Caries-risk Assessment and Management for Infants, Children, and Adolescents

Latest Revision
2022

Abstract
This best practice reviews caries-risk assessment and patient care pathways for pediatric patients. Caries-related topics presented include caries-risk assessment, active surveillance, caries prevention, sealants, fluoride, diet, radiology, and non-restorative treatment. Caries-risk assessment forms are organized by age: 0-5 years and ≥ 6 years old, incorporating three factor categories (social/behavioral/ medical, clinical, and protective factors) and disease indicators appropriate for the patient age. Each factor category lists specific conditions to be graded yes if applicable, with the answers tallied to render a caries-risk assessment score of high, moderate, or low. The care management pathway presents clinical care options beyond surgical or restorative choices and promotes individualized treatment regimens dependent on patient age, compliance with preventive strategies, and other appropriate strategies. Caries management forms also are organized by age: 0-5 years and ≥ 6 years old, addressing risk categories of high, moderate, and low, based on treatment categories of diagnostics, interventions (fluoride, diet counseling, sealants), and restorative care. Caries-risk assessment and clinical management pathways allow for customized periodicity, diagnostic, preventive, and restorative care for infants, children, adolescents, and individuals with special needs.

This document was developed through a collaborative effort of the American Academy of Pediatric Dentistry Councils on Clinical Affairs and Scientific Affairs to offer updated information and recommendations regarding assessment of caries risk and risk-based management protocols.

KEYWORDS: CARIES-RISK ASSESSMENT, CARIES PREVENTION, CLINICAL MANAGEMENT PATHWAYS, DENTAL SEALANTS, FLUORIDE

Abbreviation
AAPD: American Academy of Pediatric Dentistry
Purpose
The American Academy of Pediatric Dentistry (AAPD) recognizes that caries-risk assessment and caries management protocols, also called care pathways, can assist clinicians with decisions regarding treatment based upon child’s age, caries risk, and patient compliance and are essential elements of contemporary clinical care for infants, children, and adolescents. These recommendations are intended to educate healthcare providers and other interested parties on the assessment of caries risk in contemporary pediatric dentistry and aid in clinical decision-making regarding evidence- and risk-based diagnostic, fluoride, dietary, and restorative protocols.

Methods
This document was developed by the Council on Clinical Affairs, adopted in 2002, and last revised in 2019. To update this document, an electronic search was conducted of publications from 2012 to 2021 that included systematic reviews/meta-analyses or reports from expert panels, clinical guidelines, and other relevant reviews using the terms: caries risk assessment AND diet, sealants, fluoride, radiology, non-restorative treatment, active surveillance, caries prevention. Five hundred ninety-two articles met these criteria. Papers for review were chosen from this list and from references within selected articles. When data did not appear sufficient or were inconclusive, recommendations were based upon expert and/or consensus opinion by experienced researchers and clinicians.

Background
Caries-risk assessment
Risk assessment procedures used in medical practice generally have sufficient data to accurately quantitate a person’s disease susceptibility and allow for preventive measures. However, in dentistry there are limited sufficiently validated multivariate screening tools to determine which children are at a higher risk for dental caries. Two caries risk assessment tools, namely the Cariogram and CAMBRA tools, have been validated in clinical trials and clinical outcomes studies. Several other published caries-risk assessment tools utilize similar components but have not been clinically validated. Nevertheless, caries-risk assessment:

1. fosters the treatment of the disease process instead of treating the outcome of the disease.
2. allows an understanding of the disease factors for a specific patient and aids in individualizing preventive discussions.
3. individualizes, selects, and determines frequency of preventive and restorative treatment for a patient.
4. anticipates caries progression or stabilization.
5. determines different treatment plan options and tailors the specific individualized self-management goals.

