Annual Report of the Council on Communications

Chair: Carrie Arquitt                                      Date: May 2005

Board Liaison: Rhea M. Haugseth

Staff Liaison: Gina Sandoval, Cindy Hansen

Charge or Project Number: 1

Description: Review and make recommendations to the Board of Trustees regarding the content, viability and marketability of the following print/electronic publications, utilizing specific sales and inventory information, according to the outlined periodicity schedule:

a. Pediatric Dentistry Today                   Annually
b. AAPD Web site Home Page                Annually
   Review headquarters staff efforts to
   list membership publication services
   on the Web site.

c. Practice Management and Marketing News     Annually

d. Patient Education Brochures                Three years

e. Visual Reference Cards                     Three years
f. New Pediatric Dentist’s Guide to Beginning
   Practice                                    Three years

Status of Charge or Project: See below for each individual document
These charges are ongoing every year

Completed
This publication is very good and we recommend its continuation with the following recommendations: 1) Keep a consistent cover style; 2) have information about the website in each issue to prompt membership’s review; 3) increase the number of pictures; 4) have sections of articles of similar subject matter color tabbed together; 5) have a professional review of this publication every 5 years. The last review was 2001 by Tina Steger Gratz.

b. AAPD Web site Home Page
Completed
The website is easy to read and navigate. Our recommendations are: 1) give ability to change the password with a popup to remember the password; 2) link to http://babelfish.altavista.com/babelfish/tr to translate text for international members; 3) create a listing on the left side of the home page for “publications” to easily access all publications available on the Web site.
c. Practice Management and Marketing News
Completed
Quality and value to our membership continues to be high. This is currently only available on the website. Two recent membership surveys both indicate our membership would prefer this printed instead of online. Our suggestions are: 1) Blast email to remind readers when a new issue is available online (this has been implemented); 2) publish an index of the available articles in Pediatric Dentistry Today; 3) produce and sell bound volumes of archived issues of PMMN; 4) Make PMMN available in a printed, mailed version in addition to the online version.

d. Patient Education Brochures
Completed
All old ASDC brochures have been reviewed by the council during the 2003-2004 and 2004-2005 year. The text and pictures have been incorporated into the existing AAPD brochures and sent to the Council on Clinical Affairs for their review (see Appendix A).

Previously approved cards (“The Sippy Cup“, oral piercing, “Pediatric Dental Card for Health Care Professionals) were also re-reviewed by the Councils on Communications and Clinical Affairs before they are made available to our membership for purchase (see Appendix B).

Recommendations: 1) Only package and sell brochures in groupings of 100 to keep the inventory down and make analysis of sales easier. 2) Designate a “minimum order number”. If a brochure does not meet a minimum order number, it should be deleted and/or merged into existing brochures. 3) The membership survey indicated the desire for brochures printed in Spanish is low. We recommend not translating any more brochures at this time. 4) Have an outside professional review of the brochures be done. 5) All brochures should have a uniform design and format.

e. Visual Reference Cards
Completed
This year we evaluated the Trauma Card and the Pediatric Dental Reference Card. Please see Appendix C for the Trauma Card and below for the Pediatric Dental Reference card.

For the Pediatric Dental Reference card, we recommend the following: (New text is in caps, text recommended for deletion has a strikethrough)

Ectopic Eruption
Treatment: PRIMARY TEETH MAY BE EXTRACTED TO ALLOW UPRIGHTING AND BETTER ERUPTION OF THE ECTOPICALLY ERUPTING TOOTH.
Referral Age: Any seven-year-old with missing primary canines or unerupted first permanent molars should be expected of having ectopic
eruption.

f. New Pediatric Dentist's Guide to Beginning Practice
This is a brand new publication and will be reviewed after it has been available to the membership for 3 years.

Charge or Project Number: 2
Description: First Aid For Dental Emergencies: Develop a small, “hand-held” version, suitable for purchase by members for distribution to parents, coaches, school nurses, caregivers, etc.

Status of Charge or Project: Completed

Progress Report: This has been approved and will be printed and available soon to purchase.

