

Guideline on Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance/Counseling, and Oral Treatment for Infants, Children, and Adolescents

Originating Committee

Clinical Affairs Committee

Review Council

Council on Clinical Affairs

Adopted

1991

Revised

1992, 1996, 2000, 2003, 2007, 2009

Purpose

The American Academy of Pediatric Dentistry (AAPD) intends this guideline to help practitioners make clinical decisions concerning preventive oral health interventions, including anticipatory guidance and preventive counseling, for infants, children, and adolescents.

Methods

This guideline is a compilation of related policies and guidelines developed by the AAPD, in addition to pediatric oral health literature and national reports and recommendations. The related policies and guidelines provide additional references for individual recommendations.

Background

Professional care is necessary to maintain oral health.¹ The AAPD emphasizes the importance of initiating professional oral health intervention in infancy and continuing through adolescence and beyond.^{1,2} The periodicity of professional oral health intervention and services is based on a patient's individual needs and risk indicators.^{3,4} Each age group has distinct developmental needs to be addressed at specific intervals as part of a comprehensive evaluation.⁵⁻⁷ Continuity of care is based on the assessed needs of the individual patient and assures appropriate management of all oral conditions, dental disease, and injuries.⁸⁻¹⁰ The early dental visit to establish a dental home provides a foundation upon which a lifetime of preventive education and oral health care can be built.¹¹ Anticipatory guidance and counseling are essential components of the dental visit.^{5,7,11-18}

Recommendations

This guideline addresses periodicity and general principles of examination, preventive dental services, anticipatory guidance/counseling, and oral treatment for children who have no

contributory medical conditions and are developing normally. An accurate, comprehensive, and up-to-date medical history is necessary for correct diagnosis and effective treatment planning. Recommendations may be modified to meet the unique requirements of patients with special needs.

Clinical oral examination

The first examination is recommended at the time of the eruption of the first tooth and no later than 12 months of age.¹¹ The developing dentition and occlusion should be monitored throughout eruption at regular clinical examinations. Unrecognized dental disease can result in exacerbated problems which lead to more extensive and expensive care,¹⁹⁻²¹ whereas early detection and management of oral conditions can improve a child's oral health, general health and well-being, and school readiness.^{12,22-27} Early diagnosis of developing malocclusions may allow for timely therapeutic intervention.²⁸

Components of a comprehensive oral examination include assessment of:

- General health/growth
- Pain
- Extraoral soft tissue
- Temporomandibular joint
- Intraoral soft tissue
- Oral hygiene and periodontal health
- Intraoral hard tissue
- The developing occlusion
- Caries risk
- Behavior of child

Based upon the visual examination, the dentist may employ additional diagnostic aids (eg, radiographs, photographs, pulp testing, laboratory tests, study casts).

The most common interval of examination is 6 months; however, some patients may require examination and preventive

services at more frequent intervals, based upon historical, clinical, and radiographic findings.^{3,29-34} Caries and its sequelae are among the most prevalent health problems facing infants, children, and adolescents in America.¹ Caries is cumulative and progressive and, in the primary dentition, is highly predictive of caries occurring in the permanent dentition.^{35,36} Reevaluation and reinforcement of preventive activities contribute to improved instruction for the caregiver of the child or adolescent, continuity of evaluation of the patient's health status, and repetitive exposure to dental procedures, potentially allaying anxiety and fear for the apprehensive child or adolescent.

Caries-risk assessment

Risk assessment is the key element of contemporary preventive care for infants, children, adolescents, and persons with special health care needs. Its goal is to prevent disease by identifying and minimizing causative factors (eg, microbial burden, dietary habits, plaque accumulation) and optimizing protective factors (eg, fluoride exposure, oral hygiene, sealants).³⁷ A caries-risk assessment tool (CAT) simplifies and clarifies the process.¹³ Sufficient evidence demonstrates certain groups of children at greater risk for development of early childhood caries (ECC) would benefit from infant oral health care.^{12,22,38,39} Infants and young children have unique caries-risk factors such as ongoing establishment of oral flora and host defense systems, susceptibility of newly erupted teeth, and development of dietary habits. Children are most likely to develop caries if mutans streptococci are acquired at an early age.^{39,40} The characteristics of ECC and the availability of preventive methods support anticipatory guidance/counseling as an important strategy in addressing this significant pediatric health problem. ECC can be a costly, devastating disease with lasting detrimental effects on the dentition and systemic health.^{12,19-27} Adolescence can be a time of heightened caries activity due to an increased intake of cariogenic substances and inattention to oral hygiene procedures.^{41,42} Risk assessment can assure preventive care is tailored to each individual's needs and direct resources to those for whom preventive interventions provide the greatest benefit. Because a child's risk for developing dental disease can change over time due to changes in habits (eg, diet, home care), oral microflora, or physical condition, risk assessment must be repeated regularly and frequently to maximize effectiveness.