Caries-risk assessment is part of a comprehensive treatment plan approach based on age of the child, starting with the age one visit. Caries-risk assessment models currently involve a combination of factors including diet, fluoride exposure, a susceptible host, and microflora that interplay with a variety of social, cultural, and behavioral factors. Caries-risk assessment is the determination of the likelihood of the increased incidence of caries (i.e., new cavitated or incipient lesions) during a certain time period or the likelihood that there will be a change in the size or activity of lesions already present. With the ability to detect caries in its earliest stages (i.e., non-cavitated or white spot lesions), health care providers can help prevent cavitation.

Caries risk factors are variables that are thought to cause the disease directly (e.g., microflora) or have been shown useful in predicting it (e.g., life-time poverty, low health literacy) and include those variables that may be considered protective factors. The most-used caries risk factors include low salivary flow, visible plaque on teeth, high frequency sugar consumption, presence of appliance in the mouth, health challenges, socio-demographic factors, access to care, and cariogenic microflora. The presence of caries lesions, either non-cavitated or cavitated, also has been shown in numerous studies to be a strong indicator of caries risk. Clinical observation of existing caries lesions or restorations recently placed because of such lesions are best thought of as disease indicators, rather than risk factors, since these lesions do not cause the disease directly or indirectly but, very importantly, indicate the presence of the factors that cause the disease. Protective factors in caries risk include a child’s receiving optimally-fluoridated water, having teeth brushed daily with fluoridated toothpaste, receiving topical fluoride from a health professional, and having regular dental care.

Some limitations with the risk factors include the following:

- Past caries experience is not particularly useful in young children and activity of lesions may be more important than number of lesions.
- Low salivary flow is difficult to measure and may not be relevant in young children.
- Frequent sugar consumption is hard to quantitate.
- Socio-demographic factors are just a proxy for various exposures/behaviors which may affect caries risk.
- Predictive ability of various risk factors across the life span and how risk changes with age have not been determined.
Genome-level risk factors may account for substantial variations in caries risk.\textsuperscript{14} Risk assessment tools can aid in the identification of specific behaviors or risk factors for each individual and allow dentists and other health care professionals to become more actively involved in identifying and referring high-risk children. Tables 1 and 2 incorporate available evidence into practical tools to assist dental practitioners, physicians, and other non-dental health care providers in assessing levels of risk for caries development in infants, children, and adolescents. As new evidence emerges, these tools can be refined to provide greater predictably of caries in children prior to disease initiation. Furthermore, the evolution of caries-risk assessment tools and care pathways can assist in providing evidence for and justifying periodicity of services, modification of third-party involvement in the delivery of dental services, and quality of care with outcomes assessment to address limited resources and work-force issues.

**Care pathways for caries management**

Care pathways are documents designed to assist in clinical decision-making; they provide criteria regarding diagnosis and treatment and lead to recommended courses of action.\textsuperscript{15} The pathways are based on evidence from current peer-reviewed literature and the considered judgment of expert panels, as well as clinical experience of practitioners. Care pathways for caries management in children aged 0-2 and 3-5 years old were first introduced in 2011.\textsuperscript{16} Care pathways are updated frequently as new technologies and evidence develop.

Historically, the management of dental caries was based on the notion that it was a progressive disease that eventually destroyed the tooth unless there was surgical/restorative intervention. Decisions for intervention often were learned from unstandardized dental school instruction and then refined by clinicians over years of practice. It is now known that surgical intervention of dental caries alone does not stop the disease process. Additionally, many lesions do not progress, and tooth restorations have a finite longevity. Therefore, modern management of dental caries should be more conservative and includes early detection of non-cavitated lesions, identification of an individual’s risk for caries progression, understanding of the disease process for that individual, and active surveillance to apply preventive measures and monitor carefully for signs of arrest or progression.