Charge or Project Number: 3
Description: In conjunction with the New Pediatric Dentist Committee and Headquarters Office staff, complete the New Pediatric Dentist's Guide to Beginning Practice and develop a marketing plan that will take into account availability to the new pediatric dentist converting graduate to active membership as well as sale ability to the remainder of the membership.

Status of Charge or Project: Completed

Progress Report: The guide will be initially available as a written document in a “perfect bound” format.

Marketing plan:
Target group – pediatric dental residents, dental students, any dentist who wants to open a pediatric dental office or office that sees children.
1) Send an advertisement letter to all pediatric dental residents and pediatric dentistry residency program directors advertising the guide with excerpts.
2) Announce the publication of the guide at the Graduate Student Lunch and Learn. Have copies available to review at the lunch and at the new dentist happy hour.
3) Advertise the guide in ASDA publications.
4) Advertise to dental supply companies for them to buy as a gift for dentists they are helping to set up an office.
Charge or Project Number: 4

Description: From existing Academy resource materials, including materials developed as part of the AAPDF Good Health Starts Here campaign, put together a salable package of materials appropriate for member’s use on early infant dental visits.

Status of Charge or Project: Completed

Progress Report: The package consists of a folder with spaces for brochures on the right and paperwork on the other side. The purchaser can customize their folder by choosing the brochures they would like. The folder will also have a fact sheet (see appendix C).

Charge or Project Number: 5

Description: Develop and propose to the Board of Trustees by January 2005 a broad-based, multi-year promotional campaign aimed at the membership to promote the Age One Dental Visit.

Status of Charge or Project: Ongoing

Progress Report: We recommend the following to promote the Age One Dental Visit:
1) Highlight the age one dental visit in Pediatric Dentistry Today; 2) Develop a panel discussion about the age one visit to occur at the annual session and/or pediatric CE; 3) Have a PR firm create a public service announcement highlighting the age one dental visit; 4) Develop a brochure for pediatricians to promote the age one dental visit.

Charge or Project Number: 6

Description: Develop and present to the Board of Trustees no later than January 2005 a proposal for promotion of pediatric dentistry as a career choice to dental students and recent dental graduates.

Status of Charge or Project: Completed

Progress Report: The Council on Communications in conjunction with the Council on Membership has developed the following recommendations for establishing dental school based organizations for students interested in Pediatric Dentistry to promote the specialty.

1. The Councils on Membership and Communications, in conjunction with Council on Pre-doctoral Education, should establish a mentor program for pre-doctoral students and dental school graduates who express an interest in pediatric dentistry training. The mentor would adopt the interested person as a “Pedo Pledge.” Specific guidelines for
what would involve being a mentor should be developed. This program has been successful in Texas where local mentors host a pre-doctoral, pedo-interested student and include them in local programs and meetings. The mentor should offer student membership in the AAPD to enhance their interests.

2. Host a pizza night, possibly with other Post-Doctoral Dental specialties, where the Pre-Doctoral students may be introduced to the Pediatric Dental Specialty outside of the clinical routine. The evening may start with an introduction, perhaps a “Welcome” type video from the President of the AAPD. This video would be in DVD format and set for minimal cost. DVD format would allow easy coordination with a computer for simple presentation format. This would be a good replacement for the existing career choice videocassette. A Pediatric Dentist should then offer a small presentation about the specialty. This presentation should allow time for a question and answer session. The existing video about the specialty of pediatric dentistry was developed in 1992 and is dated. There have been 9 videos purchased since 2002. Headquarters staff has estimated the cost to produce a similar updated video would cost $30,000.

3. Develop AAPD student chapters at dental schools. Their purpose would be to involve students in the AAPD at an early level and provide an opportunity for social interactions.

4. A coordinated effort with Council on Pre-Doctoral Education is suggested. In order to facilitate these recommendations we ask for Council on Pre-Doctoral Education to identify a contact person at each Dental School, whereas a location for these programs could be facilitated. A proposed time-line would be to complete the contact information in the summer, and then a fall presentation would be feasible.

5. We do not recommend developing a new videocassette to replace the current one as is due to the estimated cost to make a new video ($30,000).
Appendix A

Charge: Review ASDC brochures/publications to evaluate their relevance, content, sales history and duplication of AAPD materials. Recommend continuation, revision or discontinuation of these items to the Board. (This is how the charge was worded as charge #7 for the council’s 2003-2004 charges. There is not an official charge for the 2004-2005 year. We did continue to work on this charge as it was not completed at the time of the 2004 annual session.)

