When The Toothfairy Won’t Do:

PEDIATRIC PATIENTS NEED YOU...PLUS

RESTORATIVE
RICHARD TRUSHKOWSKY, DDS

ENDODONTICS
JOHN NUSSTEIN, DDS, MS, ET AL

ESTHETICS
LUKE KAHNG, CDT
Once upon a time,
a small child lost his first tooth.
His well-meaning parents
carefully wrapped the tooth
in a tissue, placed it under his
pillow that night, and the
next morning he found a
shiny new coin in its place.
“The Tooth Fairy came,” said his beaming parents. “Wow,” thought the little boy. “I can’t wait to lose another one!” By the time the boy lost all of his baby teeth, he’d made about $50, and lived happily ever after.
Not so fast. The days of childhood’s only dental experience involving a make-believe character with wings and a wand who exchanges teeth for money are over. With all we now know about early childhood caries and the increasing evidence of oral health’s contribution to overall health, no one in the dental profession can afford to leave the dentitions of children in the hands of a fictitious fairy. Children’s teeth need to be under the care of a dentist, and the earlier that happens, the better.

“Parents are going to need to be educated about the importance of oral health for their children,” says Frank Catalano, DMD, a professor in the Department of Community Dentistry and Behavioral Sciences at the University of Florida College of Dentistry. “We must get them to abandon the typical idea that, ‘These are only baby teeth; they’re going to fall out.’ As practitioners, we need to overcome parental inertia and educate them on the importance of early dental care for their children.”

Joel Berg, DDS, MS, the Lloyd and Kay Chapman Chair of Oral Health in the Department of Pediatric Dentistry at the University of Washington, affirms what the modern practice of pediatric dentistry recommends. “I think the important point is that even though organized dentistry has already developed this mantra that the age-one dental visit is very important, with that being the recommendation of the American Dental Association (ADA) and the American Academy of Pediatric Dentistry (AAPD), on the medicine side the American Academy of Pediatrics (AAP) is also now recommending a dental screening at 6 months of age.”

This month, Inside Dentistry explores the world of pediatric dentistry, and how you can play an integral role in the future oral health of our children. We’ll examine why and how to integrate children into the general practice, how to educate parents on the importance of early and regular dental care, and what issues the profession needs to be aware of when it comes to treating the youngest and smallest dental patients.

Why Should You Bring The Kids Along?

Consider this fact, first published in Oral Health in America: A Report of the Surgeon General and supported by the ADA: dental caries is the most prevalent infectious disease among US children. It is well known that caries in primary teeth increases the risk of the secondary teeth also developing the disease. Also according to the ADA, 51 million school hours are lost every year from dental problems and their accompanying discomfort. When children are in pain from dentally related causes, that pain either directly or indirectly affects their ability to speak, eat, sleep, or concentrate. Then there are the social effects of dental problems in children. When the ability to speak, particularly, is affected, so too is the social experience for that child.

Then there are the extreme cases, such as the widely publicized death of Deamonte Driver last year from a brain infection resulting from an abscessed tooth. Had the 12-year-old from Maryland had a dental home and appropriate access to care, his case may not have had the tragic results it did. While the widespread media coverage (led by the very poignant article in The Washington Post) galvanized the dental profession, child advocacy groups, and even Congress to do something—anything—to prevent this from happening again, what is perhaps even more tragic is that his death was not the first, nor the last, of a child who did not receive appropriate dental care. Two years before Deamonte died, 13-year-old Taran Francis of The Bronx in New York City was declared brain dead after suffering acute swelling resulting from an infected tooth; that suffering was compounded by a complete lack of appropriate and timely care for that tooth. He was eventually taken off life support so that his organs could be harvested. And just days after Deamonte died, 6-year-old Alexander Callender collapsed on his school bus near Pass Christian, Mississippi, and died from an abscess where two teeth had been extracted from his lower jaw. The county coroner determined that the little boy had gone into shock from the infection and his body shut down.

While these cases are extreme, they still drive home a critically important point: Children’s dental health cannot and should not be ignored. No one expects children to die from a lack of dental care, but these three cases show that not only they can, they do. Both the ADA and the Centers for Disease Control and Prevention (CDC) continue to collect data showing that while Americans overall continue to improve their oral health, the rate of tooth decay in children aged 2 to 5 years has increased for the first time in years and continues to rise. The CDC’s study found that the rate increased by 15%, that 28% of young children had experienced cavities, and of those, 74% were already in need of dental repair.

But it is also well known that dental caries in children can be prevented with proper care and diligence to oral hygiene. This is where general practitioners come in, to partner with patients and their parents to ensure that a good foundation of oral health is started early.

Within the first couple of years there aren’t that many teeth in the mouth yet, which is great because you want to get to the patients before they get the disease,” says Dr. Berg. “But it can happen very quickly in those first couple years, so everyone needs to be diligent.”