Prophylaxis and topical fluoride treatment

The interval for frequency of professional preventive services is based upon assessed risk for caries and periodontal disease. Gingivitis is nearly universal in children and adolescents⁴³; it usually responds to thorough removal of bacterial deposits and improved oral hygiene.^{43,44} Self-administered plaque control programs without periodic professional reinforcement are inconsistent in providing long-term inhibition of gingivitis.⁴⁴ Many patients lack the skill or motivation to become and remain plaque-free for a significant time.⁴⁴ Hormonal fluctuations, including those occurring during the onset of puberty, can modify the gingival inflammatory response to dental plaque.⁴³

Children can develop any of the several forms of periodontitis, with aggressive periodontitis occurring more commonly in children and adolescents than adults.⁴³

Caries risk may change quickly during active dental eruption phases. Newly erupted teeth may be at higher risk of developing caries, especially during the post-eruption maturation process. Children who exhibit higher risk of developing caries would benefit from recall appointments at greater frequency than every 6 months. This allows increased professional fluoride therapy application, microbial monitoring, antimicrobial therapy reapplication, and reevaluating behavioral changes for effectiveness.^{3,45,46} An individualized preventive plan increases the probability of good oral health by demonstrating proper oral hygiene methods/techniques and removing plaque, stain, calculus⁴⁷, and the factors that influence their build-up.⁴⁸⁻⁵⁰

Professional topical fluoride treatments should be based on caries risk assessment.^{13,14,51-53} A pumice prophylaxis is not an essential prerequisite to this treatment.⁵⁴ Appropriate precautionary measures should be taken to prevent swallowing of any professionally-applied topical fluoride. Children at moderate caries risk should receive a professional fluoride treatment at least every 6 months; those with high caries risk should receive greater frequency of professional fluoride applications (eg, every 3-6 months).^{52,55,56,57-62} Ideally, this would occur as part of a comprehensive preventive program in a dental home.¹¹

Fluoride supplementation

Fluoride contributes to the prevention, inhibition, and reversal of caries.^{53,62,63} The AAPD encourages optimal fluoride exposure for every child, recognizing fluoride in the community water supplies as the most beneficial and inexpensive preventive intervention. Fluoride supplementation should be considered when fluoride exposure is not optimal.⁶² Supplementation should be in accordance with the guidelines jointly recommended by the AAPD⁶², the American Academy of Pediatrics⁶³, and the American Dental Association (ADA)⁶⁴, and endorsed by the Centers for Disease Control and Prevention.¹⁴

Anticipatory guidance/counseling

Anticipatory guidance is the process of providing practical, developmentally-appropriate information about children's health to prepare parents for the significant physical, emotional, and psychological milestones.⁶⁵ Appropriate discussion and counseling should be an integral part of each visit. Topics to be included are oral hygiene and dietary habits, injury prevention, nonnutritive habits, substance abuse, intraoral/perioral piercing, and speech/language development.