Listed below are the changes our council recommends to the brochures, incorporating all of the ASDC brochures into existing AAPD brochures, with the exception of the ASDC brochure of “Baby Teeth and Beyond”. The additions are in capital letters and the verbiage recommended for deletion has a strikethrough.

Baby Teeth and Beyond (Please note that the intent of this brochure is to inform about the sequence of eruption of the primary and permanent teeth)

Cover- Change the title to YOUR CHILD’S changEInG MOUTH and change the picture graphic to a graphic of a child sleeping with the tooth fairy making a visit. The current graphic is of a walrus/cat combo brushing their teeth.

Content changes- “We frequently judge a child’s stage of DENTAL development by when THE first BABY teeth emerge and by when they are naturally lost AND THE NEW PERMANENT TEETH EMERGE.”

“The primary teeth” section- “The normal ages of eruption vary greatly from child to child, although the sequence in which the teeth erupt does not.”

Figure 1 picture- Change to a CROSSSECTION PICTURE OF HOW THE PERMANENT TEETH DEVELOP UNDER THE BABY TEETH.

Figure 2 graphic — MOVE SO THAT IS DIRECTLY AFTER THE SECTION TITLED “The Sequence of Appearance of the Primary Teeth”

The “permanent teeth” section — ADD A PICTURE THAT SHOWS THE PERMANENT/6 YEAR MOLAR ERUPTING BEHIND THE PRIMARY SECOND MOLAR TO ILLUSTRATE HOW THIS LOOKS.

“Your CHILD’S/PEDIATRIC dentist is interested in your child’s dental health and how it contributes to THEIR his overall health. You and your child with the dentist’s GUIDANCE help should attempt to keep your child’s mouth clean and healthy. ONE WAY your CHILD’S/PEDIATRIC dentist helps to achieve this important goal IS by carefully monitoring the eruption of your child’s teeth during THROUGH periodic examinations.”

ADD A TABLE WHERE THE PARENTS CAN RECORD THE ERUPTION DATES AND EXFOLIATION DATES OF THE PRIMARY TEETH

Baby’s Bright Smile - Merge into Aid’s Dental Care for Your Baby

Q. Why so early? What dental problems could a baby have?

A. The most important reason is to begin a thorough prevention program. Dental problems can begin early. A big concern is Early Childhood Caries (also know as baby bottle tooth decay or nursing caries). Your child runs the risk of severe decay from using a bottle during naps, at night, or when they nurse continuously from the breast. WHEN AN
INFANT FEEDS ACTIVELY, THEY SWALLOW. ONCE THE NUTRITIONAL NEEDS ARE MET, SUCKING BECOMES PASSIVE AND THE LIQUID CLINGS TO THE TEETH. THE SUGAR IN THE LIQUID IS CONVERTED TO ACID, STARTING THE PROCESS OF CAVITY FORMATION. ALMOST ANY LIQUID, EXCEPT PLAIN WATER, CONTAINS SUGAR, ESPECIALLY FRUIT JUICES, SODA POP, FORMULA, COW’S MILK, AND EVEN MOTHER’S BREAST MILK. The earlier the dental visit, the better the chance of preventing dental problems. Children with healthy teeth chew food easily, learn to speak clearly and smile with confidence. Start your child now on a lifetime of good dental habits.

Q. How can I prevent tooth decay from a bottle or nursing?
A. Encourage your child to drink from a cup as they approach their first birthday. Children should not fall asleep with a bottle. At-will nighttime breast-feeding should be avoided after the first primary (baby) teeth begin to erupt. Drinking juice from a bottle OR CUP should also be avoided BE IN MODERATION (AROUND 2-4 OZ A DAY MIXED 50:50 WITH WATER). When juice is offered, it should be in a cup.

Q. When should I start cleaning my baby’s teeth?
A. The sooner the better! Starting at birth, clean your child’s gums with a soft infant toothbrush and water AFTER THE MORNING FEEDING AND BEFORE BEDTIME. Remember that most small children do not have the dexterity to brush their teeth effectively. PARENTS SHOULD ASSIST THEIR CHILD’S BRUSHING UNTIL THEY ARE AT LEAST 8 YEARS OLD. Unless it is advised by your child’s pediatric dentist, do not use fluoridated toothpaste until age 2-3.