Some general practitioners may cringe at the thought of taking on screaming, squirming children in their otherwise tranquil practice. That’s why it’s necessary, according to Constance M. Killian, DMD, an adjunct associate professor of pediatric dentistry at the University of Pennsylvania with a private practice in Doylestown, Pennsylvania, “to challenge the accepted views of many general practitioners: that children are a problem in the office because they cry and are not cooperative, that treating the primary dentition is not critical, that there is nothing to be gained by trying to focus preventive messages on a 1-year-old,” she says.

“T”In trying to encourage general practitioners to adopt the age-one dental visit, it’s necessary to educate them,” explains Dr. Killian. “Yes, children may cry, but that is normal behavior for this age group. Children at age one are not uncooperative; they are pre-cooperative; that is, they just...
haven’t developed to the point to be able to cooperate. Our medical colleagues understand this and forge ahead with necessary screenings and therapies. We need to do the same. We also need to educate our colleagues in general practice about the importance of prevention for a 1-year-old child. Evidence suggests that children who have had caries by a very young age are more likely to have caries throughout their life, so starting the message before the disease process has been successful can have long-term implications,” she asserts.

Kevin Donly, DDS, MS, professor and chair of pediatric dentistry at the University of Texas Health Science Center, agrees. “Certainly it’s a practice builder but more than that I think dentists really want to do what’s right. So we have to convince people that this is now the standard of care. The age-three visit was embedded into the profession for so long that it’s hard to make this switchover to age-one. The great part about it is that if you can keep a child caries-free, it’s very simple to keep that child in your practice. There are just not enough pediatric dentists out there to do it all, so I think by truly partnering with general practitioners and focusing on prevention, we can keep many of these kids dentally healthy.”

While pediatric dentistry is a well-established specialty in which its practitioners have completed a minimum of an additional 2 years of residency training, a dentist does not necessarily have to be a pediatric dentist to treat children. While pediatric dentistry is “an age-defined specialty that provides primary and comprehensive preventive and therapeutic oral healthcare for infants and children through adolescence, including those with special healthcare needs,” according to the ADA’s Definition of Pediatric Dentistry, general dentists most definitely have a place in the care of young children. As with any other branch of specialty dentistry, often it’s the general dentist who first examines a patient and diagnoses a problem. And because there is such an emphasis today on pediatric dentistry being preventive, there’s even a place for the dental hygienist in your practice to actively help establish and maintain good oral health for the infants, children, and adolescents in your practice. Then, when you and your team do identify a problem with a pediatric patient, it offers you an opportunity to partner with a pediatric dentist with whom you can collaborate on an interdisciplinary level.

“It’s no different than general practitioners providing a large amount of the care in periodontics, endodontics, or orthodontics,” says Dr. Berg. “They refer to the specialists for complex cases or for parts of cases that they don’t want to treat or don’t have enough training to treat. And the patient then comes back to them in the dental home. So it’s certainly reasonable that general practitioners could manage infants and toddlers, and when there are restorative needs beyond their skill set or comfort level, they can refer those needs to a pediatric dentist. After the complex care is rendered by the pediatric dentist, then the patient comes back to the general practitioner as part of the family dentistry situation,” he explains.

In fact, all of the experts we talked to wholeheartedly agreed that general practitioners need to see as many children in their practices as they are willing and able to see, because there are less than 5,000 board-certified pediatric dentists in the country, and millions of kids who need a dental home. And if seen as early as the first birthday, as the ADA and AAPD recommend, taking kids into the practice does not mean that the dentist and his or her staff will be spending so much extra time on these patients that they lose time on more profitable adult restorative and reconstructive work. It does mean that by spending just a little time examining a
Little mouth, general dentists can potentially head off time-consuming, expensive, and traumatic dental work in young children and ease the burden on their pediatric colleagues.

“The reality is that very few kids actually get an age-one dental visit,” says Dr. Berg. “So we have a long way to go. But there’s a huge opportunity here, if general practitioners approach this from the point of view that bringing kids into their practice can actually be a great practice builder. And it can be very good for their practice, because it brings families together, it focuses attention on the need for good oral health for all ages, and it can be financially beneficial to the practice because if they engage in this in a positive way, it can actually be a money maker,” he explains.