Oral hygiene counseling involves the parent and patient. Initially, oral hygiene is the responsibility of the parent. As the child develops, home care is performed jointly by parent and child. When a child demonstrates the understanding and ability to perform personal hygiene techniques, the health care professional should counsel the child. The effectiveness of home care should be monitored at every visit and includes a discussion on the consistency of daily preventive activities.³

High-risk dietary practices appear to be established early, probably by 12 months of age, and are maintained throughout early childhood.^{66,67} Frequent bottle feeding at night, breastfeeding on demand, and extended and repetitive use of a no-spill training cup are associated with, but not consistently implicated in, ECC.⁶⁸ The role of carbohydrates in caries initiation is unequivocal. Acids in carbonated beverages can have a deleterious effect (ie, erosion) on enamel. Excess consumption of carbohydrates, fats, and sodium contribute to poor systemic health. Dietary analysis and the role of dietary choices on oral health, malnutrition, and obesity should be addressed through nutritional and preventive oral health counseling at periodic visits.¹⁵ The US Department of Agriculture's Food Pyramid⁶⁹ and Center for Disease Control and Prevention/National Center for Health Statistics' Growth Charts⁷⁰ provide guidance for parents and their children and promote better understanding of the relationship between healthy diet and development.

Facial trauma that results in fractured, displaced, or lost teeth can have significant negative functional, esthetic, and psychological effects on children.⁷¹ Practitioners should provide age-appropriate injury prevention counseling for orofacial trauma.^{16,17} Initially, discussions would include play objects, pacifiers, car seats, and electrical cords. As motor coordination develops, the parent/patient should be counseled on additional safety and preventive measures, including mouthguards for sporting activities. The greatest incidence of trauma to the primary dentition occurs at 2 to 3 years of age, a time of increased mobility and developing coordination.⁷² The most common injuries to permanent teeth occur secondary to falls, followed by traffic accidents, violence, and sports.⁷³⁻⁷⁶ Dental injuries could have improved outcomes if the public were aware of first-aid measures and the need to seek immediate treatment.

Nonnutritive oral habits (eg, digital and pacifier habits, bruxism, abnormal tongue thrusts) may apply forces to teeth and dentoalveolar structures.¹⁸ Although early use of pacifiers and digit sucking are considered normal, habits of sufficient frequency, intensity, and duration can contribute to deleterious changes in occlusion and facial development. It is important to discuss the need for early additional sucking, then the need to wean from the habits before malocclusion or skeletal dysplasias occur. Early dental visits provide an opportunity to encourage parents to help their children stop sucking habits by age 3 years or younger. For school-aged children and adolescent patients, counseling regarding any existing habits (eg, fingernail biting, clenching, bruxism) is appropriate.¹⁸

Speech and language is an integral component of a child's early development.⁷⁷ Deficiencies and abnormal delays in speech and language production can be recognized early and referral made to address the concerns appropriately. Communication and coordination of appliance therapy with a speech and language professional can assist in the timely treatment of these disorders.

Smoking and smokeless tobacco use almost always are initiated and established in adolescence.⁷⁸⁻⁸⁰ During this time period, children may be exposed to opportunities to experiment

with other substances that negatively impact their health and well-being. Practitioners should provide education regarding the serious health consequences of tobacco use and exposure to second hand smoke.⁸¹ The practitioner may need to obtain information regarding tobacco use and alcohol/drug abuse confidentially from an adolescent patient.⁶ When substance abuse has been identified, referral for appropriate intervention is indicated.

Complications from intraoral/perioral piercings can range from pain, infection, and tooth fracture to life-threatening conditions of bleeding, edema, and airway obstruction.⁸² Although piercings most commonly are observed in the teenaged pediatric dental patient, education regarding pathologic conditions and sequelae associated with these piercings should be initiated for the preteen child/parent and reinforced during subsequent periodic visits.

Radiographic assessment

Appropriate radiographs are a valuable adjunct in the oral health care of infants, children and adolescents.^{29,30} Timing of initial radiographic examination should not be based upon the patient's age.²⁹ Rather, after review of an individual's history and clinical findings, judicious determination of radiographic needs and examination can optimize patient care while minimizing radiation exposure.^{29,30} The US Food and Drug Administration/ADA guidelines were developed to assist the dentist in deciding under what circumstances specific radiographs are indicated.³⁰

Treatment of dental disease/injury

Healthcare providers who diagnose oral disease or trauma should either provide therapy or refer the patient to an appropriately-trained individual for treatment.⁸³ Immediate intervention is necessary to prevent further dental destruction, as well as more widespread health problems. Postponed treatment can result in exacerbated problems that may lead to the need for more extensive care.¹⁹⁻²¹ Early intervention could result in savings of health-care dollars for individuals, community health care programs, and third party payors.