ADD ONE OF THE PICTURE SETS FROM BABY’S BRIGHT SMILE THAT ILLUSTRATES EARLY CHILDHOOD CARIES

Beyond Your Child’s Smile — Merge into AAPD’s X-Ray Use and Safety

Why should X-ray films be taken if my child has never had a cavity?
X-ray films detect much more than cavities. For example, X-rays may be needed to survey erupting teeth, EVALUATE THE DEVELOPMENT OF THE TEETH AND JAWS, diagnose bone AND TOOTH DISEASES (INCLUDING PERIODONTAL DISEASE, CYSTS AND TUMORS OF THE JAW, AND MISSING OR EXTRA TEETH), and evaluate the results of an injury or plan orthodontic treatment

How safe are dental X-rays?
Pediatric dentists are particularly careful to minimize the exposure of child patients to radiation. With contemporary safeguards, the amount of radiation received in a dental X-ray examination is extremely small. The risk is negligible. In fact, dental X-rays represent a far smaller risk than an undetected and untreated dental problem. IN FACT, THE BENEFITS GAINED FROM USE OF DENTAL X-RAYS FAR OUTWEIGHT ANY RISK.

PICTURE RECOMMENDATIONS: SUBSTITUTE THE ASDC PICTURES FOR THE AAPD PICTURES AND THEY ARE LABELED MORE CLEARLY AND SHOW WHAT CAVITIES
AND DEVELOPING TEETH LOOK LIKE ON A RADIOGRAPH. IF THESE ARE
SUBSTITUTED, WE RECOMMEND THAT FIGURE 2 BE MODIFIED SO THAT THE CAVITIES
ON TEETH #’S S AND T ARE ALSO CIRCLED AS THEY ARE MUCH LARGER AND EASY
TO SEE THAN THE ONES CIRCLED ON A AND B.

Healthy Gums — delete
Tough Teeth — delete
Primary Importance — delete

Straighten up — Merge with AAPD’s Early Orthodontic Care brochure

It's never too early to keep an eye on your child's oral development. Your pediatric dentist can
identify malocclusion—crowded or crooked teeth or bite problems—and actively intervene to
guide the teeth as they emerge in the mouth. Orthodontic treatment early can prevent more
extensive treatment later. INTERCEPTIVE ORTHODONTICS IS A MEANS OF TREATING
BITE PROBLEMS AS A CHILD’S FACE, TEETH, AND OTHER ORAL STRUCTURES ARE
DEVELOPING. THESE BITE PROBLEMS, WHICH ARE USUALLY NOT SELF-CORRECTING,
CAN USUALLY BE SUCCESSFULLY TREATED AND GREATLY IMPROVE YOUR CHILD’S
APPEARANCE AND CHEWING EFFICIENCY. INTERCEPTIVE ORTHODONTICS MAY
ALSO REDUCE THE NEED FOR MORE EXTENSIVE TREATMENT LATER.

What is early orthodontic treatment like?
Some are fixed (GLUED TO THE TEETH); others are removable.

Early orthodontics can enhance your child’s smile, but the benefits far surpass appearance.
Pediatric orthodontics can straighten crooked teeth, guide erupting teeth into position, correct
bite problems, even prevent the need for tooth extractions. Straight teeth are easier to keep clean
and less susceptible to tooth decay and gum disease.