**Learning Your ABCs**

For the general practitioner who has a desire for accommodating very young children into the practice, there is plenty of support and resources for training, beginning with the AAPD itself. The organization’s current membership of 7,200+ is comprised of less than 5,000 pediatric dentists; the rest is made up of students, general practitioners, and other healthcare providers. Dr. Donly explains the history of the AAPD this way: “When dentistry for children was founded, there was an American Society of Dentistry for Children (ASDC), before the specialty of pediatric dentistry was formally recognized through educational and accrediting agencies in this country. Then in the 1970s, as things became more systematic and education became more prevalent and many of the specialties were formed, the American Academy of Pediatric Dentistry became more nationally recognized. Several years ago the ASDC and the AAPD merged because we wanted to have one voice for children. That merge brought together general dentists who were excited to treat children and were part of the ASDC with the specialists in pediatric dentistry. The AAPD has an affiliate member category that is made up largely of general dentists, who are openly welcome to come to the annual meeting to receive more CE in children’s dentistry than any other group offers. And by being an affiliate member you also get the journals: The Journal of Dentistry for Children and Pediatric Dentistry, which will give a general practitioner additional information in pediatric dentistry.”

When it comes down to the brass tacks of taking children into a general practice, our experts have sound advice as well. According to our panel, accommodating children into the general practice can be made easier by depending on the existing auxiliary staff to render patient care and parent education.

“If the staff is involved, they can be doing preventive oral health tasks without taking a lot of time from the dentist, and the staff can also do a lot of the education,” Dr. Berg says. “When it’s managed well, taking care of children can be integrated into the practice fairly seamlessly.”

Beverly Largent, DMD, who has a private practice in Paducah, Kentucky, and is Fellowship in the American College of Dentists (FACD) in 1993. He also had licences to practice dentistry in the states of Illinois, Indiana, Louisiana, and Ohio.

Cliff, as he was affectionately called, was sought after by many national and international dental associations and societies to lecture, including the American Dental Association, the National Dental Association, the American Academy of Esthetic Dentistry, the American Society of Dentistry for Children, the California Dental Association, the Yankee Dental Conference, the Hinman Dental Association, the New Orleans Dental Association, the American Association for Dental Research, the International Association for Dental Research, the Dental Associations of Brazil and Jamaica, the Costa Rican Society of Dentistry for Children, and the Mexican Academy of Pediatric Dentistry, among many others. He was one of the original three lecturers presenting the “Pediatric Dentistry Review Course” for specialty board certification.

Dr. Dummett published many articles, abstracts, and book chapters. He made several television appearances, and was involved with several other multimedia events. He taught and mentored scores of pediatric dental students and postgraduate dental residents in research, didactics, and clinical pediatric dentistry. Cliff was a very compassionate teacher, role model, and friend who was inspirational to all those who came in contact with him. His colleagues and friends around the world appreciated his contributions to dentistry and its related fields.

To celebrate the legacy of Dr. Clifton O. Dummett, Jr., the LSU School of Dentistry and the Louisiana Academy of Continuing Dental Education have established an Annual Memorial Continuing Education Course in Pediatric Dentistry. In addition, the Clifton O. Dummett, Jr Scholarship has been established at Earlham College, his alma mater, in Richmond, Indiana.

Dr. Dummett is survived by his father, Dr. Clifton O Dummett, Sr, a retired dentist, historian for the National Academy of Continuing Dental Education and Research Foundation during his graduate program. In 1975 he received his Fellowship in the American Academy of Pediatric Dentistry (AAPD). He was installed into the Honorary Dental Fraternity, Omicron Kappa Upsilon, in 1978, and served as president of the Theta Kappa Chapter of OKU. In 1980, he received a master’s degree in education from the University of New Orleans School of Education, where he majored in curriculum and instruction.

Before coming to the LSU School of Dentistry, he was the coordinator of dental research at Children’s Medical Center in Dayton, Ohio, and the director of Pediatric Dentistry Services at the Charles R. Drew Neighborhood Health Center in Dayton, Ohio. Dr. Dummett was recruited to come to the LSU School of Dentistry in 1974, and quickly moved up the academic ranks to tenured professorship in 1982. He was the chief of the Pediatric Dentistry Section at Charity Hospital in New Orleans from 1974 until 2005, when Charity Hospital was devastated by Hurricane Katrina. Dr. Dummett was also the coordinator of Postgraduate Pediatric Dentistry from 1978 to 2006, and department head from 2000 to 2006.

Dr. Dummett was elected to serve as the president of the New Orleans Section of the American Association of Dental Research in 1977, president of the Louisiana Academy of Pediatric Dentistry in 1986, and trustee member-at-large of the Board of the AAPD from 1993 to 1996. He received his Diplomate status with the American Board of Pediatric Dentistry in 1980, and obtained his Fellowship in the American College of Dentists (FACD) in 1993. He also had licences to practice dentistry in the states of Illinois, Indiana, Louisiana, and Ohio.

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**Written by:**

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All of us at Inside Dentistry strive to deliver clear, objective, and relevant reporting of the issues that face the general oral healthcare profession. The publishers and staff gratefully acknowledge the following individuals, without whom this Inside look at pediatric dentistry and the general practitioner would not have been possible. The candid comments and professional insights of our panel of experts were invaluable to developing a comprehensive and meaningful presentation.