Treatment of developing malocclusion

Guidance of eruption and development of the primary, mixed, and permanent dentitions is an integral component of comprehensive oral health care for all pediatric dental patients.²⁸ Early diagnosis and successful treatment of developing malocclusions can have both short-term and long-term benefits, while achieving the goals of occlusal harmony and function and dentofacial esthetics.⁸⁴⁻⁸⁷ Early treatment is beneficial for many patients, but may not be indicated for every patient. When there is a reasonable indication that an oral habit will result in unfavorable sequelae in the developing permanent dentition, any treatment must be appropriate for the child's development, comprehension, and ability to cooperate. Use of an appliance is indicated only when the child wants to stop the habit and would benefit from a reminder.²⁸ At each stage of occlusal development, the objectives of intervention/treatment include: (1) reversing

adverse growth; (2) preventing dental and skeletal disharmonies; (3) improving esthetics of the smile; (4) improving self-image; and (5) improving the occlusion.²⁸

Sealants

Sealants reduce the risk of pit and fissure caries in susceptible teeth and are cost-effective when maintained.^{88,89} They are indicated for primary and permanent teeth with pits and fissures that are predisposed to plaque retention. At-risk pits and fissures should be sealed as soon as possible. Because caries risk may increase at any time during a patient's life due to changes in habits (eg, dietary, home care), oral microflora, or physical condition, unsealed teeth subsequently might benefit from sealant application.⁸⁸ The need for sealant placement should be reassessed at periodic preventive care appointments. Sealants should be monitored and repaired or replaced as needed.

Third molars

Panoramic or periapical radiographic assessment is indicated during late adolescence to assess the presence, position, and development of third molars.^{29,30} A decision to remove or retain third molars should be made before the middle of the third decade.⁹⁰ Consideration should be given to removal when there is a high probability of disease or pathology and/or the risks associated with early removal are less than the risks of later removal.¹⁰

Referral for regular and periodic dental care

As adolescent patients approach the age of majority, it is important to educate the patient and parent on the value of transitioning to a dentist who is knowledgeable in adult oral health care. At the time agreed upon by the patient, parent, and pediatric dentist, the patient should be referred to a specific practitioner in an environment sensitive to the adolescent's individual needs.^{6,91} Until the new dental home is established, the patient should maintain a relationship with the current care provider and have access to emergency services. Proper communication and records transfer allow for consistent and continuous care for the patient.

Recommendations by age

6 to 12 months

1. Complete the clinical oral examination with adjunctive diagnostic tools (eg, radiographs as determined by child's history, clinical findings, and susceptibility to oral disease) to assess oral growth and development, pathology, and/or injuries; provide diagnosis.
2. Provide oral hygiene counseling for parents, including the implications of the oral health of the caregiver.
3. Remove supragingival and subgingival stains or deposits as indicated.
4. Assess the child's systemic and topical fluoride status (including type of infant formula used, if any, and exposure to fluoridated toothpaste) and provide counseling regarding fluoride. Prescribe systemic fluoride supplements,

if indicated, following assessment of total fluoride intake from drinking water, diet, and oral hygiene products.

5. Assess appropriateness of feeding practices, including bottle and breast-feeding, and provide counseling as indicated.
6. Provide dietary counseling related to oral health.
7. Provide age-appropriate injury prevention counseling for orofacial trauma.
8. Provide counseling for nonnutritive oral habits (eg, digit, pacifiers).
9. Provide required treatment and/or appropriate referral for any oral diseases or injuries.
10. Provide anticipatory guidance.
11. Consult with the child's physician as needed.
12. Complete a caries risk assessment.
13. Determine the interval for periodic reevaluation.

12 to 24 months

1. Repeat 6 to 12-month procedures every 6 months or as indicated by individual patient's risk status/susceptibility to disease.
2. Assess appropriateness of feeding practices (including bottle, breast-feeding, and no-spill training cups) and provide counseling as indicated.
3. Review patient's fluoride status (including any childcare arrangements which may impact systemic fluoride intake) and provide parental counseling.
4. Provide topical fluoride treatments every 6 months or as indicated by the individual patient's needs.