Snacking Good Foods — Merge with AAPD’s Diet and Snacking brochure

Q. MY CHILD REALLY LIKES TO SNACK BETWEEN MEALS, HOW CAN I GIVE THEM THE
MOST TOOTH FRIENDLY FOOD?
A. CONSISTENCY AND THE FORM OF FOOD ARE ALSO OF GREAT IMPORTANCE.
PEANUTS ARE CLEARED FROM THE MOUTH MORE QUICKLY THAN STICKY PEANUT
BUTTER. THE LONGER THE FOOD IS RETAINED ON THE TEETH, THE LONGER
BACTERIA IN THE MOUTH CAN FORM ACID THAT CAUSES CAVITIES. STARCHY AND
STICKY FOODS SUCH AS CRACKERS AND POTATO CHIPS ARE BETTER COMBINED
WITH MEALS AND AVOIDED IN BETWEEN MEALS AND AT BEDTIME. AT BEDTIME
TEETH ARE ESPECIALLY SUSCEPTIBLE TO CAVITIES BECAUSE THE FLOW OF SALIVA
SLOWS AND THE ACID CAN BE ACTIVE ON THE TEETH FOR LONGER PERIODS OF
TIME.
Q. Any final advice?
A. 7. THE TYPES OF SNACKS CHILDREN CHOOSE ARE DEPENDENT ON THE EATING
HABITS PARENTS HELP THEM FORM.

Invisible Fillings — Merge with AAPD’s Tooth Colored Fillings
Q. What are the advantages of tooth colored fillings?
A. ...A tooth can be filled and sealed at the same time to prevent further decay. ...ONLY DECAYED TOOTH STRUCTURE IS REMOVED, RETAINING MORE OF THE HEALTHY TOOTH.
Q. What are the disadvantages?
A. THIRD, THEY CANNOT BE PLACED ON A WET TOOTH, THEREFORE PATIENT COOPERATION IS CRITICAL.

Be Cool — Merge with AAPD Dental Care for your Baby and Calming the Anxious Child

Dental Care for your Baby

Q. Why so early? What dental problems could a baby have?
A. Start you child now on a lifetime of good dental habits. ALSO, BEGINNING YOUR CHILD’S DENTAL EXAMINATIONS AS EARLY AS SIX MONTHS OF AGE STARTS BUILDING A CARING AND COOPERATIVE RELATIONSHIP BETWEEN YOUR DENTIST AND YOUR CHILD. IT IS DURING THE FIRST EIGHT MONTHS OF LIFE THAT YOUR BABY WILL LEARN TO TRUST PEOPLE, TO KNOW THAT THEY ARE BEING CARED FOR.

Calming the Anxious Child

Q. Should I accompany my child into treatment?
A. SOME DENTISTS THINK IT IS HELPFUL TO HAVE THE PARENT PRESENT IN THE ROOM DURING DENTAL TREATMENT. OTHERS FEEL IT IS MORE DIFFICULT TO ESTABLISH A RELATIONSHIP WITH THE PATIENT WHEN THE PARENT IS PRESENT. THE AGE OF THE CHILD AND THEIR PREVIOUS DENTAL EXPERIENCES ARE JUST TWO FACTORS THAT WILL HELP THE DENTIST MAKE THE BEST DECISIONS REGARDING YOUR PRESENCE IN THE ROOM.
Q. What is a child misbehaves during treatment?
A. YOU SHOULD NOT BE SURPRISED OR EMBARRASSED WHEN YOUR CHILD DOES NOT COOPERATE IN THE DENTAL OFFICE. THE DENTIST AND STAFF ARE EXPERIENCED IN COPING WITH THIS BEHAVIOR. Occasionally a child’s behavior during treatment requires assertive management to protect him or her from possible injury. Voice control (speaking calmly but firmly) usually takes care of it. Some children need gentle restraint of the arms or legs as well.
IT IS NORMAL FOR A CHILD TO ATTEMPT TO AVOID NEW EXPERIENCES, SO AS A PARENT, DO NOT OVERREACT. A PARENT WHO OVERREACTS ADMITS TO THEIR FEARS ARE JUSTIFIED. FURTHERMORE, IN ORDER TO GAIN THE CHILD’S TRUST, THEY SHOULD NOT BE MISLED ABOUT THEIR DENTAL TREATMENT. WHEN PREPARING THEM FOR A DENTAL VISIT, DO NOT USE WORDS THAT WILL FRIGHTEN THEM LIKE “NEEDLE”, “SHOT”, OR “DRILLING”. TERMS SUCH AS “A LITTLE PINCH”, “SLEEPY WATER FOR YOUR TOOTH”, AND “THE TICKLER” ARE MUCH BETTER UNDERSTOOD AND ACCEPTED BY CHILDREN. THE DENTIST AND THE DENTAL STAFF CAN HELP YOU WITH APPROPRIATE WORDS.
THE CHILD’S EMOTIONAL BEHAVIOR SHOULD BE DISCUSSED WITH THE DENTIST BEFORE THE APPOINTMENT SINCE THEIR EMOTIONAL BEHAVIOR CAN BE SEVERELY
AFFFECTED BY DIVORCE, ILLNESS, A DEATH IN THE FAMILY, OR PROBLEMS IN SCHOOL. SUCH INFORMATION IS HELPFUL AND NECESSARY FOR YOUR DENTIST TO WORK SUCCESSFULLY WITH YOUR CHILD.