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the president-elect of the AAPD, describes what a typical pediatric dental appointment might look like. “The entire appointment may last about 30 minutes, and that depends on what the parent wants to know, how interested the parent is, and how many questions the parent has. The actual appointment where the dentist examines the child’s teeth is a very short appointment. Dental assistants or dental hygienists can help with what we call anticipatory guidance. This is showing the parents how to brush the child’s teeth, showing them what plaque does, and asking questions, such as, ‘Do you put your baby to bed with a bottle? Does your child have a sippy cup? What does that sippy cup have in it in between meals?’ These educational issues are sometimes handled by me and sometimes they’re handled by my dental assistants,” she explains.

Further, as Dr. Killian points out, the most extensive part of a typical adult examination appointment can, in most cases, be skipped altogether in the very young ones. “Communicating with the parent about the child’s oral health is the primary focus of the visit. Typically, dental visits for 1-year-old children are less focused on the examination than on preventive counseling with the parents. Most infant oral exams don’t require radiographs, which is in stark contrast with adult dentistry, where the clinical and radiographic examination is usually the most extensive part of the visit,” she says.

Among the many benefits to general practitioners who decide to treat children in their practices is relationship-building. Often, these dentists are already treating an entire family and have established strong relationships with each member. Detailed knowledge of the family has already been obtained and trust has already been established, both of which could be incredibly important when it comes time to treat a family’s newest member. “In a practice-type setting, if the parents already have established a relationship with the dentist for themselves or for other children in the family, the arrival of a new baby into the family is the perfect opportunity to begin the dialogue about the importance of the age-one dental visit,” offers Dr. Killian. She suggests that there are emotional benefits to having children in a general practice as well: “As many general dentists already know, it’s fun to have young children in the practice, and it’s not a far stretch to extend that welcome to 1-year-olds.”

But Dr. Killian also points out the painfully obvious, points that are echoed by her colleagues on our panel: “On a more serious note, general practitioners far outnumber pediatric dentists and are important sources for oral healthcare. In cases where there is no pediatric dentist in the geographic area, children may be left with no dental home. It seems only natural that when a general practitioner is providing care for other family members that the children also be included,” she emphasizes.

And this is where the general practitioner can really benefit from their existing relationships with the current, new, and prospective parents that already exist in their patient base. “The best way is to have parents understand that the general practitioner is qualified, capable, and willing to be the oral healthcare provider for their child,” Dr. Killian says. She points out that the general practitioner can begin this relationship when the expectant mom is in the office for her own dental care; then, as the baby/toddler accompanies the parent for their visits, the general practitioner can continue the dialogue and recommend that they establish a dental home for the child.

She does add a word of caution, though: “Recognizing that in a general practice some adults may find a crying child disconcerting, it may be necessary to modify the practice schedule for the comfort and benefit of both adults and children,” she counsels.

What general practitioners really need to ask themselves—and answer with brutal honesty—is whether their own temperament, patience level, and practice goals are conducive to treating children, many of whom will push the outer limits of noncompliance simply because sitting in a dentist’s chair is a totally new experience for them. “For little kids, it’s a new day every day,” says Dr. Largent. “Every time you see them you have to go through the routine of explaining everything to them. We go through that routine every time until they’re 4 or 5 years old, because if they have any anxieties at all, if you surprise them at all, then they’re a lost cause,” she explains. This is, very likely, the biggest difference general dentists will experience between their pediatric and adult patients. Dr. Largent advises, “I think that’s the hardest thing, because if you’re a general dentist, you put your patient in the chair and all adults know that the first thing you’re going to do is recline the chair and turn on the light. Children don’t know that, so you have to greet them and say, ‘Go ahead and sit in the chair. Now I’m going to move the chair up. Now I’m going to move the chair back. It’s going to be like you’re lying in your bed or on the couch. Now I’m going to turn on the light. See the light on mom’s hand? See the light on your hand? Now I’m going to put this light on your chin. It’s a big flashlight. We call it Mr. Sunshine.’ Those things are said over and over and over so that the child understands that this is not a bad thing,” she explains.

She also warns that even if the first appointment goes well, the dentist needs to remember the “new day every day” mindset of children. “Let’s say that the child...
is anxious about going to the visit and the first visit goes okay. That doesn’t tell the child automatically, or adults either, that the second visit is going to be okay. The child may still be anxious, and children can imagine all sorts of bad things,” she says.

And here is where real difficulties can surface. Say the child comes into your practice and the first visit goes well but on the second visit the child comes in and has a problem and there’s pain involved. It doesn’t go as well. How do you prepare for that third appointment?