2 to 6 years

1. Repeat 12- to 24-month procedures every 6 months or as indicated by individual patient's risk status/susceptibility to disease. Provide age-appropriate oral hygiene instructions.
2. Scale and clean the teeth every 6 months or as indicated by individual patient's needs.
3. Provide pit and fissure sealants for caries-susceptible primary molars and fissure sealants for permanent molars, premolars, and anterior teeth.
4. Provide counseling and services (eg, mouthguards) as needed for orofacial trauma prevention.
5. Provide assessment/treatment or referral of developing malocclusion as indicated by individual patient's needs.
6. Provide required treatment and/or appropriate referral for any oral diseases, habits, or injuries as indicated.
7. Assess speech and language development and provide appropriate referral as indicated.

6 to 12 years

1. Repeat 2- to 6-year procedures every 6 months or as indicated by individual patient's risk status/susceptibility to disease.
2. Provide substance abuse counseling (eg, smoking, smokeless tobacco).
3. Provide counseling on intraoral/perioral piercing.

12 years and older

1. Repeat 6- to 12-year procedures every 6 months or as indicated by individual patient's risk status/susceptibility to disease.
2. During late adolescence, assess the presence, position, and development of third molars, giving consideration to removal when there is a high probability of disease or pathology and/or the risks associated with early removal are less than the risks of later removal.
3. At an age determined by patient, parent and pediatric dentist, refer the patient to a general dentist for continuing oral care.

References

1. US Dept of Health and Human Services. Oral Health in America: A Report of the Surgeon General. Rockville, Md: US Dept of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health; 2000.
2. Lewis DW, Ismail AI. Periodic health examination, 1995 Update: 2. Prevention of dental caries. The Canadian Task Force on the Periodic Health Examination. *Can Med Assoc J* 1995;152(6):836-46.
3. US Preventive Services Task Force. Guide to Clinical Preventive Services. 2nd ed. Baltimore, Md: Williams and Wilkins; 1996.
4. Beirne P, Forgie A, Clarkson J, Worthington HV. Recall intervals for oral health in primary care patients. *Evid Based Dent* 2005;6(3):62-3.
5. American Academy of Pediatric Dentistry. Guideline on infant oral health care. *Pediatr Dent* 2009;31(special issue):95-9.
6. American Academy of Pediatric Dentistry. Guideline on adolescent oral health care. *Pediatr Dent* 2008;30(suppl):94-101.
7. American Academy of Pediatric Dentistry. Guideline on the role of prophylaxis in pediatric dentistry. *Pediatr Dent* 2008;30(suppl):119-20.
8. American Academy of Pediatric Dentistry. Guideline on pediatric restorative dentistry. *Pediatr Dent* 2008;30(suppl):169-9.
9. American Academy of Pediatric Dentistry. Guideline on acquired temporomandibular disorders in infants, children, and adolescents. *Pediatr Dent* 2008;30(suppl):202-4.
10. American Academy of Pediatric Dentistry. Guideline on pediatric oral surgery. *Pediatr Dent* 2008;30(suppl):205-11.