Care pathways for children further refine the decisions concerning individualized treatment and treatment thresholds based on a specific patient’s risk levels, age, and compliance with preventive strategies (Tables 3 and 4). Such clinical pathways yield greater probability of success, fewer complications, and more efficient use of resources than less standardized treatment.\textsuperscript{15}
Content of the present caries management protocol is based on results of systematic reviews and expert panel recommendations that provide better understanding of and recommendations for diagnostic, preventive, and restorative treatments. Recommendations for the use of fluoridated toothpaste are based on four systematic reviews, dietary fluoride supplements are based on the Centers for Disease Control and Prevention’s fluoride guidelines, professionally-applied and prescription strength home-use topical fluoride are based on two systematic reviews, and the use of silver diamine fluoride to arrest caries lesions also is based on two systematic reviews. Radiographic diagnostic recommendations are based on the uniform guidelines from national organizations. Recommendations for pit and fissure sealants are based on two systematic reviews, with only the American Dental Association/AAPD review addressing sealants for primary teeth. Dietary interventions are based on a systematic review of strategies to reduce sugar-sweetened beverages. Caries risk is assessed at both the individual level and tooth level. Treatment of caries with interim therapeutic restorations is based on the AAPD policy and recommended best practices. Active surveillance (prevention therapies and close monitoring) of enamel lesions is based on the concept that treatment of disease may only be necessary if there is disease progression, and that caries can arrest without treatment.

Other approaches to the assessment and treatment of dental caries will emerge with time and, with evidence of effectiveness, may be included in future guidelines on caries-risk assessment and care pathways.

**Recommendations**

1. Dental caries-risk assessment, based on a child’s age, social/behavioral/medical factors, protective factors, and clinical findings, should be a routine component of new and periodic examinations by oral health and medical providers.

2. While there is not enough information at present to have quantitative caries-risk assessment analyses, estimating children at low, moderate, and high caries risk by a preponderance of risk and protective factors and disease indicators will enable a more evidence-based approach for referrals by medical providers, as well as establish periodicity and intensity of diagnostic, preventive, and restorative services.

3. Care pathways, based on a child’s age and caries risk, provide health providers with criteria and protocols for determining the types and frequency of diagnostic, preventive, and restorative care for patient-specific management of dental caries.
References


# Table 1. Caries-risk Assessment Form for 0-5 Years Old

Use of this tool will help the health care provider assess the child’s risk for developing caries lesions. In addition, reviewing specific factors will help the practitioner and parent understand the variable influences that contribute to or protect from dental caries.

<table>
<thead>
<tr>
<th>Risk factors, social/behavioral/medical</th>
<th>High risk</th>
<th>Moderate risk</th>
<th>Low risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother/primary caregiver has active dental caries</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent/caregiver has lifetime of poverty, low health literacy</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child has frequent exposure (&gt;3 times/day) between-meal sugar-containing snacks or beverages per day</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child uses bottle or non-spill cup containing natural or added sugar frequently, between meals and/or at bedtime</td>
<td></td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Child is a recent immigrant</td>
<td></td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Child has special health care needs(^\alpha)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk factors, clinical</th>
<th>High risk</th>
<th>Moderate risk</th>
<th>Low risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child has visible plaque on teeth</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child presents with dental enamel defects</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Protective factors</th>
<th>High risk</th>
<th>Moderate risk</th>
<th>Low risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child receives optimally-fluoridated drinking water or fluoride supplements</td>
<td></td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Child has teeth brushed daily with fluoridated toothpaste</td>
<td></td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Child receives topical fluoride from health professional</td>
<td></td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Child has dental home/regular dental care</td>
<td></td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Disease indicators(^\beta)</th>
<th>High risk</th>
<th>Moderate risk</th>
<th>Low risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child has non-cavitated (incipient/white spot) caries</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child has visible caries lesions</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child has recent restorations or missing teeth due to caries</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\(^\alpha\) Practitioners may choose a different risk level based on specific medical diagnosis and unique circumstances, especially conditions that affect motor coordination or cooperation.

\(^\beta\) While these do not cause caries directly or indirectly, they indicate presence of factors that do.

**INSTRUCTIONS**

Circle YES that corresponds with those conditions applying to a specific patient. Use the circled responses to visualize the balance among risk factors, protective factors, and disease indicators. Use this balance or imbalance, together with clinical judgment, to assign a caries risk level of low, moderate, or high based on the preponderance of factors for the individual. Clinical judgment may justify the weighting of one factor (e.g., heavy plaque on the teeth more than others).