Tooth Rescue — Merge with AAPD’s Emergency Care and Mouth Protectors brochure
Q. What should I do if my child’s baby tooth is knocked out?
A. Contact your pediatric dentist as soon as possible. DO NOT REPLACE A BABY TOOTH. BRING THE TOOTH TO THE DENTIST TO CHECK.

Seal Out Trouble — Merge with AAPD’s Sealants brochure
FIGURE 2 PICTURE THAT SHOWS HOW A SINGLE BRUSH BRISTLE CANNOT GET DOWN INTO THE TOOTH GROOVE BUT BACTERIA CAN.

(THE PICTURES IN THE ASDC BROCHURE ARE BETTER, PROVIDE A MORE CLEAR DESCRIPTION OF WHAT SEALANTS ARE AND WHY THEY ARE PLACED) (WE DO NOT WANT TO GIVE PARENTS A FALSE SENSE OF SECURITY WITH SEALANT PLACEMENT.)
Appendix B

Oral Piercing

CAUTION!

Did You Know?

- That piercing your tongue may lead to nerve damage, loss of taste, and cause a speech impediment?
- That the barbell balls can cause gum and tooth damage, including breaking off large pieces of front or back teeth?
- That tongue piercing can lead to infection of the tongue, neck and brain; even life threatening infections such as hepatitis and endocarditis?
- That labrets can damage teeth, gums and supporting bone, and may result in significant facial scarring?
- That piercings on the lip and face can lead to facial scarring?

The Sippy Cup

Use of sippy cups with diluted liquids or anything other than water can increase your child’s risk for tooth decay.

Ask your Pediatric Dentist About Sippy Cup Tips

To reduce the risk of cavities, please read the following:

- The sippy cup is designed to be a training tool to help children transition from a bottle to a cup. It should not be used for a prolonged period of time. The sippy cup is not a bottle and it is not a pacifier.
- Unless being used at mealtime, the sippy cup should be filled ONLY with WATER. Remember, frequent drinking of any liquid, even if diluted, from a bottle or no-spill training cup should be avoided.
- Sippy cups should not be used at naptime or bedtime unless they have only water in them. Always remember to clean your child’s teeth before placing him or her in bed.
Pediatric Dental Card For Health Care Professionals

INFANT ORAL EXAMINATION
(6 TO 12 MONTHS)
Concept: The infant oral examination serves as the foundation of preventive education and dental care to assure optimal oral health.
Components: This visit should include:
• Caries risk assessment (see below) and formulation of a preventive plan
• Comprehensive orofacial examination
• Discussion of oral developmental milestones
• Oral hygiene instructions
• Fluoride status—Evaluate and optimize fluoride exposure
• Counseling regarding diet, feeding practices and counseling regarding non-nutritive sucking habits
• Counseling regarding trauma and injury prevention
• Education on infant oral health
• Referral to a pediatric dentist by 12 months of age

CARIES-RISK ASSESSMENT
Concept: An infant’s, child’s or adolescent’s risk for developing caries is based upon clinical, environmental and general health indicators. Using AAPD’s Caries-risk Assessment Tool provides a means of classifying dental caries risk at a point in time. Since caries-risk indicators change, assessment should be performed on a periodic basis.
Risk Indicators:
• History — medical, dental, complications during pregnancy and infancy
• Diet and nutrition—special dietary considerations, infant feeding practices, chronic medications
• Fluoride — sources including type of dietary sources, toothpaste and supplementation
• Family history of dental caries, especially the mother
• Oral hygiene — visible plaque, brushing and flossing
• Child’s caries history
• Presence of orthodontic appliances
• Socioeconomic status of caregiver
• Regular use of dental services
• Teeth and saliva — enamel quality, adequate spacing, adequate salivary flow

EARLY CHILDHOOD CARIES (ECC)
Definition: The presence of 1 or more decayed (cavitated or non-cavitated), missing (due to caries), or filled surfaces in any primary tooth in a child 5 years—71 months of age or younger.
Etiology: Multiple exposures to fermentable carbohydrates, without appropriate preventive practices, by an at-risk individual.