“That’s really hard,” Dr. Largent laments. “It’s like you’re starting all over again to build trust with that child. Sometimes little children come in and I know they’ve been hurt, I know they don’t want to do that again, but still they have to get that next appointment under their belt to understand that bad things don’t happen every time.”

Are We There Yet?

According to the American Academy of Pediatric Dentistry (AAPD)’s Guideline on Behavior Guidance for the Pediatric Dental Patient, “a dentist who treats children should have a variety of behavior guidance approaches and...should be able to assess accurately the child’s developmental level, dental attitudes, and temperament and to predict the child’s reaction to treatment.”

According to Keith Morley, CD, BSc, DMD, FRCD(C), the current president of the AAPD, “The AAPD encourages general practitioners to become involved in the dental home, examining and providing oral healthcare for children. There are not enough pediatric dentists to provide all the care for children; therefore, the involvement of general practitioners is essential,” he says. And he assures general dentists that they can be successful with a little help from their friends. “Once a general practitioner becomes familiar with and completes an age-one visit for children, then he or she should have no problem incorporating children into their practice. If a general practitioner finds that he or she is not comfortable with completing treatment for a child, whether it is because of the child’s age, medical condition, behavioral challenge, etc, then a referral to a pediatric dentist would be appropriate.”

If that’s the case, Dr. Morley recommends using the resources of the AAPD to their fullest. “If a general practitioner feels uncomfortable with the challenges of dealing with young children, they can take any one of a number of courses that are offered on this subject, seek guidance from a pediatric dentist in the community, join the AAPD as an Affiliate Member, and have further access to many aspects of pediatric dentistry through the AAPD Guidelines and other educational materials, as well as attend our Annual Session and CE courses,” he explains. “The crucial aspect for general practitioners today is to feel comfortable with seeing and integrating children into their practices and completing anticipatory guidance for the child and the parent.”

By far, the most critical component of treating a pediatric patient is allaying any fear or anxiety the child has. Many times this will mean allaying any fear or anxiety the parent has about bringing their child to the dentist in the first place. This can be especially challenging when the parent is a dental-phobe themselves.

Theodore Croll, DDS, the author of Kid’s Mouth Book and whose private practice in Doylestown, Pennsylvania, is limited to infants, children, and adolescents, says, “The toughest part is preparing for parents whose trust must be obtained and maintained. This is more difficult today than in the past when parents were not as stressed about child
Suggestions For GPs

“General dentists who wish to incorporate infant oral healthcare into their practice should expect the patient to cry or be upset during the examination phase of the visit, and the parents are typically very concerned about the child’s reaction to the dentist,” says Dr. Killian. She recommends that to help allay concerns, general practitioners should gain comfort and skill in examining the young patient (typically with parental assistance), and become knowledgeable and confident in the major areas of preventive counseling.

Dr. Killian also says that demonstrating a gentle and caring approach with the child, using basic behavior guidance skills such as tell-show-do, distraction, positive reinforcement (small toy rewards as well as smiles) and having a reassuring manner are all positive ways that the dentist can be successful in managing young children. It is important to elicit the assistance and collaboration of the parent as much as possible, so that they can be confident that the child is aware of their presence and support. Essentially, the dentist who treats young children should convey to the parent the sense that she/he is knowledgeable about the care needed for the child, that she/he has the skills necessary to provide that care (or to refer if it is in the patient’s best interest), and that she/he will do so in a caring and positive environment.

Further, she counsels that general practitioners should expect that at any time, the child’s behavior may deteriorate such that the care cannot be safely or successfully completed. “Many problems develop when the dentist becomes so focused on the planned procedure and the need to continue that she or he forgets that there is a person attached to the procedure, namely the child,” she says. When this happens, the dentist should demonstrate compassion for the patient as well as what is truly best for the patient as a whole by stopping the procedure as soon as feasible, and include the parent in the discussion and provide alternatives to completing the care as planned.

Dr. Catalanotto concurs. “With the child who has a temper tantrum, the child who doesn’t respond well, the biggest challenge is having the parent know what you’re going to do before the child has the tantrum,” he says. “You can say, ‘Miss Jones, if Johnny doesn’t react to this, I plan to wrap my arms around him tightly, hold his arms, and my assistant is going to do this, and I’m going to need you to do that.’ Thinking about what you’re going to do ahead of time and making sure the parent understands what you’re going to do ahead of time will keep the parent from being shocked. And if they object to your plan, they have a chance to tell you ahead of time, so that you’re not shocked,” Dr. Catalanotto. “But above all else, you don’t fight with children,” he emphasizes.

He also wants general practitioners to know that there is a way out of a seemingly impossible situation. “It’s absolutely perfectly appropriate to say, ‘Well, I can’t do this today, I can’t go any further, we tried.’ If the child is in acute need, if the tooth is infected or in serious decay, and you feel that you don’t have the right training or experience, a referral to a pediatric dentist is certainly appropriate in that situation,” he says.