**Overall assessment of the child’s dental caries risk:** High ☐ Moderate ☐ Low ☐

Adapted with permission from the California Dental Association, (Ramos-Gomez et al. 2007)\(^{33}\). Copyright © October 2007.
Table 2. Caries-risk Assessment Form for ≥6 Years Old

(For Dental Providers)

Use of this tool will help the health care provider assess the child’s risk for developing caries lesions. In addition, reviewing specific factors will help the practitioner and patient/parent understand the variable influences that contribute to or protect from dental caries.

<table>
<thead>
<tr>
<th>Factors</th>
<th>High risk</th>
<th>Moderate risk</th>
<th>Low risk</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Risk factors, social/behavioral/medical</strong></td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Patient has lifetime of poverty, low health literacy</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient has frequent exposure (&gt;3 times/day) between-meal sugar-containing snacks or beverages per day</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient is a recent immigrant</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient uses hyposalivatory medication(s)</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient has special health care needs&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Risk factors, clinical</strong></td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Patient has low salivary flow</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient has visible plaque on teeth</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient presents with dental enamel defects</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient wears an intraoral appliance</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient has defective restorations</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Protective factors</strong></td>
<td></td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Patient receives optimally-fluoridated drinking water</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient has teeth brushed daily with fluoridated toothpaste</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient receives topical fluoride from health professional</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient has dental home/regular dental care</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Disease indicators&lt;sup&gt;β&lt;/sup&gt;</strong></td>
<td></td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Patient has interproximal caries lesion(s)</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient has new non-cavitated (white spot) caries</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient has new cavitated caries lesions or lesions into dentin radiographically</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient has restorations that were placed in the last 3 years (new patient) or in the last 12 months (patient of record)</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<sup>a</sup> Practitioners may choose a different risk level based on specific medical diagnosis and unique circumstances, especially conditions that affect motor coordination or cooperation.

<sup>β</sup> While these do not cause caries directly or indirectly, they indicate presence of factors that do.

**INSTRUCTIONS**

Circle YES that corresponds with those conditions applying to a specific patient. Use the circled responses to visualize the balance among risk factors, protective factors, and disease indicators. Use this balance or imbalance, together with clinical judgment, to assign a caries risk level of low, moderate, or high based on the preponderance of factors for the individual. Clinical judgment may justify the weighting of one factor (e.g., heavy plaque on the teeth more than others.)

**Overall assessment of the dental caries risk:** High □ Moderate □ Low □

Adapted with permission from the California Dental Association, (Featherstone et al)<sup>34</sup>. Copyright © October 2007.
## Table 3. Example of a Caries Management Pathways for 0-5 Years Old

<table>
<thead>
<tr>
<th>Risk category</th>
<th>Diagnostics</th>
<th>Interventions</th>
<th>Dietary counseling</th>
<th>Sealants</th>
<th>Restorative</th>
</tr>
</thead>
</table>
| **Low risk**  | – Recall every six to 12 months  
– Radiographs every 12 to 24 months  
– Recall every six months  
– Radiographs every six to 12 months | – Drink optimally-fluoridated water  
– Twice daily brushing with fluoridated toothpaste  
– Fluoride supplements with fluoride-deficient water supplies  
– Twice daily brushing with fluoridated toothpaste | Yes  
– Surveillance | Yes  
– Yes | – Surveillance |
| **Moderate risk** | – Recall every three months  
– Radiographs every six months | – Professional topical treatment every six months  
– Drink optimally-fluoridated water (alternatively, take fluoride supplements with fluoride-deficient water supplies)  
– Twice daily brushing with fluoridated toothpaste  
– Professional topical treatment every three months  
– Silver diamine fluoride on cavitated lesions | Yes  
– Yes | – Active surveillance of non-cavitated (white spot) caries lesions  
– Restore of cavitated or enlarging caries lesions | – Interim therapeutic restorations (ITR) may be used until permanent restorations can be placed |
| **High risk** | – Recall every three months  
– Radiographs every six months | – Drink optimally-fluoridated water (alternatively, take fluoride supplements with fluoride-deficient water supplies)  
– Twice daily brushing with fluoridated toothpaste  
– Professional topical treatment every three months  
– Silver diamine fluoride on cavitated lesions | Yes  
– Yes | – Active surveillance of non-cavitated (white spot) caries lesions  
– Restore of cavitated or enlarging caries lesions | – Interim therapeutic restorations (ITR) may be used until permanent restorations can be placed |