Prevention:
- Discourage at-will nocturnal breast-feeding and use of a bottle containing any substance other than water with eruption of the first tooth
- Wean from bottle by 12-14 months of age. Discourage extended and repetitive use of a no-spill training (sippy) cup that contains anything but water
- Practice good oral hygiene and healthy dietary habits
- Assess and reduce mother’s levels of mutans streptococci to decrease the transmission of cariogenic bacteria
- Establish a dental home between 6 and 12 months of age to determine caries risk and develop an individualized preventive program

Intervention: Referral to a pediatric dentist for evaluation and treatment.

Pediatric Dental Card For Health Care Professionals

FLUORIDE
Concept: Fluoride is an important component of preventive dentistry. A caries-risk assessment and fluoride history, including all dietary sources, are important to determine the infant’s, child’s or adolescent’s fluoride needs.

Vehicles:
- Community water fluoridation — most cost effective, 1 ppm concentration
- Commercial products — (professional-applied and OTC) pastes, gels, rinses, and varnishes. Topical fluoride-containing products must be used with caution in young children to prevent ingestion of excessive amounts of fluoride.
- Systemic supplementation — only if indicated after a thorough fluoride assessment. Caution: Should be exercised in the 3 and under age group to prevent fluorosis of the permanent teeth.

DIET AND NUTRITION
Concept: Dietary choices affect oral health as well as general health and well-being. Frequent ingestion of sugars and other carbohydrates, and prolonged contact of these substances with teeth are particular risk factors in the development of dental caries.

Infant and Preschool
- Wean by 12-14 months, no bottle to bed unless it contains only water
- Water only for at-will drinking (bottle, sippy cup or cup)
- Avoid sweetened and/or acidic beverages, including juice, between meals
- Be aware that chronic medications with sugar may require aggressive preventive measures
- Consume sticky, fermentable carbohydrates and sugary snacks in moderation
- Limit fast food and high saturated fatty foods
- Drink water when thirsty and avoid sweetened and/or acidic beverages, soda and sports drinks between meals

School age
- Avoid sweetened and/or acidic beverages and soda, including juice, between meals
• Consume candy, cookies, sweetened breakfast cereal, chips, and gum in moderation, as a dessert with a meal
• Encourage sugar-free chewing gum
• Limit between meal snacking
• Limit fast food and high saturated fatty foods
• Drink water when thirsty

Adolescent
• Limit fast food and high saturated fatty foods
• Be aware of the potential for eating disorders
• Avoid sweetened and/or acidic beverages, soda and sports drinks between meals
• Drink water when thirsty
• Poor eating habits and increased autonomy in dietary and hygiene decisions can lead to an increase in dental caries in newly erupted teeth
• Consume candy, cookies, sweetened breakfast cereal, chips, and gum in moderation, as a dessert with a meal
• Encourage sugar-free chewing gum
• Limit between meal snacking

NON-NUTRITIVE SUCKING
Concept: Sucking digit, pacifier or other object can be considered normal behavior in infants and young children. Dentoalveolar changes depend upon the frequency, intensity, direction, and/or duration of the habit. Non-nutritive sucking habits that persist in children beyond the age of 3 years should be evaluated by a pediatric dentist.