11. American Academy of Pediatric Dentistry. Policy on the dental home. *Pediatr Dent* 2008;30(suppl):22-3.
12. American Academy of Pediatric Dentistry. Policy on early childhood caries: Classifications, consequences, and preventive strategies. *Pediatr Dent* 2008;30(suppl):40-3.
13. American Academy of Pediatric Dentistry. Policy on the use of a caries-risk assessment tool (CAT) for infants, children, and adolescents. *Pediatr Dent* 2008;30(suppl):29-33.
14. CDC. Recommendations for using fluoride to prevent and control dental caries in the United States. *MMWR Recomm Rep* 2001;50(RR14):1-42.
15. American Academy of Pediatric Dentistry. Policy on dietary recommendations for infants, children, and adolescents. *Pediatr Dent* 2008;30(suppl):47-8.
16. American Academy of Pediatric Dentistry. Policy on prevention of sports-related orofacial injuries. *Pediatr Dent* 2008;30(suppl):58-60.
17. American Academy of Pediatric Dentistry. Guideline on management of acute dental trauma. *Pediatr Dent* 2008;30(suppl):175-83.
18. American Academy of Pediatric Dentistry. Policy on oral habits. *Pediatr Dent* 2006;28(suppl):43.
19. Lee JY, Bouwens TJ, Savage MF, Vann WF Jr. Examining the cost-effectiveness of early dental visits. *Pediatr Dent* 2006;28(2):102-5, discussion 192-8.
20. Griffin SO, Gooch BF, Beltrán E, Sutherland JN, Barsley R. Dental services, costs, and factors associated with hospitalization for Medicaid-eligible children, Louisiana 1996-97. *J Public Health Dent* 2000;60(1):21-7.
21. Ramos-Gomez FJ, Huang GF, Masouedis CM, Braham RL. Prevalence and treatment costs of infant caries in Northern California. *ASDC J Dent Child* 1996;63:108-12.
22. American Academy of Pediatric Dentistry. Policy on early childhood caries: Unique challenges and treatment options. *Pediatr Dent* 2008;30(suppl):44-6.
23. Acs G, Lodolini G, Kaminsky S, Cisneros GJ. Effect of nursing caries on body weight in a pediatric population. *Pediatr Dent* 1992;14(5):302-5.
24. Ramage S. The impact of dental disease on school performance. *J Southeast Soc Pediatr Dent* 2000;6:26.
25. National Center for Education in Maternal and Child Health. Oral health and learning. Bethesda, Md. National Center for Education in Maternal and Child Health and Georgetown University; 2001.
26. Clarke M, Locker D, Berall G, Pencharz P, Kenny DJ, Judd P. Malnourishment in a population of young children with severe early childhood caries. *Pediatr Dent* 2006;28(3):254-9.
27. Ayhan H, Suskan E, Yildirim S. The effect of nursing or rampant caries on height, body weight, and head circumference. *J Clin Pediatr Dent* 1996;20(3):209-12.
28. American Academy of Pediatric Dentistry. Guideline on management of the developing dentition and occlusion in pediatric dentistry. *Pediatr Dent* 2009;31(special issue):196-208.
29. American Academy of Pediatric Dentistry. Guideline on prescribing dental radiographs. *Pediatr Dent* 2009;31(special issue):250-2.
30. American Dental Association, US Dept of Health and Human Services. The selection of patients for dental radiographic examinations – 2004. Available at: "http://www.ada.org/prof/resources/topics/topics_radiography_examinations.pdf". Accessed June 16, 2009.