**Notes for caries management pathways tables:**

Twice daily brushing: Parental supervision of a “smear” amount of fluoridated toothpaste twice daily for children under age 3, pea-size amount for children ages 3-6.

Surveillance: Periodic monitoring for signs of caries progression; Active surveillance: Active measures by parents and oral health professionals to reduce cariogenic environment and monitor possible caries progression.

Silver diamine fluoride: Use of 38 percent silver diamine fluoride to assist in arresting caries lesions; Informed consent particularly highlighting expected staining of treated lesions.

Sealants: The decision to seal primary and permanent molars should account for both the individual-level and tooth-level risks.
<table>
<thead>
<tr>
<th>Risk category</th>
<th>Diagnostics</th>
<th>Interventions</th>
<th>Dietary counseling</th>
<th>Sealants</th>
<th>Restorative</th>
</tr>
</thead>
</table>
| Low risk     | – Recall every six to 12 months  
– Radiographs every 12 to 24 months  
– Recall every six months  
– Radiographs every six to 12 months | – Drink optimally fluoridated water  
– Twice daily brushing with fluoridated toothpaste  
– Drink optimally fluoridated water (alternatively, take fluoride supplements with fluoride-deficient water supplies)  
– Twice daily brushing with fluoridated toothpaste  
– Professional topical treatment every six months  
– Silver diamine fluoride on cavitated lesions | Yes | Yes | – Surveillance |
| Moderate risk| – Recall every three months  
– Radiographs every six months | – Drink optimally fluoridated water (alternatively, take fluoride supplements with fluoride-deficient water supplies)  
– Brushing with 0.5 percent fluoride gel/paste  
– Professional topical treatment every three months  
– Silver diamine fluoride on cavitated lesions | Yes | Yes | – Active surveillance of non-cavitated (white spot) caries lesions  
– Restore of cavitated or enlarging caries lesions  
– Interim therapeutic restorations (ITR) may be used until permanent restorations can be placed |
| High risk    | – Recall every three months  
– Radiographs every six months | – Drink optimally fluoridated water (alternatively, take fluoride supplements with fluoride-deficient water supplies)  
– Brushing with 0.5 percent fluoride gel/paste  
– Professional topical treatment every three months  
– Silver diamine fluoride on cavitated lesions | Yes | Yes | – Active surveillance of non-cavitated (white spot) caries lesions  
– Restore of cavitated or enlarging caries lesions  
– Interim therapeutic restorations (ITR) may be used until permanent restorations can be placed |

**Notes for caries management pathways tables:**

Twice daily brushing: Parental supervision of a pea-size amount for children 3-6 years of age.

Surveillance: Periodic monitoring for signs of caries progression; Active surveillance: Active measures by parents and oral health professionals to reduce cariogenic environment and monitor possible caries progression.

Silver diamine fluoride: Use of 38 percent silver diamine fluoride to assist in arresting caries lesions. Informed consent particularly highlighting expected staining of treated lesions.

Sealants: Although studies report unfavorable cost/benefit ratio for sealant placement in low caries risk children, expert opinion favors sealants in permanent teeth of low-risk children based on possible changes in risk over time and differences in tooth anatomy. The decision to seal primary and permanent molars should account for both the individual-level and tooth-level risks.