes break outward before 2 in (the patient sees 2 tips). Scored by watching the eyes, not by asking. 78.8% of cases vs 10.9% of controls in roadside data — but 49.2% of a placebo group also failed it.

Either one positive (convergence or rebound dilation) = 92.7% sensitivity. Better than either alone. Run both; they take under half a minute together.

Nystagmus = something ELSE is on board. Cannabis does not cause it (VGN 0/302; HGN 2.65% vs 0.33%, NS). Think alcohol, benzos, barbiturates, ketamine/PCP, inhalants, phenytoin, carbamazepine, lithium, vestibular disease. **Hold sedation until you know what.**

Rebound dilation — the high-specificity one. Direct light, watch 15 sec. **Normal:** pupil constricts and stays constricted while the light is on. **Abnormal:** it constricts briefly, then steadily re-opens and never returns to the constricted size. 70.9% of cases vs 1.0% of controls. Not pupillary unrest, which flickers both ways under steady light.

Conjunctival injection. Bilateral, diffuse, 5–15 min after inhaling. 77.5% of cases. Allergies, dry eye, contacts, fatigue, alcohol do the same thing. A reason to look further.

Careful: physiologic gaze-evoked nystagmus is in 21% of healthy people at 10° and 71% at 30°. Do not eyeball 45 degrees. If you're not confident, score it absent.

6 DIVIDED ATTENTION — AND THE TEACH-BACK

Finger to nose. Eyes closed, head back, arms out. Call the hand; fingertip to nose tip. 6 trials. Record misses. 3+ misses of 6 is the threshold in the roadside data.

Teach-back — this is the one that goes in the chart. "Tell me back in your own words what we're doing today, and name one thing that could go wrong." Pass = understanding + appreciation on the record. Fail = a documented capacity problem, and you never used the word impaired.

2-part question. One instruction, 2 components: "Take your glasses off and tell me the last thing you ate today." See whether both survive.

Careful: DRE instructors called 49.2% of a placebo group impaired. Roughly half of sober people fail this. Use it to decide how carefully to proceed, never to conclude a patient is high.

7 · DECIDE

PROCEED

Lucid · consents · teach-back intact · vitals OK · no nystagmus · no rebound dilation · routine care.

Mind epinephrine in a tachycardic patient. Cannabis + nitrous / benzo / opioid is additive sedation.

Document use, the screen findings including the negatives, and vitals.

DEFER

Converging findings with a failed teach-back · can't consent · vitals in the cardiac window.

BP guide: ~180+/100+ in an otherwise normotensive patient. Individualize to baseline; not a bright line.

Reschedule elective care. Emergency? Limit to what needs no consent for an irreversible procedure.

REFER / EMERGENCY

BP ≥ 180/120 with symptoms (chest pain, dyspnea, neuro changes), or acute cardiac / neurologic signs.

The hypertensive-emergency line, separate from the cannabis question.

Call emergency care or refer, not a dental procedure. Denial doesn't change the number.

DOCUMENT (THROUGHOUT)

Vitals with numbers, time, and baseline · eye exam including convergence, rebound dilation, and **whether nystagmus was present or absent** · finger-to-nose misses · the teach-back in the patient's own words · card + issuing state · the decision and the reason. **Record the negatives.** "No nystagmus, no rebound, converges to 2 in, 0/6 misses" is what makes a decision to proceed defensible later. Never chart a conclusion ("patient was high") you can't prove.

The question a dentist answers

Whether someone is legally impaired belongs to law enforcement. Whether this patient can consent, and whether it's safe to add nitrous, a benzo, or an opioid, is yours. Chart the second one.

Baseline does most of the work

Every finding has an innocent explanation: allergies, age, essential tremor, an anticonvulsant, or plain fear of the dentist. Know the baseline or weight the finding accordingly and say so.

Before you refuse a cardholder

A card is a clinical flag, not a license to be impaired. On its own it is not a reason to refuse care. Know your state; an out-of-state card is a real possibility. Confer with counsel first.

Companion to the CE Dojo course "Cannabis & Dentistry," David Lambert, DDS. A clinical framework, not legal advice. Screening data from roadside DRE research, never validated in a dental population.

Post in the operatory