31. Greenwell H, Committee on Research, Science and Therapy American Academy of Periodontology. Guidelines for periodontal therapy. *J Periodontol* 2001;72(11):1624-8.
32. Flores MT, Andreasen JO, Bakland LK, et al. Guidelines for the evaluation and management of traumatic dental injuries (part 3 of the series). *Dental Traumatol*. 2001;17(3):97-102.
33. Flores MT, Andreasen JO, Bakland LK, et al. Guidelines for the evaluation and management of traumatic dental injuries (part 4 of the series). *Dental Traumatol* 2001;17(4):145-8.
34. Flores MT, Andreasen JO, Bakland LK, et al. Guidelines for the evaluation and management of traumatic dental injuries (part 5 of the series). *Dental Traumatol* 2001;17(5):193-6.
35. Li Y, Wang W. Predicting caries in permanent teeth from caries in primary teeth: An eight-year cohort study. *J Dent Res* 2002;81(8):561-6.
36. Helfenstein V, Steiner M, Marthaler TM. Caries prediction on the basis of past caries including precavity lesions. *Caries Res* 1991;25(5):372-6.
37. Fontana M, Zero DT. Assessing patients' caries risk. *J Am Dent Assoc* 2006;137(9):1231-9.
38. Marino R, Bonze K, Scholl T, Anhalt H. Nursing bottle caries: Characteristics of children at risk. *Clin Pediatr* 1989;28(3):129-31.
39. Harris R, Nicoll AD, Adair PM, Pine CM. Risk factors for dental caries in young children: A systematic review of the literature. *Community Dent Health* 2004;21(suppl):71-85.
40. Berkowitz RJ. Mutans streptococci: Acquisition and transmission. *Pediatr Dent* 2006;28(2):106-9.
41. American Psychological Association. *Developing adolescents: A reference for professionals*. Washington, DC: American Psychological Association; 2002.
42. Macgregor ID, Regis D, Balding J. Self-concept and dental health behaviors in adolescents. *J Clin Periodontol* 1997;24(5):335-9.
43. Califano JV, Research Science and Therapy Committee American Academy of Periodontology. Periodontal diseases of children and adolescents. *J Periodontol* 2003;74(11):1696-704.
44. Research Science and Therapy Committee American Academy of Periodontology. Treatment of plaque-induced gingivitis, chronic periodontitis, and other clinical conditions. *J Periodontol* 2001;72:1790-800. Erratum *J Periodontol* 2003;74(10):1568.
45. Featherstone JDB. Caries prevention and reversal based on the caries balance. *Pediatr Dent* 2006;28(2):128-32.
46. Anderson MH, Shi W. A probiotic approach to caries management. *Pediatr Dent* 2006;28(2):151-3.
47. Clerehugh V, Tugnait A. Periodontal diseases in children and adolescents: 2. Management. *Dent Update* 2001;28(6):274-81.
48. Roulet JF, Roulet-Mehrens TK. The surface roughness of restorative materials and dental tissues after polishing with prophylaxis and polishing pastes. *J Periodontol* 1982;53(4):257-66.
49. Hosoya Y, Johnston JW. Evaluation of various cleaning and polishing methods on primary enamel. *J Pedod* 1989;13(3):253-69.
50. Quirynen M, Bollen CML. The influence of surface roughness and surface-free energy on supra- and subgingival plaque formation in man. A review of the literature. *J Clin Periodontol* 1995;22(1):1-14.
51. Facts about Fluoride. *CDS Rev* 2006;99(1):44.
52. American Dental Association Council on Scientific Affairs. Professionally-applied topical fluoride: Evidence-based clinical recommendations. *J Am Dent Assoc* 2006;137(8):1151-9.
53. Adair SM. Evidence-based use of fluoride in contemporary pediatric dental practice. *Pediatr Dent* 2006;28(2):133-42.
54. Johnston DW, Lewis DW. Three-year randomized trial of professionally applied topical fluoride gel comparing annual and biannual applications with/without prior prophylaxis. *Caries Res* 1995;29(5):331-6.
55. Bader JD, Shugars DA, Bonito AJ. A systematic review of selected caries prevention and management methods. *Community Dent Oral Epidemiol* 2001;29(6):399-411.
56. Axelsson S, Söder B, Nordram G, et al. Effect of combined caries-preventive methods: A systematic review of controlled clinical trials. *Acta Odontol Scand* 2004;62(3):163-9.
57. Källestål C. The effect of five years' implementation of caries-preventive methods in Swedish high-risk adolescents. *Caries Res* 2005;39(1):20-6.
58. Featherstone JD, Adair SM, Anderson MH, et al. Caries management by risk assessment: Consensus statement, April 2002. *J Calif Dent Assoc* 2003;331(3):257-69.
59. Featherstone JD. The caries balance: The basis for caries management by risk assessment. *Oral Health Prev Dent* 2004;2(suppl 1):259-64.
60. Bader JD, Shugars DA, Rozier G, et al. Diagnosis and management of dental caries. *Evid Rep Technol Assess (Summ)* 2001;36:1-4.
61. Bader JD, Shugars DA, Bonito AJ. A systematic review of the performance of methods for indentifying carious lesions. *J Public Health Dent* 2002;62(4):201-13.
62. American Academy of Pediatric Dentistry. Guideline on fluoride therapy. *Pediatr Dent* 2008;30(suppl):121-5.
63. American Academy of Pediatrics Committee on Nutrition. Fluoride supplementation for children: Interim policy recommendations. *Pediatrics* 1995;95:777.
64. Meskin LH, ed. Caries diagnosis and risk assessment: A review of preventive strategies and management. *J Am Dent Assoc* 1995;126(suppl):1s-24s.