Sequelae:
• Open-bite
• Alteration of growth, speech development
• Interference with normal tooth position, crossbite

Intervention: Refer to a pediatric dentist for evaluation. Treatment will not be successful until the child psychologically is ready to stop.
Table 1. Dietary Fluoride Supplementation Schedule

<table>
<thead>
<tr>
<th>Age</th>
<th>Concentration of fluoride in water supply</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Less than 0.3 ppm F</td>
</tr>
<tr>
<td>Birth – 6 mo</td>
<td>0</td>
</tr>
<tr>
<td>6 mo – 3 y</td>
<td>0.25 mg</td>
</tr>
<tr>
<td>3 – 6 y</td>
<td>0.50 mg</td>
</tr>
<tr>
<td>6 y up to at least 16 y</td>
<td>1.00 mg</td>
</tr>
</tbody>
</table>
Appendix C

Council on Communications

Charge: Review the Visual Reference Cards: Pediatric Dental Trauma- Permanent and Primary Teeth

This card was reviewed a year early in the 3 year reviewing cycle as the trauma guidelines were revised this year. The recommendation are as follows:

Discolored primary incisor: Color change ALONE does not necessarily indicate the need for a pulpectomy or extraction, but discolored primary teeth are more likely to undergo pathologic changes. Thus, periodic follow-up is essential to DIAGNOSE PATHOLOGIC CHANGES AS SOON AS POSSIBLE and to provide the best possible health of the developing permanent teeth. VENEERING masking a discolored vital tooth may be an option for esthetic concerns. We also recommend lightening the existing picture so it matches the other pictures.

Displaced primary incisor: For extruded and laterally luxated teeth, CONSIDER repositionING the tooth and allow for healing or extract if these displacements are severe or if the primary tooth is nearing exfoliation. SPLINTING IS NOT RECOMMENDED IN THE PRIMARY DENTITION.

Permanent tooth section:
The text is in line with the updated guidelines. No changes are recommended in the text.

It was recommended that the picture for an avulsed permanent incisor show what it looks like when the incisor is avulsed. However, this is what the picture for the avulsed primary incisor already looks like, so I like the picture of a splinted incisor in place.
Appendix D

Infant Dental Exam “Fact Sheet” (Draft)

Teething
Most infants experience some symptoms with teething, including:
* Drooling
* Change in sleep habits
* Mouthing objects
* Pain and gum tenderness
* Irritability

Many children find relief from something cool or firm to chew on like a teething ring. Tylenol, Motrin, or rubbing on the gums with a clean finger can provide relief. If the symptoms persist or worsen, contact your child’s dentist.

Diet
* Infants should be weaned from the bottle and transition to the cup when they are 12 -14 months. Putting children to bed with a bottle puts them at a higher risk for dental decay and ear infections.
* Breast fed babies should not be fed “at will” after the first tooth erupts
* Use caution with sippy cups. Many infants and toddlers who drink out of the cup or bottle between meals with sugary beverages (Kool-aid®, soda, chocolate milk, fruit juices and punches, sweet tea) are at a higher risk to develop tooth decay.
* Encourage healthy, age appropriate snacks (whole grains, fruits and vegetables, cheese) Avoid cookies, candy, soda, cereals with sugar, foods that are high in carbohydrates and starch with no nutritional value. Read your labels. Many pre-packaged foods are very high in sugar and low nutrition carbohydrates. Keep juice at a minimum.

Fluoride
Fluoride plays an important role in cavity prevention. Your child may receive fluoride in many forms including toothpaste, food and water, fluoride supplements, and fluoride treatments at the dental office. A small pea-sized amount of toothpaste is recommended for children 2 ½ years and older. Careful supervision during brushing is important. Your dentist can help you determine if your child is receiving an adequate amount of fluoride.
Children who benefit the most from fluoride are those at highest risk for dental decay. Risk factors include a previous history of dental decay, high sucrose and carbohydrate diet, dry mouth, and orthodontic appliances.

Trauma prevention
Toddlers are susceptible to falls and injuries. Prevention strategies include:
* Buffer hard edges and corners
* Use nonskid mats in the tubs
* Remove or hide cords that can electrocute or strangle a child
* Put ice or a cold compress on an oral injury. See your dentist if a tooth has been fractured, knocked out, displaced in the socket, or is loose after an injury. Go to the emergency room if your child has had a severe blow to the head or a jaw fracture.
Follow up visits
Your dentist will schedule your child for regular check ups. These are important to evaluate tooth and facial development, proper oral hygiene, fluoride recommendations, preventive strategies, and to give you age appropriate recommendations concerning your child’s oral development. Your pediatric dentist is uniquely trained to develop a combination of office and home preventive care to ensure your child a happy smile.