Courtesy of Dr. Berg’s continuing education article published in Inside Dentistry in March 2007, we offer here the detailed steps of a standard knee-to-knee examination that all practitioners can follow in assessing very young children in their practices, as well as the main risk factors for early childhood caries that should be assessed in pediatric dental visits.

Knee-To-Knee Examination Steps

1. Position the child in the parent’s lap while the adult sits in a chair. Interact warmly with both the infant/toddler and the caregiver.
2. Ask if the child will allow you to pick him/her up. If you have permission, hold the child—briefly. Bounce, jostle, and interact with the youngster and then return the child to the parent. If the child is obviously reluctant to be held or the parent tells you that the child will not allow you to hold him/her, proceed to Step 3.
3. Give the child a toothbrush, removed from its packaging.
4. Determine whether the parent assists the child with toothbrushing. If so, communicate approval and praise. Request that the parent demonstrate brushing of the child’s teeth. Catch the parent “doing something right” during teeth cleaning and praise that behavior.
5. Assume the “knee-to-knee” posture. If you are sure you can successfully hold the child based on your experience in Step 2, hold the child face-to-face and place the child’s legs around your hips. Lower the child’s head onto the parent’s lap. Ask the parent to continue brushing the child’s teeth. While this is happening, observe the child’s mouth and teeth as much as possible as you supervise the cleaning activity. If you are unable to do or complete this step, proceed to Step 7.
6. You should continue to lavish praise on the parent for appropriate behaviors or skills.
7. Reverse the position of the child by asking the parent to take the child from you and reproduce the position you have just completed. Say, “Now give your child a hug and put his/her legs around your hips.” Gently lower the child’s head onto your lap. The parent can assist you by holding the child’s hands as you complete the assessment.
8. Using the child’s toothbrush, quickly assess the child’s oral condition.
9. Using a dental mirror, continue to assess the child’s oral condition and record your findings.
10. Advise the parent of your findings and recommendations for follow-up. It is essential to specifically document areas where closer attention to detail in brushing must be exerted.

Main Risk Factors to Assess During The Visit

- Mothers or other family members with untreated tooth decay.
- Evidence of poor hygiene care for the child.
- A diet high in sugar and fermentable carbohydrates.
- Improper bottle feeding and/or bottle use after age one.
- Breastfeeding at will throughout the night.
- Using pacifiers dipped in sugary substances.
- Certain characteristics of parents or caregivers.
- Single parents overloaded with responsibilities.
  - Parents of children with special healthcare needs.
  - Parents who have limited support from social services.
  - Families with a pattern of substance abuse.
There are just not enough pediatric dentists out there to do it all, so by truly partnering with general practitioners and focusing on prevention, we can keep many kids dentally healthy.

rearing. The best advice is to go slowly and surely in parent education, answer all of the parent’s questions until you are assured there is trust and understanding. As far as the dentistry itself goes, experience is the best teacher. The more you do, the better you get.

Communication will be key. All basic practice management principles come into play, starting with the initial contact, which in most practices will be the receptionist or office manager. The manner in which the child patient and his or her parent are greeted will set the tone for the entire visit. Then, it’s up to the clinical staff to ensure that the child’s experience is a good one. It goes without saying that the child’s future attitude toward visiting the dentist relies on positive experiences early on.

This doesn’t mean that if you’re in general practice that you need to redecorate an entire operatory to be kid-friendly, although that is an advantage that pediatric practices automatically have. Walk into any pediatric practice and you will find it designed to look like an extension of any child’s natural environment: bright colors, toys, lots of things to see and touch that will take the child’s mind off the purpose for being there in the first place. And while all of that is important, it’s just as important for the child to feel comfortable with who is behind the mask and goggles when they get into the chair.

To this point, Dr. Croll explains, "Office logistics for those patients would change somewhat. For example, knee-to-knee examinations with the parents assisting is the usual approach, and rubber prophylaxis cup/rotary handpiece cleanings are often not required in the early years. Often only a toothbrushing with a topical fluoride solution is needed during brushing and flossing instructions. Children’s toys, books, and other such distractions need to be available. The office staff also would need to acclimate their thinking and purpose to younger children and the logistics required. None of this is difficult; it simply requires suitable, easily implemented adjustments in the office routine."

“Certainly having the right age-appropriate materials in your office will be important,” agrees Dr. Catalanotto. “Crying children are going to be disruptive to an office, and certainly we expect that no 1- or 2-year-old is going to lovingly submit to an oral exam and the application of varnish. As simple as it is, they’re not going to love this procedure. But as a dentist gains more experience, it will become easier,” he explains. Other things that general practitioners should consider? “The dentist has enough to worry about with the technical aspects of what he or she is going to be doing with that child. Having key staff that are trained to manage children and are sensitive about managing children
is tantamount to having a positive experience with that child in your chair.”