65. Lewis CW, Grossman DC, Domoto PK, Deyo RA. The role of the pediatrician in the oral health of children: A national survey. *Pediatrics* 2000;106(6):E84.
66. Douglass JM. Response to Tinanoff and Palmer: Dietary determinants of dental caries and dietary recommendations for preschool children. *J Public Health Dent* 2000; 60(3):207-9.
67. Kranz S, Smiciklas-Wright H, Francis LA. Diet quality, added sugar, and dietary fiber intakes in American preschoolers. *Pediatr Dent* 2006;28(2):164-71.
68. Reisine S, Douglass JM. Psychosocial and behavioral issues in early childhood caries. *Comm Dent Oral Epidem* 1998;26(suppl):132-44.
69. US Dept of Agriculture. Food pyramid. Available at: "<http://www.mypyramid.gov>". Accessed March 18, 2007.
70. CDC, National Center for Health Statistics. Growth charts. Available at: "<http://www.cdc.gov/growthcharts/>". Accessed June 16, 2009.
71. Cortes MI, Marcenes W, Shelham A. Impact of traumatic injuries to the permanent teeth on the oral health-related quality of life in 12- to 14-year old children. *Comm Dent Oral Epidemiol* 2002;30(3):193-8.
72. Flores MT. Traumatic injuries in the primary dentition. *Dental Traumatol* 2002;18(6):287-98.
73. Rocha MJdC, Cardoso M. Traumatized permanent teeth in Brazilian children assisted at the Federal University of Santa Catarina, Brazil. *Dental Traumatol* 2001;17(6): 245-9.
74. Caldas FA Jr, Burgos ME. A retrospective study of traumatic dental injuries in a Brazilian dental trauma clinic. *Dental Traumatol* 2001;17(6):250-3.
75. Skaare AB, Jacobsen I. Dental injuries in Norwegians aged 7-18 years. *Dental Traumatol* 2003;19(2):67-71.
76. Tapias MA, Jiménez-García R, Lamas F, Gil AA. Prevalence of traumatic crown fractures to permanent incisors in a childhood population: Mostoles, Spain. *Dental Traumatol* 2003;19(3):119-22.
77. American Speech-Language-Hearing Association. Available at: "<http://www.asha.org/public/speech/development/chart.htm>". Accessed June 16, 2009.
78. American Lung Association. Smoking and teen fact sheet – April 2006. Available at: "<http://www.lungusa.org/site/pp.asp?c=dvLUK9O0E&b=39871>". Accessed June 16, 2009.
79. CDC. Preventing tobacco use among young people: A report of the Surgeon General (executive summary). *MMWR Recommend Reports* 1994;43(RR-4):[inclusive page numbers].
80. Albert DA, Severson HH, Andrews JA. Tobacco use by adolescents: The role of the oral health professional in evidence-based cessation program. *Pediatr Dent* 2006;28 (2):177-87.
81. American Academy of Pediatric Dentistry. Policy on tobacco use. *Pediatr Dent* 2008;30(suppl):53-5.
82. American Academy of Pediatric Dentistry. Policy on intra-oral and perioral piercing. *Pediatr Dent* 2008;30(suppl): 56-7.
83. American Academy of Pediatric Dentistry. Policy on ethical responsibility to treat or refer. *Pediatr Dent* 2008; 30(suppl):83.
84. Kanellis MJ. Orthodontic treatment in the primary dentition. In Bishara SE, ed. *Textbook of orthodontics*. Philadelphia, Pa: WB Saunders Co:2001;248-56.
85. Woodside DG. The significance of late developmental crowding to early treatment planning for incisor crowding. *Am J Orthod Dentofacial Orthop* 2000;117(5): 559-61.
86. Kurol J. Early treatment of tooth-eruption disturbances. *Am J Orthod Dentofacial Orthop* 2002;121(6):588-91.
87. Sankey WL, Buschang PH, English J, Owen AH III. Early treatment of vertical skeletal dysplasia: The hyperdivergent phenotype. *Am J Orthod Dentofacial Orthop* 2000;118(3):317-27.
88. Feigal RJ. The use of pit and fissure sealants. *Pediatr Dent* 2002;24(5):415-22.
89. Feigal RJ, Donly KJ. The use of pit and fissure sealants. *Pediatr Dent* 2006;28(2):143-50.
90. American Association of Oral and Maxillofacial Surgeons. Parameters and Pathways: Clinical Practice Guidelines for Oral and Maxillofacial Surgery (AAOMS ParPath01). *J Oral Maxillofac Surg* 2001.
91. American Academy of Pediatric Dentistry. Guideline on management of persons with special health care needs. *Pediatr Dent* 2008;30(suppl):107-11.