It also helps to be a little up to date on what’s going on in the world of children. You don’t have to watch hours of Cartoon Network, but it would probably be helpful to at least know who SpongeBob Square Pants is. “Being able to communicate with children in ways that relate to them and that they can relate back is very important,” Dr. Catalanotto says.

**WHEN DO WE START?**

According to our experts, the sooner the better. While the long-standing recommendation from the American Academy of Pediatrics (AAP) has been to strive for a by-the-third-birthday-visit to the dentist, both the AAPD and the ADA say it’s critical for early prevention and intervention to make that first visit within 6 months of first eruption or by the first birthday at the latest.

According to Dr. Killian, “the understanding of the caries process has changed over the years, and it is critical for the general practitioner to have an understanding of the most current concepts of this disease process, as it relates to young children. Being familiar with caries risk assessment is necessary for the dentist to successfully integrate pediatric dental care into her or his practice. Dental auxiliaries can be most helpful in gathering much of the information for the caries risk assessment and can be trained to deliver preventive messages that are appropriate for the age of the child. Team members are often eager and happy to have the chance to share their knowledge about diet, feeding, and caries, and can educate and assess parents’ ability to provide the necessary oral hygiene at home.”

Dr. Croll offers this advice: “Dentists who truly want to be considered ‘family practitioners’ need to get their youngest patients off to an ideal start in preventive care. For new practitioners, those babies and toddlers are the mainstay population of their practices and parents appreciate having a dental home for their young-sters from the very start. The children would benefit with healthier lives, the families would benefit financially, and the dental practice would be more effective from the business standpoint.”

**Characteristics of Early Childhood Caries**

One of the first clinical signs of the presence of early childhood caries (ECC) is the white-spot lesion. During the early white-spot stage, the condition can still be reversed by using preventive measures such as professionally applied fluoride varnish. Here are the characteristics of the disease that every dentist should be aware of:

1. It develops rapidly. Progression from the enamel into the dentin occurs in 6 months or less.
2. It affects the upper front teeth first. These teeth usually erupt at about 8 months of age.
3. Primary molars, which begin to erupt at about 1 year of age, are the next teeth to be affected.
4. Finally, the lower front teeth are affected when the disease becomes very severe.

**Possible outcomes of ECC in its advanced stages:**

- The pain may prevent the child from sleeping or being able to learn.
- The overall health of the child may be affected because of the chronic infection and high levels of bacteria in the mouth.
- The child may be unable to eat proper foods, selecting instead soft foods because of the pain.
- Children with ECC may have problems pronouncing words and may develop incorrect language patterns because of missing teeth resulting from extraction of teeth that have been severely affected by the disease.
- Children with ECC may have an increased risk of decay in permanent teeth because of high levels of bacteria in their mouths.
- The child can feel self-conscious and uncomfortable about smiling as he or she gets older.
- The long-term effects of having high levels of dental decay can even affect their future abilities socially, in school, and in the workplace.

**Source:** Berg JH, Domoto PK. The age-one dental visit—preventing early childhood caries. *Inside Dentistry.* 2007;3(3):38-44.
that the last baby teeth are not lost until the child is about 12 years old,” Dr. Berg recommends in his article.7 See “Characteristics of Early Childhood Caries,” on page 120 for more information.

Other recommendations you can make to parents include not letting children constantly sip on sugar-laden or acidic liquids—including milk and juice—from their sippy cups, and to strongly encourage children to drink from a regular cup by their first birthday. Tell parents that if they have to give a child a pacifier, it should never be dipped in anything sweet. The constant sucking on a sweetened pacifier may make for a happier child in the short-run, but like constant access to baby bottles, sets up much unhappiness later on. See “Suggestions for GPs” on page 118 for patient-education ideas for your practice.

Dr. Largent warns her patients’ parents that the flavored waters that are so popular now are a sneaky way to get sugars in that most people don’t think about. She also advises parents to limit their child’s juice intake to one cup of juice a day because of their acidity and sugar content.

So whether you’re already seeing children in your practice or are thinking about adding children to your patient base, one of the most important aspects of rendering dental treatment to pediatric patients is educating their parents.

WHERE IS THE PROFESSION GOING NOW?

All of our experts agree that the profession is growing and moving forward, and the changes in the specialty are overwhelmingly positive. The one downside remains that there just aren’t enough pediatric dentists to serve all of the children.

“Pediatric dentistry is in tremendous demand as a specialty, and is a prime choice among dentists seeking specialty training,” says Dr. Morley. “The specialty is expanding, our numbers are growing, and, specifically, the number of residency positions has more than doubled in the last 10 years, but we still need more positions as the demand for the services that our specialty provides continues to grow,” he adds.

“Prevention is the area where there will be the greatest change in approach,” Dr. Killian offers. “Traditionally, the focus of prevention has been to provide the same preventive therapies to all patients. Currently, pediatric dentists gear their preventive efforts at the specific risk factors for each child. The use of a caries risk assessment tool is becoming commonplace and helps pediatric dentists to determine the best preventive approach for the child. Looking forward, we are beginning to treat caries as a disease process, much like diabetes, and to proactively manage the ongoing disease process instead of focusing on treating the devastating consequences of the disease,” she explains.

Dr. Croll adds, “Undoubtedly this concept needs to be presented as protocol to dental students during their professional training. Dental school pediatric departments need to emphasize the ‘whys’ and ‘hows’ of early infant dental care, so that graduating students are already trained in the concept and prepared to institute its principles in practice. For general dentists already in practice, continuing professional efforts involving published articles, continuing education programs, and perhaps even commercial marketing by companies that can benefit from products used in such visits, would all be beneficial. Convincing pediatric medical specialists about the value of very early dental office interventions would also be helpful. Once convinced, those medical specialists could be instrumental in spreading the word to parents.”

Dr. Killian continues, “Speaking for myself, I am grateful that many of our general practice colleagues are continuing to stay abreast of pediatric dental advances so that they can provide care to many of the children in need. The general practitioner who treats children has a responsibility to provide care to children in a manner consistent with current techniques and guidelines, and should take advantage of educational opportunities that prepare them for this challenge. Pediatric dentists also bear a great responsibility: to provide the educational opportunities where general practitioners can learn about those current techniques, guidelines, and recommendations for care of pediatric dental patients. I would strongly encourage general practitioners to join the AAPD.”

“We now have more than 300 pediatric dentists graduating a year in the United States, which is still low given the great need for pediatric dentists,” Dr. Berg points out. “Unlike in medicine where the vast majority of children are seen by pediatricians and the minority are seen by family physicians, in dentistry it’s the opposite. About 70% of the children are seen by general dentists and 30% by pediatric dentists. So given that, I think it demonstrates the importance of training general practitioners better on how to treat young children. I think that if each general practitioner would see just a dozen or so babies in their office each month, we could accommodate the needs out there in the community. The pediatric dentists encourage partnership with general practitioners,” he emphasizes.

HERE COME THE PEDIATRICIANS

Now, the AAP is coming alongside their dental counterparts, even to the point of devoting their 2008 Annual Meeting to the topic of oral health in children.

“The AAPD and the AAP have combined forces in dealing with oral health care,” declares Dr. Morley. “The AAP has made oral healthcare one of their top three priorities, supporting the age-one dental visit and the concept of the dental home. The Executive Committees of both the AAPD and the AAP meet annually in Chicago to exchange ideas, concerns, and concepts regarding children’s health, which includes oral healthcare. And this year, the AAPD’s incoming president, Dr. Largent, has been invited to give the opening remarks to the AAP’s Ped’s 21 Symposium in Boston. Dr. Jim Grall is a keynote speaker on the topic of ECC at this same Symposium,” Dr. Morley shares.

“The prime common ground between the AAPD and the AAP is to continue to improve the health of the nation’s children, which includes oral healthcare as an integral and essential component,” he concludes.

For its part, the ADA Foundation just recently announced a $300,000 grant for “Working Together for Oral Health,” which will help teach and train pediatricians to diagnose dental problems in children younger than 3 years of age. Our experts agree that if pediatricians will partner with pediatric dentists, their help will be invaluable, because while many children do not have a dental home until they are older, most children see a pediatrician at least several times a year for well-baby checkups and immunizations. With the proper training, a pediatrician will be able to see the early signs of tooth decay while they’re already in the child’s mouth to checking the tonsils. And when the signs of disease are spotted, they can refer the child to their dental counterparts before the disease takes hold and damages the child’s oral health.

CONCLUSION

As our expert panel suggests, there is plenty of room in the profession for general practitioners who feel a call to treat children, and more importantly, those in the specialty of pediatric dentistry stand ready and waiting to help dentists do just that. From collaboration to continuing education, all of the help and resources a general practitioner would need to accommodate
children into his or her practice are there for the taking. And with the increased emphasis placed on oral health at an earlier age, the opportunity is no further away than your next patient who has young children. With time, experience, and some additional staff training, our experts are confident that any general practitioner could add this demographic fairly easily to their patient base, and could begin a life-long partnership with these new patients by the time they reach their first birthday. As Dr. Croll sums up: “Because there are so few pediatric dentists, the general practitioners who treat children are viewed as relief and not business competition. Most pediatric dentists have schedules that are bursting and would welcome help with the public demand for children’s dental care.”

REFERENCES